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	12/01/2025

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 0839 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Employ staff that are licensed, certified, or registered in accordance with state laws. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Complaint #2625762, employee file reviews, and facility staff interviews, and facility documentation, it was determined that the facility failed to employ Licensed Practical Nurses in accordance with Maryland State laws. This was found evident for 2 (LPN #8 and LPN #14) out of 4 employees reviewed for appropriate licensures during the survey.The facility continued to employ LPN # 8 and LPN # 14 after the initial identification of non-recognized licensure on 4/3/24 through 11/21/25. Residents were at risk for improper care or negligence when their care was not provided by qualified licensed personnel, therefore The Maryland Office of Health Care Quality (OHCQ) determined this concern met the Federal definition of Immediate Jeopardy and the facility was notified in writing on 11/21/25 at 2 PM. The facility submitted a plan for removal of the immediacy on 11/21/25 at 7:20 PM and it was accepted by the state agency at 7:30 PM. The deficient practice remained with the potential for more than minimal harm at a scope and severity of E. The findings include:On 11/19/25 at 7:15 AM, the surveyor reviewed complaint #2625762 which alleged that licensed practical nurse (LPN) #8 was employed as an LPN at the facility without an active license.Surveyors identified that LPN #8 was not licensed to be employed as an LPN during a Recertification survey on 4/3/24 and cited F839. Review of LPN #8's personnel file revealed that she/he currently does not have licensure to practice in Maryland as an LPN.The state of Maryland's Board of Nursing (MBON) does not recognize LPN #8 license due to graduation from a program that is not recognized and approved by the Board.A record review on 11/20/25 at 7:30 AM of LPN #8's personnel file, provided by the Human Resources Representative (HR rep) on 11/19/25 at 11:30 AM, showed LPN #8's State Identification Card issued in Virginia. LPN #8's personnel file also listed his/her primary address as Maryland.An Interview with the Nursing Home Administrator (NHA) on 11/21/25 at 8:20 AM revealed that LPN #8 did not have a primary residence in Virginia. The NHA stated that per conversation with LPN #8 on 11/20/25, LPN #8 could not verify that LPN #8 held primary residence in Virginia since 2022. The Virginia issued state identification card showed that it was issued on 05/10/2024, however, the surveyor requested documentation to show that LPN #8 met the Compact State Licensure requirement to show he/she declared Virginia as his/her primary state of residence. The NHA stated that she will call LPN #8 to retrieve all needed documents.On 11/21/25 at 8:30 AM the surveyor conducted a follow up interview with the NHA. The NHA stated that LPN #8 had difficulty attaining a Maryland LPN license due to the closing of the institution where LPN #8 gained her practical nursing education and thus was not able to retrieve his/her transcripts. The surveyor requested the name of the institution and the suggested name was confirmed by LPN#8.During the interview, the surveyor conducted research on MBON's website which revealed that on 11/05/20, this college's Practical Nursing Program graduates receive Maryland LPN licensure because the college's practical nursing program did not meet minimum qualifications for full Practical Nursing licensure in Maryland.The surveyor reviewed MBON's notice about college with the NHA and the NHA stated that effective immediately, he/she would remove LPN #8 from the schedule.On 11/21/25 at 12: 45 PM the surveyor reviewed the facility's statement of deficiencies from their recertification survey dated 4/3/24. The review revealed that the facility was cited for not employing licensed staff according to Maryland (continued on next page)

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

