STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215183	A. Building B. Wing	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fayette Health and Rehabilitation Center	1217 West Fayette Street Baltimore, MD 21223

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. 44440 Based on interviews and record review it was determined that the facility failed to honor the rights, delegated to a Resident's Representative by informing them of changes to the plan of care. This was found evident of 1 (Resident #77) of 9 residents reviewed for advanced directive during an annual and complaint survey. The finding include: On 3/19/24 at 10:08 AM, the surveyor reviewed Resident #77's medical records. The review revealed that Resident #77 was admitted to the facility in early August 2023. Further review revealed on 9/8/23 and on 9/11/23 two providers evaluated Resident #77 and documented their findings on a form titled, Physician Certification Related to Medical Condition, Substitute Decision Making, and Treatment limitations. Both providers evaluated that Resident #77 was unable to understand and sign admission documentation, unable to understand the nature, extent or probable consequences of the proposed treatment, and unable to make a rational evaluation of the burdens, risks, and benefits of the treatments. Both Providers deemed Resident #77 incapable of making an informed decision regarding the provision of withholding or withdrawing of all medical treatments. The provider on 9/8/23 checked that Resident #77 was unable to appoint a health care representative and the Provider on 9/11/23 checked that Resident #77 was able to appoint a health care representative. On 3/25/24 at 10:52 AM, the surveyor reviewed the social history assessment completed by the Social Worker's Assistant Staff #17. The assessment was completed after Resident #77's was readmitted to the facility in October of 2023. Staff #17 indicated that Resident #77 had decision making-capacity and no name was written in the section Resident's health care proxy or agent. On 3/25/24 at 11:17 AM, the surveyor interviewed the Social Worker Staff #16 and Social Worker Assistant Staff #17. The surveyor showed the social history form to Staff #16. Staff #16 stated Resident #77 came in as his own decision maker but currently his/her ex-significant other is the decision maker. She further stated the Resident #77 was evaluated by his/her provider and is currently unable to make decisions. She further stated that in order to change that decision a new evaluation would have to be completed. The surveyor asked for documentation to validate this information. The surveyor informed Staff #16 that currently the contact information in Resident #77's medical record states Resident #77's Representative as Self/Resident and listed as emergency contact as Resident #77's ex- spouse. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/25/24 at 11:35 AM, the surveyor reviewed Resident #77's recent change of condition evaluations. On 11/12/23 Resident #77 made an allegation of abuse and was injured. The name of the family/resident representative notified was Resident #77's ex-spouse. The following change of condition was written on that same day, also notified the ex-spouse of Resident #77's non-compliance with treatment of the injury. On 12/12/23 Resident #77 had an increase to his/her methadone (a medication prescribed to treat narcotic drug addiction). In the summary section it stated Nurse Practitioner (NP) notified and the Resident is his/her own Responsible Person (RP). On 2/2/24 the summary of Resident #77's change of condition summarizes that Resident #77's potassium was low, the NP is aware, and Resident is his/her own RP. On 2/6/24 Resident #77's methadone was increased again and in the change of condition summary it stated NP aware, and Resident is his/her own RP. On 3/25/24 at 1:11 PM, the surveyor interviewed Licensed Practical Nurse (LPN) Staff #38. During the interview, Staff #38 stated when needing to communicate plan of care changes to the Resident's responsible party, she would look at the face sheet. She further stated the face sheet has an area that indicates who the Resident's Representative is and if they are unable to be reached then the next person listed should be contacted. On 3/25/24 at 12:07 PM, the surveyor conducted an interview with the Nursing Home Administrator (NHA). During the interview the NHA stated she was under the impression that Resident #77 was not capable of making medical decisions. She further stated that a surrogate form should be filled out to indicate who is to help make the decision for the resident and the social services staff should have had this filled out.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 14894 Based on a review of clinical records, staff interview, and an investigation of Intake #MD00203099 it was determined that the facility staff failed to ensure a resident's personal and medical information. That was placed in another resident's clinical record. This was evident for 1 (#382) out of 48 residents in the survey sample. The findings include: A review of Resident #382's clinical record on 4/3/24 at 10:50 AM revealed that a discharge summary and Preadmission Screening and Resident Review (PASRR) form for Resident #41 was present. Interviewed the Administrator 4/3/24 at 12:12 PM. Showed the attached personal information and she stated that it should not be there.