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	08/14/2025

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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, it was determined that the facility's nursing staff failed to ensure that an newly admitted resident (resident #17) had a complete discharge summary from the local hospital. This failure to have a complete discharge summary from the local hospital led to the facility being unsure if they had the complete list of medications needed for the resident's care. This was evident for 1 of 2 residents reviewed for neglect during a complaint survey. The findings include:On 8/12/25 at 8:00am, the surveyor reviewed complaint MD00210531/ IQIES 342276 which alleged that the facility failed to provide continuous oxygen to resident #17 when he/she was admitted to the facility on the evening of 10/3/24. Resident #17 had a family member call 911 for assistance and the resident was transferred to the local hospital on [DATE]. On 8/12/25 at 8:10am, surveyor review of resident #17's medical records revealed the resident was admitted from the local hospital with a portable oxygen tank that was administering 3 liters of oxygen though a nasal cannula. Further review of the medical record revealed that the resident complained of the tank being empty at 11:15pm on 10/3/24. The oxygen tank was replaced and the resident's oxygen saturation levels were measured at 98%. Continued review of resident #17's medical record on 8/12/24 at 8:45am revealed that an emergency transport (911) came to the facility on [DATE] at approximately 4:30am to transport the resident to the local hospital after the resident's family called for assistance. Facility nursing staff assessed the resident and discovered that the resident's oxygen saturation level was 84%. Facility nursing staff exchanged the nasal cannula with a re-breather mask. The resident's oxygen saturation level remained at 84%. The resident was transferred to the local hospital for treatment. Further review of resident #17's medical record on 8/12/24 at 9:00am revealed that the nursing staff consulted a telehealth provider on 10/3/24 at approximately 11:30pm to reconcile the medication list provided on the discharge summary and to order medications necessary for the resident's stay. The provider ordered a breathing treatment that was listed on the resident's discharge summary that was needed every 8 hours. Surveyor review of resident #17's discharge instructions on 8/13/24 at 2:30pm revealed the scanned document was not complete. The surveyor observed that the document was split between two scanned documents. The 1st part of the discharge summary was pages 1-17. The second part of the discharge summary was pages 18-36. The surveyor observed that the 2nd part of the discharge summary was missing pages 21-24 and 25-26. Surveyor review of resident #17's orders revealed no evidence of an oxygen administration order. Surveyor interview of LPN #45 on 8/13/25 at 3:15pm revealed that LPN #45 did not remember resident #17 even after the surveyor reminded LPN #45 that he/she wrote the resident's change in condition note 10/4/24. He/she stated that when new residents are admitted to the facility, the admitting nursing staff would assess the resident for the admission records. If the resident came to the facility after the providers left the facility for the day, nursing staff would call the telehealth provider (Convergence) to verify the medications from the hospital discharge summary, if necessary. The telehealth provider would also order any medications needed for the resident at that time. Surveyor interview of RN #46 on 8/13/25 at 3:55pm revealed that RN #46 also did not remember resident #17 even after the surveyor reminded RN #46 that he/she wrote the admission note on 10/3/24. The surveyor asked RN#46 why would an admitting resident be using an oxygen tank instead of an oxygen concentrator. RN#46 stated that the oxygen tank would be used during the initial assessment of the resident and eventually switched to an oxygen concentrator after the assessment by the provider. During an interview of the Executive Director (ED), Director of Nursing (DON), and Regional Clinical Director #44 on 8/13/25 at 4:15pm, the surveyor stated that a review of resident #17's medical record revealed that the resident did not have an oxygen administration order and the local hospital's discharge summary was missing pages in the scanned version of the discharge summary. The ED stated that the resident's paper records would be searched for the complete discharge summary and the oxygen order. The surveyor asked the group if nursing staff were responsible for ensuring that any discharge summaries were complete. Regional Clinical Director #44 confirmed that it is a shared responsibility for nursing staff and providers to ensure that a resident's discharge summaries are complete. Regional Clinical Director #44 also stated that every resident that required oxygen must have an order for oxygen administration. On 8/14/25 at 9:00am, interview of the ED, DON and Regional Clinical Director #44 confirmed that resident #17's medical records failed to contain an order for oxygen administration and a complete discharge statement from the local hospital. The ED also confirmed that the nursing staff and the provider failed to confirm that the discharge