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F 0839 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	State law and LPN #8 was identified as a staff member under that citation.Further review of the facility's plan of correction and credible evidence revealed the facility alleged they met compliance by:- Staff #13 {currently identified as LPN # 8} had moved back to Virginia as their state of primary residence-The HR Director will audit all employee files for appropriate licensure status. Findings will be corrected as appropriate.- Regional HR Director will re-educate the facility's HR Director regarding licensure audit and the use of the electronic portal to track license expirations and Primary State of Residence changes that might affect licensure.- A photocopy of staff #13's {now LPN #8} LPN license issued by Virginia Board of Nursing on 10/29/21with an expiration date 12/21/26.The facility was aware of this deficient practice from 4/3/24 through 11/21/25. The facility failed to correct the deficiency. Residents were at risk for improper care or negligence when their care was not provided by qualified licensed personnel, therefore an Immediate Jeopardy was determined on 11/21/25 at 2 PM. On 11/21/25 at 2:05 PM the surveyors conducted an in person interview with the NHA and Regional Director of Clinical Operations (RDCO) who were notified of the identified Immediate Jeopardy and findings, verbally and in writing, at that time. The surveyors remained at the facility until an acceptable abatement plan was confirmed.On 11/21/2025 at 2:51 PM the surveyor interviewed LPN #8 via telephone call, who confirmed his/her first and last name and stated that he/she worked at the facility since May 2022 as an LPN. LPN #8 continued to state that their primary state of residence was Maryland for several years and that he/she did not know that they were required to obtain a Maryland LPN license since he/she resided in Maryland.On 11/21/25, at 4:30 PM, surveyors reviewed the documentation related to licensure audits conducted by the facility as part of their plan of correction from a survey on 4/3/24. The review revealed the facility identified LPN #14's licensure was captured as a compact LPN license without compact status verification at that time. The surveyor shared this info with the NHA and RDCO at the time of discovery.On 11/21/25 at 6:25 PM the NHA and RDCO submitted their abatement plan for the identified practice. This plan was rejected, and the facility submitted a revised abatement plan on 11/21/25 at 6:45 PM. The surveyors reviewed the plan, and it was accepted on 11/21/25 at 7:20 PM.On 11/21/25 at 7:35 PM the NHA verbally confirmed, during interview with the surveyors, that LPN # 8 was not in the building, and not on the schedule moving forward.On 11/24/25 at 7:30 AM the surveyors reviewed the facility's Plan of Correction which stated:- LPN #8 was removed from the schedule after discovery on 11/21/25- The facility Human Resources representative will audit all licensed nurses' employee files to validate that the nurse has an active Maryland license via the Maryland Board of Nursing Lookup or if they do not have a Maryland license that they have an active Compact License status and have on file the required documentation for compact status by 11/21/25.- Facility Human Resources representatives will be educated on 11/21/25 by the regional Human Resources Director on the process to validate employees' licenses for Maryland and compact state.- Facility Human Resources' representative will ensure there is required documentation included in the employees' file to validate their compact status. This evidence may include but is not limited to a current: (a) driver's license with a home address; (b) voter's registration card with a home address; (c) federal income tax return with a primary state of residence declaration; (d) military form np. 2058 (state of legal residence certificate); (e) from the United States government or any bureau, division, or agency thereof, indicating residence.On 11/24/25 at 7:45 AM the surveyor began to verify the plan of correction. An interview was conducted with the NHA who confirmed that LPN #8 was instructed to not return to the building and was taken off schedule.On 11/24/25 at 8:30 AM the surveyors reviewed the facility's audit of all currently employed licensed staff. The review revealed that LPN #8 and LPN #14 were identified as nurses who held LPN licenses issued in Virginia, and their compact status requirements were not verified.On 11/24/25 at 11:39 AM the surveyor continued to verify the plan of correction on the abatement plan. The surveyor interviewed LPN #14 and asked LPN #14 what his/her role at the facility was, what licensure they currently held, and where he/she primarily resided. LPN #14 replied: I am an MDS Coordinator with my LPN licensure issued in Virginia. I live in Maryland 5 days a week (continued on next page)