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 49815 Based on record review, review of facility incidents, and interviews it was determined that the facility failed to ensure that a resident was free from verbal abuse. This was found to be evident for 2 (Resident #24 and #78) out of 9 residents reviewed for abuse. The findings include: 1) On 3/20/24 at 12:18 PM, the surveyors reviewed the Facility Reported Incident (FRI) dated 11/27/23 that had an allegation of verbal abuse against Resident #24. The resident alleged that the Registered Nurse (RN) used profane words and was dismissive when he/she advised the RN that he/she had a cold room.The statement obtained by the facility during their investigation revealed an admission from the RN that she had used profanity and was dismissive of the resident's concern. The surveyors reviewed the facility's Policies and Standard Procedures for Abuse on 3/20/23 at 12:45 PM. The definition of verbal abuse means the use of oral, written, or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents, or within hearing distance, regardless of their age, ability to comprehend, or disability. On 3/19/23 at 8:20 AM the surveyors conducted an interview with Resident #24 who did not recall that the incident occurred but stated, that the staff was rude. The surveyors conducted an interview with the Nursing Home Administrator (NHA) on 3/21/24 at 12:15 PM about the allegation of verbal abuse. During the interview the NHA stated that she vaguely remembered the incident that occurred with the resident and the nurse. NHA stated that she and her corporate office felt as though there was no intent of the verbal abuse by the nurse and that was why the NHA concluded that the allegation could not be verified; therefore, the allegation of verbal abuse was unsubstantiated. The NHA added that the nurse felt very remorseful and did not mean to cause agitation to the resident by her response to him/her. On 3/22/24 at 10:58 AM the NHA provided the surveyors with the In-Service Training Report and in-service content dated 11/30/23 that RN #60 received for abuse training. 14894 2) An investigation of intake #MD00203099 on 3/20/24 revealed the Administrator was informed by an anonymous caller on 2/2/24 that a video was being circulated online of an alleged verbal abuse of a resident by a staff member. The staff members were interviewed and there were no witnesses of the alleged abuse. The allegation was verified as evident of staff witnessing the alleged verbal abuse of video. Staff education and in-service on abuse was conducted on 2/2/24. Resident reported to staff on 2/2/24 that he/she did not feel disrespected in any way. The Director of Nursing (DON) was interviewed on 3/20/24 at 10:42 AM. Another resident recorded the incident and posted it. That resident then took it down. Staff member was terminated as a result. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Administrator was informed of the findings and the conclusion on 4/2/24 at 10:05 AM. She said she was aware of the incident and understood it as a concern.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49815 Based on interviews and medical record review, it was determined that the facility failed to have an effective system in place to ensure that residents and resident representatives are notified in writing of the bed hold policy upon transfer to the hospital. This was found to be evident for 4 (Residents #16, #63, #109, and #117) out of 6 residents reviewed for hospitalization during the annual survey. The findings include: A Bed Hold is the act of holding or reserving a resident's bed while the resident is absent from the facility for therapeutic leave or hospitalization . It must be provided to all facility residents regardless of payment source. Bed Hold policy should be disclosed in the admission packet during initial admission to the facility and it should be disclosed to resident and, if applicable, resident representatives at the time of transfer; if emergency transfer, within 24 hours. 1) On 3/28/24 at 9:40 am the surveyor conducted a review of Resident #16's medical record. According to the documentation in the medical record Resident #16 called 911 on 3/6/24 to be transferred to the hospital. Resident #16 is his own responsible party and there was no emergency contact listed. Further review of the medical record by the surveyor on 4/1/24 at 8:48 am failed to indicate that the bed hold was offered to Resident #16 upon transfer, and there was no documentation of Resident #16 being offered a bed hold in his/her physical chart on the nursing unit. On 4/1/24 at 8:50 am the surveyor interviewed Licensed Practical Nurse (LPN) #43 in reference to the procedure to offer a bed hold to a Resident upon transfer to the hospital. LPN #43 stated that she completes the information on the etransfer form in the computer and that she has only transferred one Resident to hospital since she has been employed here at facility. LPN #43 stated that she did not offer Resident a bed hold. At 8:54 am on 4/1/24 the surveyor interviewed LPN #6 in reference to the procedure to offer a bed hold to a Resident upon transfer to the hospital. LPN #6 stated that she will document the note in the electronic medical record within 4 hours if the Resident stayed in the hospital or returned to the facility. LPN #6 further stated that she did not offer Residents a bed hold upon transfer to hospital. During an interview conducted by the surveyor with the Nursing Home Administrator (NHA) on 4/2/24 at 9:02 am, the NHA stated that the expectation for staff was to offer and document bed holds to Residents or their responsible parties upon transfer to hospital. The surveyor conveyed to the NHA the response from the two nurses regarding the bed hold process. NHA further stated that she was unable to locate any documentation that staff offered a bed hold to Resident #16 upon transfer to hospital on 3/6/24. 