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. (continued on next page)

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, the facility's nursing staff and telehealth provider failed to ensure that a newly admitted resident with respiratory issues (resident #17) had an order for oxygen administration. This was evident for 1 of 2 residents reviewed for neglect during a complaint survey. The findings include:On 8/12/25 at 8:00am, the surveyor reviewed complaint MD00210531/ IQIES 342276 which alleged that the facility failed to provide continuous oxygen to resident #17 when he/she admitted to the facility on the evening of 10/3/24. Resident #17 had a family member call 911 for assistance and the resident was transferred to the local hospital on [DATE]. On 8/12/25 at 8:10am, surveyor review of resident #17's medical records revealed the resident was admitted from the local hospital with a portable oxygen tank that was administering 3 liters of oxygen though a nasal cannula. Further review of the medical record revealed that the resident complained of the tank being empty at 11:15pm on 10/3/24. The oxygen tank was replaced and the resident's oxygen saturation levels were measured at 98%. Continued review of resident #17's medical record on 8/12/24 at 8:45am revealed that an emergency transport (911) came to the facility on [DATE] at approximately 4:30am to transport the resident to the local hospital after the resident's family called for assistance. Facility nursing staff assessed the resident and discovered that the resident's oxygen saturation level was 84%. Facility nursing staff exchanged the nasal cannula with a re-breather mask. The resident's oxygen saturation level remained at 84%. The resident was transferred to the local hospital for treatment. Further review of resident #17's medical record on 8/12/24 at 9:00am revealed that the nursing staff consulted a telehealth provider on 10/3/24 at approximately 11:30pm to reconcile the medication list provided on the discharge summary and to order medications necessary for the resident's stay. The provider ordered a breathing treatment that was listed on the resident's discharge summary that was needed every 8 hours. Surveyor review of resident #17's discharge instructions on 8/13/24 at 2:30pm revealed the scanned document was not complete. The surveyor observed that the document was split between two scanned documents. The 1st part of the discharge summary was pages 1-17. The second part of the discharge summary was pages 18-36. The surveyor observed that the 2nd part of the discharge summary was missing pages 21-24 and 25-26. 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The surveyor asked RN#46 why would an admitting resident be using an oxygen tank instead of an oxygen concentrator. RN#46 stated that the oxygen tank would be used during the initial assessment of the resident and eventually switched to an oxygen concentrator after the assessment by the provider. During an interview of the Executive Director (ED), Director of Nursing (DON), and Regional Clinical Director #44 on 8/13/25 at 4:15pm, the surveyor stated that a review of resident #17's medical record revealed that the resident did not have an oxygen administration order and the local hospital's discharge summary was missing pages in the scanned version of the discharge summary. The ED stated that the resident's paper records would be searched for the complete discharge summary and the oxygen order. The surveyor asked the group if nursing staff were responsible for ensuring that any discharge summaries were complete. Regional Clinical Director #44 confirmed that it is a shared responsibility for nursing staff and providers to ensure that a resident's discharge summaries are complete. Regional Clinical Director #44 also stated that every resident that required oxygen must have an order for oxygen administration. On 8/14/25 at 9:00am, interview of the ED, DON and Regional Clinical Director #44 confirmed that resident #17's medical records failed to contain an order for oxygen administration and a complete discharge statement from the local hospital. The ED also confirmed that the nursing staff and the provider failed to confirm that the discharge summary from the hospital was complete. The ED also confirmed that the telehealth provider failed to issue an oxygen administrator order for the resident after chart