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F 0839 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	and I file my taxes in Maryland. I vote in Maryland.On 11/24/25 at 12:00 PM the surveyor interviewed the NHA who confirmed that LPN #14's compact status documentation had not yet been received from LPN #14. The surveyor advised the NHA that the alleged date of compliance the facility listed on the abatement plan was in fact not 11/21/25, since they failed to verify LPN #14's documentation on 11/21/25. The NHA and the RDCO then revised the abatement plan and submitted it to the survey team on 11/24/25. The survey team accepted the plan with the additional information as required.The survey team returned to the facility on [DATE] and began to verify the plan of correction for the 11/24/25 abatement plan.The amended abatement plan stated: - LPN number 8 was removed from schedule after discovery on 11/21/25. LPN #14 was removed from schedule after discovery on 11/24/25.- Facility Human Resources representative will audit all licensed nurses' employee files to validate that each nurse has an active Maryland license via the Maryland board of nursing license lookup or if they do not have a Maryland license that they have an active compact license status and have on file the required documentation for compact status by 11/24/25.- Facility Human Resources representatives will be educated on 11/21/25 by the Regional Human Resource Director on the process of validating these licenses for main compact state.On 11/24/25 at 12:45 PM The NHA verbally confirmed that LPN #14 was taken off the schedule.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Reasonably accommodate the needs and preferences of each resident. Based on observations and interviews it was determined that the facility staff failed to ensure that residents had their call bells to notify the staff when assistance was needed. This deficient practice was evidenced in 9 (#16, #27, #48, #51, #52, #69, #89, #112, & #116) of 33 residents screened on Patuxent Hall during the recertification survey.The findings include:On 11/18/25 at 7:30 am during observation rounds on Patuxent Hall the surveyor observed Resident #116 call bell clipped onto the cord on the wall. The resident was in bed. At 7:39 am the surveyor observed Resident #51 in bed with their call bell hanging from the cord on the wall. At 7:42 am Resident #48 call bell was on the floor near the head of the bed and Resident #16 call bell and bed control was on the floor under the head of the bed. At 7:47 am Resident #27 call bell was clipped to the cord on the wall and resident #89 call bell was on the bedside table and the resident was unable to reach the call bell. At 8:03 am Resident #112 call bell was on the floor on the left side of the bed. At 8:15 am the surveyor observed resident #69 did not have access to their call bell. At 8:17 am Resident #52 call bell was clipped on the cord hanging from the wall.On 11/20/25 at 9:20 am the surveyor reported to the Administrator their were multiple resident's located on Patuxent hall who did not have access to their call bell.On 11/24/25 at 11:22 am the surveyor asked Geriatric Nursing Assistant (GNA) # 29 to describe their typical morning when their shift starts. GNA #29 verbalized after receiving their assignment, rounds are completed to make sure the residents are alright. During rounds they make sure each resident has their call bell.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews it was determined that the facility staff failed to 1) store and process linen properly and 2)maintain effective infection prevention practices. This deficient practice had the potential to affect all the residents who were in the facility during the recertification survey.The findings include: On 11/20/25 at 10:30 am during a tour of the laundry facilities the surveyor observed clean linen in the laundry area that was not covered, clean linen in the hallway outside the laundry area that was not covered and there were multiple soiled tiles in the laundry storage room. The surveyor observed particles from the tile on the clean laundry. On 10/20/24 at 10:35 am during an interview with Environmental Services Manager #20 verbalized the clean and dirty laundry should not be in the same room and the clean laundry should be covered. Laundry Aid #21 verbalized they were multitasking, and they were about to put the laundry away. On 11/20/25 at 11:56 am Health Services Group District Manager #22 verbalized the linen in the storage room was not covered before the tiles were changed but the covered the linen before the work was done. The surveyor reported that particles were observed on the clean linen. On 11/20/25 at 9:30 AM the surveyor conducted a tour on the third floor with the Nursing Home Administrator (NHA) and the Director of Maintenance. We visited room [ROOM NUMBER] and the surveyor observed: a trash bin on top of a chest of drawers, several used, wet, white washcloths hanging on a bar in the ensuite bathroom. The surveyor also observed that the bathroom was a shared bathroom for up to 6 female residents. The NHA stated that the trash should have been on the floor and never on top of any other surface and the used washcloths were to be placed in the soiled linen bin. On 11/20/2025 at 10:47 AM the surveyor conducted an interview with the Infection Preventionist. The surveyor explained the previous observations made while on tour of the third floor and he/she stated that the expectation is that the washcloths were to be put out for laundry the same day and staff are to conduct frequent rounding to residents' rooms to collect soiled or used linens to be laundered.