48393 (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) On 03/22/2024 at 08:13 AM, a review of Resident #63's electronic and paper medical record revealed that Resident #63 was transferred to the hospital on 02/17/2023 due to abdominal pain and vomiting. Further review of Resident #63's medical record revealed no documentation that the resident/resident representative was given a copy of the bed hold policy. 03/25/24 08:35 AM, an interview conducted with RN #4 regarding the bed hold policy. RN #4 confirmed that a copy of the bed hold policy for Resident #63 was not in the medical record. RN #4 stated that the social worker reviews the bed hold policy with the resident during the admissions process. RN #4 further stated that he/she verbally lets the resident know that their bed will be held for 24 hours when they transfer and that he/she does not give the resident a copy of the bed hold policy. On 03/25/24 08:40 AM, an interview was conducted with the Director of Nursing (DON) #4. DON #4 confirmed that the social worker reviews the bed hold policy with the resident once, on admission. DON #4 further confirmed that the nursing staff does not provide written notice of the bed hold policy to residents when they transfer out of the facility. On 03/25/2024 at 11:26 AM, an interview was conducted with the Social Worker #16. Social Worker #16 stated, We don't go over bed holds on admission, that is nursing. On 03/25/24 at 11:32 AM, an interview was conducted with the Administrator. The Administrator stated that nursing should offer a written copy of the bed hold policy when the resident goes out to hospital. The Administrator further stated that the Admissions department should be reaching out to the resident within 24 hours of transfer to let him/her know they may not be going back to the same room when they return to the facility. At the time of exit conference, the facility did not provide any evidence that a copy of the bed hold policy was given to Resident #63 and the resident'ss representative. 3) On 03/22/2024 at 08:13 AM, a review of Resident #109 's electronic and paper medical record revealed that Resident #109 was admitted to the facility on [DATE] and transferred to the hospital on 1/10/2024 due to the facility not having appropriate respiratory equipment on hand. Further review of Resident #109's medical record revealed no documentation that the resident/resident representative was given a copy of the bed hold policy. 03/25/24 08:35 AM, an interview conducted with RN #4 regarding the bed hold policy. RN #4 confirmed that a copy of the bed hold policy for Resident #63 was not in the medical record. RN #4 stated that the social worker reviews the bed hold policy with the resident during the admissions process. RN #4 further stated that he/she verbally lets the resident know that their bed will be held for 24 hours when they transfer and that he/she does not give the resident a copy of the bed hold policy. On 03/25/24 08:40 AM, an interview was conducted with the Director of Nursing (DON) #4. DON #4 confirmed that the social worker reviews the bed hold policy with the resident once, on admission. DON #4 further confirmed that the nursing staff does not provide written notice of the bed hold policy to residents when they transfer out of the facility. On 03/25/2024 at 11:26 AM, an interview was conducted with the Social Worker #16. Social Worker #16 stated, We don't go over bed holds on admission, that is nursing. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/25/24 at 11:32 AM, an interview was conducted with the Administrator. The Administrator stated that nursing should offer a written copy of the bed hold policy when the resident goes out to hospital. The Administrator further stated that the Admissions department should be reaching out to the resident within 24 hours of transfer to let him/her know they may not be going back to the same room when they return to the facility. At the time of exit conference, the facility did not provide any evidence that a copy of the bed hold policy was given to Resident #109 and the resident's representative. 14894 4) A review of Resident #117's clinical record on 3/21/24 revealed that the resident was sent to the hospital on 3/9/24. There was no documentation that the resident was provided with a copy of the facility bed hold policy at the time of being sent out or having the policy sent to the hospital at a later time. The Administrator and Regional Clinical Director was interviewed on 4/2/24 at 11:00 AM. Informed them of the concern as well as the need to inform the residents and reminded the Administrator that I had requested the bed hold notice days earlier. They did not dispute the findings or provide any evidence that the resident was notified.