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews it was determined that the facility staff failed to maintain a comfortable, clean and homelike environment for the residents as evidenced of residents not having pillows and residents' clothing not being stored in the closet or armoire. This deficient practice was evidenced in 5 (#116, #40, #51, #27, & #89) of 33 residents residing on Patuxent Hall during the recertification survey.The findings include:On 11/18/25 at 7:30 am during observation rounds the surveyor observed Resident #116 clothes on top of a tall grey basket. There was a soiled gown and a blue article of clothing on the floor in the shared bathroom. At 7:34 am Resident #40 was in bed sleeping and there were two pair of black sweatpants and grey sweatshirt on the right side of the bed on the floor. At 7:39 am the surveyor observed Resident #51 in bed without a pillow. At 7:45 the surveyor observed a large clear plastic bag with clothing on the floor in room [ROOM NUMBER]. At 7:47 am the surveyor observed Resident #27 & Resident #89 in bed without pillows. At 8:07 am the surveyor observed a large black garage bag on the floor in room [ROOM NUMBER].On 11/25/25 at 11:15 am the surveyor reported the findings to Assistant Director of Nursing (ADON) #2. ADON #2 verbalized every resident should have their clothing in the closet, but extra clothing could be taken to storage.On 11/25/25 at 11:45 am Licensed Practical Nurse #27 verbalized every resident should have a pillow. They have plenty of pillows in Central Supply.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review and interviews it was determined that the facility staff failed to generate person centered care plans for a resident with Dementia, two residents with visual disturbances, and a resident who needed to wear a helmet to protect their brain while out of bed. This deficient practice was evidenced in 2 (#12, #91) of 5 resident records reviewed for care plans during the recertification survey.The findings include:On 11/19/25 at 8:53 am, during an interview with Resident #12, the resident verbalized their vision was blurred. A review of the resident's diagnoses revealed the resident had a history of Primary Open Angled Glaucoma. A review of the residents' care plans revealed there was not a care plan initiated for vision.On 11/21/25 at 11:12 am, during an interview with the Director of Nursing (DON), the surveyor asked how they ensure residents receive vision care. The DON verbalized Health drive comes to the facility; they have a list of residents that need vision or dental and they will schedule an appointment to come into the facility. The surveyor reported Resident #12 had a history of Glaucoma with blurred vision; the resident did not have a care plan for vision. On 11/25/25 at 12:32 pm, a review of Resident #91 electronic medical record (EMR) revealed the resident's last eye exam was done by Health Drive on 07/24/24 with a recommendation of new glasses. A review of the residents' diagnoses revealed the resident had a history of blindness in one eye. The diagnosis was dated 11/01/24. Further review of the EMR revealed a care plan for the resident's impaired vision was not initiated.During an interview with the Administrator, the surveyor reported the resident was supposed to receive glasses last year and the resident did not have a care plan for impaired vision. The Administrator verbalized the residents are usually seen yearly. The Administrator verbalized an appointment would be made with Health Drive for Resident #91 to receive vision care.On 11/26/25 at 12:57 pm, the surveyor spoke with Resident #91 in their room. The surveyor asked the resident how their vision was and did they receive glasses as recommended during their last eye exam. Resident #91 verbalized being blind in their right eye and their vision was blurred in the left eye due to a cataract. Also, the resident verbalized they never received glasses.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on medical record review and interviews it was determined that the facility staff failed to complete quarterly care plan meetings. This deficient practice was evidenced in 1 (#96) of 2 resident records reviewed for care plan meetings during the recertification survey.The finding include:On 11/21/25 at 12:11 pm during an interview with Social Services Director #30 the surveyor asked to explain the process of care plan meetings. Social Services Director #30 verbalized care plan meetings are set up twice a week, on Mondays and Wednesday for long-term care residents. They reach out to the representative for the meeting; they meet in person or via phone. Each department who is related to the resident care attends the meeting. The long-term care meetings are held quarterly and annually. They also have meetings upon request and if there is a significant change as well. On 11/25/25 at 9:42 am a review of Resident #96 electronic health record (EHR) revealed there were no documented care plan meeting notes from 03/20/23-07/24/25. On 11/25/25 12:21 pm the surveyor asked the Administrator to verify if Resident #96 had any care plan meetings. At 1:26 pm the regional Director of Clinical Services verified the resident did not have any care plan meetings and that a house wide audit will be completed.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on record review and interviews it was determined that the facility staff failed to adhere to professional nursing standards as evidenced by a resident received hospice care for 12 days without a physician order, the facility staff failed to coordinate the residents' care with the hospice nurse, and a resident was prescribed psychotropic medication without behavioral monitoring or monitoring for extrapyramidal side effects. This deficient practice was evidenced in 1 (#43) of 1 hospice record reviewed and 1 (#10) of 2 records reviewed for extrapyramidal side effects/behavioral monitoring during the recertification survey.The findings include:On 11/19/25 at 8:16 am a review of Resident #43 electronic health record revealed the resident was receiving hospice care with Adoration Hospice. The consent for hospice care was signed 03/14/25. A review of the residents' orders revealed an order was written for hospice care on 03/26/25. Licensed Practical Nurse #31 verbalized the hospice nurse comes to the facility to see the resident twice a week. A review of the paper chart revealed there were no hospice notes in Resident #43 medical record. On 11/21/25 at 10:18 am during an interview with the Director of Nursing (DON) he/she verbalized the patient was already admitted to hospice and they have their own physician in house. They write their own orders and run them by in-house physician. The staff communicate with the hospice nurse by telephone and sometimes they send email. When Resident #43 was admitted he/she was not working in the facility. There was no documentation to verify the staff was communicating with the hospice nurse and there was no order written before the resident received hospice care. On 11/20/25 at 3:40 pm a review of Resident #10 medication administration record (MAR) revealed on 10/24/25 at 6:00 pm the resident was prescribed Risperidone 1 mg by mouth (PO) in the evening for Schizophrenia with dinner. The medication was discontinued on 11/11/25 at 9:21 am. On 11/11/25 at 5:00 pm the resident was prescribed Risperdal 0.5 mg PO daily for Psychosis. Further review of the EHR revealed the resident was not being monitored for extrapyramidal side effects or behavioral monitoring. On 11/20/25 at 4:15 pm the Regional Director of Clinical Services confirmed Resident #10 was not being monitored for extrapyramidal side effects and the staff was not receiving behavioral monitoring.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on medical record review, observation and resident and staff interviews it was determined the facility staff failed to ensure that dependent resident's personal hygiene needs were adequately met by offering and providing podiatry services to get their toenails trimmed on a regular basis. This was evident for 1 of 30 (#119) residents reviewed during the survey process. The findings include:Resident #119 reported that their toenails were extremely long and uncomfortable. He stated he hadn't seen a podiatrist in a while and that the podiatrist tried to break their toenails off instead of trimming them. The resident said that they had told that podiatrist he didn't want to see them again but wanted another podiatrist. The resident stated that they had not had their toenails cut since then and that they were very long. The resident also stated that they were diabetic and knew they should take care of their feet.The surveyor reviewed the medical record and only found one podiatry consult note dated 2022. There was a doctor's order for podiatry consults as needed. The surveyor interviewed the ADON who stated they would review the hard copy chart for possible consult documentation and come back later saying they could not find any. The ADON stated the resident would be put on the podiatry list to be seen the next time the podiatrist was visiting.