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49815 Based on staff interview and medical record review, it was determined that the facility failed to accurately document resident assessment on the MDS (Minimum Data Set) as evidenced by the inaccurate coding for residents. This was found to be evident for 4 out of 6 Residents (#13, #16, #24, & #28) reviewed for accuracy of MDS assessments. The findings include: The MDS (Minimum Data Set) is a health status screening and assessment tool used for all residents of long-term care nursing facilities. The MDS is part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes. This process provides a comprehensive assessment of each resident's functional capabilities and helps nursing home staff identify health problems. Hemodialysis is a process of filtering the blood of a person whose kidneys are not working normally and is a treatment to filter wastes and water from the blood, as the kidneys did when they were healthy. Hemodialysis helps control blood pressure and balance important minerals, including potassium, sodium, and calcium in the blood. 1) On 03/18/24 at 9:59 AM, the surveyor conducted medical record review for Resident #16. The medical record revealed that Resident #16 had a medical diagnosis of ESRD (End Stage Renal Disease) and was dependent on dialysis as documented in the Medical Diagnosis tab of the electronic medical record. Further review of the medical record on 3/25/24 at 11:40 AM, revealed that Resident #16 had a quarterly MDS assessment dated [DATE]. Section I of the MDS had a diagnosis of Dependence on Renal Dialysis listed, but Section O of the MDS had dialysis not checked. On 4/3/24 at 12:50 PM the surveyor reviewed Resident #16's MDS assessment dated [DATE] with the NHA (Nursing Home Administrator) and explained that Section I of the MDS assessment had a diagnosis of Dependence on Renal Dialysis, but Section O of the MDS did not indicate that the resident received dialysis. The NHA confirmed that Resident #16 did not receive dialysis. 2) On 3/27/24 at 7:15 AM a review of Resident #28's medical record by the surveyor revealed an annual MDS assessment dated [DATE]. Section J had documented that the resident's Health Condition for Current Tobacco Use is checked as, no. Further review of the medical record revealed that the resident had Smoking Assessments completed on the following dates 11/7/22, 11/29/22, 10/18/23, and 2/17/24 which indicated that the resident uses nicotine. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/3/24 at 11:20 AM the surveyor reviewed Resident #28's MDS assessment dated [DATE] with the Lead MDS Coordinator (Staff #46) via telephone interview and in the presence of the NHA. The surveyor explained that, no, was checked on the MDS for Tobacco use, and that the four smoking assessments indicated that the resident uses nicotine. The Lead MDS Coordinator (#46) stated that she was not aware that the resident is a smoker. 3) On 4/1/24 review of the Resident #24's medical record by the surveyor revealed that the resident had a medical diagnosis of Depression and Anxiety disorder, unspecified as documented on the encounter progress note dated 1/20/24 by the psychiatric Nurse Practitioner (NP #51) from Brighter Days Recovery Center. The quarterly MDS assessment dated [DATE] Section I did not have Anxiety Disorder or Depression checked as active diagnoses, but Section N did have antianxiety and antidepressant medication checked as being used by the resident. On 4/3/24 at 11:20 AM the surveyor reviewed Resident #24's MDS assessment dated [DATE] with Lead MDS Coordinator (#46) via telephone interview and in the presence of the NHA. The surveyor explained that Section I of the MDS assessment did not indicate that the resident has an active diagnosis of depression and anxiety disorder, and Section N of the MDS indicated that the resident does receive antianxiety and antidepressant medications. The Lead MDS Coordinator (#46) stated, I see that, error on our part, can we do a modification. 45733 4) During observation and interview, on 03/18/24 at 10:06 AM, Resident #13 was in a sitting upright position with visible two above-the-knee stumps. The resident reported he/she had bilateral above knee amputations several years ago but could not remenber what year. Record review, on 3/26/24 at 3:11 PM, of Resident #13's MDS assessment found that the resident had the following diagnoses: bilateral above knee amputations, mood disturbance and anxiety. Resident #13's two MDS assessments contained the following documentation: Dated 9/26/23 by MDS Staff #34 under GG section -H putting on/off footwear was coded maximal assistance. Dated 12/26/23 by MDS Staff #23 under GG section -H putting on/off footwear was coded maximal assistance. However, Resident #13 had bilateral above knee amputation years ago and did not have protheses. During an interview, on 3/27/24 at 11:50 AM, the MDS Coordinator (Staff #23) stated that she oversaw the putting on/off footwear section and miscoded the level of assistance was maximal. During interview, on 3/27/24 at 12:50 AM, the Administrator stated that she was not aware of the MDS incorrect coding under the GG section, letter H and agreed that it was an MDS coding error.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 44440 Based on interviews, record review, and observation it was determined that the facility failed to provide wound care treatments according to professional standards. This was found evident of 4 (Resident #101, #21, #332, and #74) of 6 Residents reviewed for skin and wound care. The findings include: 1) On 3/22/24 at 11:54 AM, the surveyor interviewed Resident #101 along with his/her significant other. During the interview Resident #101 stated his/her significant other was performing the wound care and that he/she was content with this arrangement. Resident #101's significant other stated he/she had no problem with providing the wound care. He/she further stated that until recently the facility's wound nurse would watch and evaluate the wounds while they were being changed; however, the wound nurse had not been in for several weeks and since then no other staff had watched the wound dressing change. On 3/26/24 at 9:53 AM, the surveyor reviewed Resident #101's care plan. On 2/14/24 a care plan was initiated that stated Resident #101 had his/her wound care treatment preference. On 7/27/23 an intervention was initiated that stated; evaluate existing wound daily for changes (redness, edema, drainage, pain and foul odor). On 3/26/24 at 1:35 PM, the surveyor reviewed the progress notes for Resident #101. On 2/13/24 at 4:19 PM, Wound Nurse Staff #39, wrote a progress note and documented the size, skin characteristic and drainage of all 5 of Resident #101's wounds. She wrote treatment for the resident's right foot wound would change and ended her note by writing, nursing to continue with the current plan of treatment for the rest of the wounds. On 2/20/24 a progress note written by Wound Nurse Practitioner Staff # 40 documented an assessment on all 5 of Resident #101's wounds. The assessment included size, skin characteristics and drainage. The assessment documented that Resident #101's right toe wound status was resolved and the other 4 were either stable or stalled. On 3/22/24 at 11:22 AM the surveyor reviewed a progress note written by Staff # 40. In this progress note Staff #40 wrote; the wound was not seen. If further stated; patient was unable to be evaluated by the skin and wound team today; patient refused care today. The notes next stated, Staff reports [significant other] has been completing wound dressing changes. On 3/6/24 at 10:38 AM, the surveyor interviewed Licensed Practical Nurse (LPN) Staff #45. During the interview staff #45 stated the facility used to have a wound nurse who would perform the wound care but a few weeks ago she left. He further stated the nurses are now doing their Resident's wound cares. Staff #45 stated the wound Nurse Practitioner still comes once a week and does wound care evaluations and is responsible for measurements of the wounds to keep consistent documentation. He further stated the nurse should assess the wound each dressing change and notify the provider if there are any changes. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of Resident #101's medical record revealed wound care signed off on the Resident #101's Treatments Administration Record (TAR) however, no size, skin characteristic or drainage was noted since the 2/20/24 progress note written by NP Staff #40. On 3/28/24 at 9:23 AM, the surveyor interviewed the Nursing Home Administrator (NHA) along with Resident #101's Nurse Practitioner Staff # 41 about the lack of wound documentation. During this interview the NHA confirmed that on 2/27/24 the facility's wound nurse no longer worked at the facility and that the nurses are expected to provide their Resident's wound care Staff #41 stated that Resident #101 should have had his/her wounds assessed and documentation of that assessment should be in the medical record. On 4/1/24 at 7:30 AM, the surveyor reviewed the facility's Skin Care and Wound Treatment policy the NHA provided when asked for skin and wound policy. The policy was specific to a skin tear wound (a laceration of the epidermis (superficial layer of the skin)). In the policy it states that documentation of the wounds measurements and characteristics should be completed no less than weekly. At the time of exit no additional assessments were provided with wound care assessments. 2) On 3/25/24 at 7:59 AM, the surveyor reviewed Resident #21's medical record. The review revealed in March the Wound Nurse Practitioner (NP) Staff #40 evaluated Resident #21's left ankle wound on 3/5/24, 3/12/24 and attempted to 3/22/24 but was unable to due to Resident #21 not present in the facility at the time of the visit. On further review no documentation of Resident #21's wounds measurements were found after the 3/12/24 visit from the wound NP. On 3/25/24 at 1:20 PM, the surveyor interviewed Resident #21. During the interview Resident #21 stated that during the night he/she had to remove his/her sock because the left leg started to hurt. He/she told the night nurse and she changed the dressing on his/her left leg wound. Resident #21 further stated that the Nurse Practitioner Staff #41 was in to see the wound and told him/her she would be starting antibiotics due to the leg wound infection. The surveyor observed Resident #21's left leg. The leg appeared red, swollen and Resident #21 reported it be hot to touch. On 3/25/24 at 1:26PM, the surveyor reviewed the orders. Resident #21 had an order placed on 