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. Based on record review and interviews it was determined that the facility staff failed to ensure residents who had impaired vision received vision care and a recommended assistive device. This deficient practice was evidenced in 2 (#12 & #91) of 2 resident records reviewed for vision services during the recertification survey.The findings include:On 11/19/25 at 8:53 am, while interviewing Resident #12, they verbalized their vision was blurred. A review of the resident's diagnoses revealed the resident had a history of Primary Open Angled Glaucoma.On 11/21/25 at 11:12 am during an interview with the Director of Nursing (DON) the surveyor asked how they ensure residents receive vision care. The DON verbalized Health Drive comes to the facility; they have a list of residents that need vision care, and they will schedule an appointment for them to come into the facility. The surveyor reported Resident #12 had a history of Glaucoma with blurred vision.On 11/25/25 at 12:32 pm a review of Resident #91 electronic medical record (EMR) revealed the resident's last eye exam was done by Health Drive on 07/24/24 with a recommendation of new glasses. A review of the residents' diagnoses revealed the resident had a history of blindness in one eye. The diagnosis was dated 11/01/24. During an interview with the Administrator the surveyor reported the resident was supposed to receive glasses last year. The Administrator verbalized the residents are usually seen yearly. The Administrator verbalized an appointment would be made with Health Drive for Resident #91 to receive vision care.On 11/26/25 at 12:57 pm the surveyor went to speak with Resident #91 in their room. The surveyor asked the resident how their vision was and did they receive glasses as recommended during their last eye exam. Resident #91 verbalized being blind in their right eye and their vision was blurred in the left eye due to a cataract. Also, the resident verbalized they never received glasses. On 11/26/25 at 1:00 pm the surveyor asked Licensed Practical Nurse # 17 if they ever saw Resident #91 wearing glasses. LPN # 17 verbalized they do not recall seeing the resident wearing glasses.

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	12/01/2025

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on record review and interviews, it was determined that the facility failed to ensure that Nephrostomy drainage bag care was provided to a resident with a Nephrostomy . This was evident for 1 (#4) of 1 resident reviewed with a Nephrostomy. The findings include: On 11/24/2025 at 11:08 AM, during the initial interview of Resident #4, they stated that the staff did not empty or change their nephrostomy drainage bag and that they were forced to take care of it themselves and that their family provided the bags. On 11/24/2025 at 1:15 PM during a record review, it was noted that on the Task Administration Record (TAR) there is no documentation of the resident's urostomy bag being emptied and changed. On 11/24/2025 at 2:00 PM, The Director of Nursing (DON) was interviewed and he/she stated the urostomy bag was being changed but the staff was not documenting it. The DON was asked that if it wasn't documented how could they be sure that the change had been made and just as importantly how could the facility prove it had been done. The DON acknowledged that they couldn't.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews with facility staff, it was determined that the facility failed to maintain proper infection control procedures while serving breakfast. This was evident during the annual rectification survey. The findings include:On November 20, 2025, at 9:06 AM, the surveyor observed Staff #5, a Dietary Aid, while preparing beverages on clean trays for breakfast. Staff #5 knocked a tray onto the floor, then picked up the tray along with the silverware, napkin, and beverages from the floor. Staff #5 placed these items back on the tray and then positioned the fallen tray beside the clean trays on the serving line. Staff #6, another Dietary Aid, informed Staff #5 that this was unacceptable and removed the tray. No staff member cleaned the counter after the fallen tray was removed from beside the clean trays. Staff continued to serve breakfast, sliding clean trays down the service line over the area where the dirty tray had been. Staff #3, the Dietary Manager, was made aware that a tray fell and was picked up with the silverware and beverages, and that the items were placed on the clean serving area. Staff #3 immediately stopped the serving process, removed the trays, and placed them in an area for cleaning. Staff #3 then sanitized the countertop on the service line in the serving area before serving resumed.On November 20, 2025, at 9:15 AM, Staff #3, the Dietary Manager, and Staff #4, the District Manager for Health Care Service, were interviewed and asked if standard practice permits picking up a tray that has fallen on the floor, picking up food and utensils from the floor, and continuing to serve. Both Staff #3 and Staff #4 confirmed that this action was against protocol and presented an infection control risk.