3/25/24 for clindamycin (antibiotic) described for cellulitis (skin infection). On 3/26/24 at 9:23 AM, the surveyor reviewed Resident #21's March Treatment Administration Record (TAR). The TAR had a chart to document daily assessment of the left ankle wound. Drainage, dressing, infection, necrotic (dead) tissue present, odor, surrounding skin, and pain at wounds site were to be assessed. Instructions were Y=yes, N=No and specifically for surrounding skin, N=normal A=abnormal and level of pain. On further review NA was documented in all the assessment boxes on three of the days in March. On three additional days the boxes were left blank and on 3/14/24 0 was in all of the assessment boxes. On 3/25/24 and 3/26/24 the assessment for infection was documented no and the assessment for surrounding skin was normal even as the Resident was on antibiotics for the infection. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215183	A. Building B. Wing	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fayette Health and Rehabilitation Center	1217 West Fayette Street Baltimore, MD 21223

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/28/24 at 9:28 AM, the surveyor conducted an interview with the Regional Director of Clinical Operations Staff #20. During the interview the concern of lack of and inaccurate wound documentation was discussed. Staff #20 stated he would look into the documentation and return with the rationale the documentation. At the time of exit not additional information was provided. 3) On 3/22/24 at 7:41 AM, the surveyor reviewed Resident #332's medical record. The record revealed that in late February Resident #332 was discharged from a hospital and readmitted to the facility. On further review Resident #332 was seen by the Wound Nurse Practitioner (NP) Staff # 40 on 3/1/24. Staff #40 evaluated Resident #332's wounds. Resident #332's right hand and right ischium (back/hip) wound had measurement and treatment recommendation and his/her left heel wound was assessed as resolved. On 3/26/24 at 10:46 AM, the surveyor observed Resident #332 in the hallway. Resident #332's right hand had a dressing covering his/her hand and forearm. The dressing was dated 3/22/24 to indicate when it was last changed. On 3/27/24 at 11:39 AM, the surveyor reviewed additional wound notes written by Staff NP #40. The note written on 3/22/24 stated Resident #332's skin and wound was not seen. It further stated; patient was unable to be evaluated by skin and wound team today; primary nurse reported he already completed wound dressing. The note written on 3/26/24 stated skin and wound was not seen again and that Resident was in the hallway and when asked to return to his room for the dressing change did not comply. After returning to attempt dressing change again Resident #332 was not available. No documentation of wound measurements or skin characteristics were found between these missed dressing changes. On 3/27/24 at 11:45 AM, the surveyor reviewed the wound care orders for Resident #332. No wound care order was found for Resident #332's right hand wound. No documentation was found on the Treatment Administration Record (TAR) for Resident #332's right hand wound. On 3/28/24 at 9:19 AM, the surveyor conducted and interview with Nurse Practitioner Staff #41 and the Nursing Home Administrator (NHA). During the interview Staff #41 stated that the wound Nurse Practitioner will write recommendations for dressing changes in her note and sometimes the wound nurse working with her will write the orders. Staff #41 confirmed if a wound care needs to be done there should be an order for it in the medical record. The NHA stated currently the facility does not have a dedicated wound nurse. She reported the wound nurse they had left on February 27th. On 3/29/24 at 1:55 PM, the surveyor conducted an interview with the wound Nurse Practitioner Staff #40. During the interview the surveyor asked Staff #40 how wound care orders get placed. Staff #40 confirmed that the nurse she works with writes verbal orders for the wound treatment. Staff #40 was not aware Resident #332 did not have right arm treatment orders. 47758 4) During an interview with a complainant on 3/18/24 at 8:27 AM the surveyor was informed that the facility had to be reminded to perform bandage changes on Resident #74 or they were not completed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215183	A. Building B. Wing	04/03/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review by the surveyor on 3/21/24 at 7:10 AM, revealed that Resident #74 had 12 out of 60 wound care dressing changes for September of 2023 that were not documented as completed on the Treatment Administration Record. During an interview on 3/21/2024 at 8:55 AM, the Director of Nursing (DON) was informed of the concern that 12 out of 60 dressing changes were not documented as complete on Resident #74 in September of 2023. She stated 12 missing doses out of 60 was a lot and she would look for documentation in the record and that it may have been documented by the wound nurse. The DON returned on 03/21/2024 at 10:33 AM and stated that she found notes related to two of the dressing changes for Resident #74, but I would have expected to find notes for all wound cares that were not completed. She further stated that staff would be educated on documentation and wound care requirements.