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews it was determined that the facility staff failed to maintain the facility in a safe operating condition as evidenced by the heating/AC unit front in a resident's room was on the floor, damaged drywall in residents' rooms, a sink wasn't secured to the bathroom wall, holes in residents' bathroom door, an electrical plate was not secured to the wall, a bed control had exposed wires, an armoire with dry rotten wood, damaged tile in the shower room, a hole in the wall in the laundry room & damaged floor tile, multiple soiled ceiling tile in the stored linen room. This deficient practice was discovered in different areas in the facility during the recertification survey.The findings include:On 11/18/25 at 7:30 am during observation rounds the surveyor observed the front of the heating/AC unit was on the floor in room [ROOM NUMBER]. In the shared bathroom in room [ROOM NUMBER] the surveyor observed holes in the bathroom door. At 7:43 am while in room [ROOM NUMBER] the electrical outlet plate was not secured to the wall behind Bed-A. The wood to the armoire was dry rotted in room [ROOM NUMBER]. At 7:55 am while in room [ROOM NUMBER], the surveyor observed damaged drywall, corner bead exposed in the bathroom, and the sink was not secured to wall. At 8:08 am the Central Spa Room located on Patuxent Hall had damaged tile near the drain. At 8:21 am the surveyor observed the armoire in room [ROOM NUMBER] had missing wood trim. On 11/20/25 at 9:21 am during an interview with Maintenance Director #16 the surveyor asked what process is in place to notify maintenance when repairs are needed. Maintenance Director #16 said they have TELS which is a website the staff uses to notify maintenance of problems, and they use word of mouth. The surveyor asked if there is a preventative maintenance schedule. They have a list of things that must be done weekly and monthly. They have tasks that must be completed by the end of the week. They have two techs that assist with maintenance repairs; each is assigned a floor. On 11/20/25 at 9:28 am the surveyor reported the maintenance concerns with Maintenance Director #16 and the Administrator. They were shown pictures to verify the concerns. On 11/20/25 at 10:30 am during a tour of the laundry area the surveyor observed damaged drywall behind the sink, holes in the wall, the eyewash station was not installed, the pipe insulation was damaged, and there were damaged floor tiles. The room where the linen was stored had at least four heavily soiled ceiling tiles and the pipe insulation was soiled.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observations and interviews it was determined that the facility failed to keep a sanitary environment. This was evident for 2 of 2 Residents (Residents # 64 and # 72) rooms observed during the annual recertification survey.The findings include:On 11/18/2025 at 11:27 AM, during the initial observation, a fly strip containing several dead flies and other insects was observed suspended from a cork bulletin board positioned directly above Resident #64's bed. Resident #64 was lying in bed, asleep, beneath the fly strip at the time of the observation.On 11/19/2025 at 10:34 AM, Staff #7, a Licensed Practical Nurse (LPN), was interviewed about the item hanging from the cork bulletin board above Resident #64's bed. Staff #7 identified the item as a fly strip/trap, explaining that Resident #64 had previously complained about flies in the room. When asked about the dead insects on the strip, Staff #7 confirmed, stating, there are dead flies and bugs stuck on the fly trap/strip above the residents bed. Staff #7 acknowledged that having a fly trap with dead insects in the resident's room was unsanitary. Staff #7 then put on gloves and removed the fly trap.On 11/19/2025 at 1:37 PM, a separate surveyor observed a fly strip attached to the cork bulletin board above Resident #72's head. Dead flies were noted adhering to the fly strip. Resident #72 reported experiencing an issue with bugs in their room as well. Maintenance personnel were notified, and the fly strip/trap was subsequently removed.