STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215241	A. Building B. Wing	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Nursing Home Operator, LLC	1601 East Belvedere Avenue Baltimore, MD 21239

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41274 Based on records review and interviews during a complaint survey, the facility did not ensure each resident had the right to participate in the development and implementation of their person-centered plan of care, including to participate in the planning process and to request meetings for one resident (Resident # 8) out of three residents reviewed for resident rights. Specifically, the facility did not schedule quarterly case plan conferences to evaluate Resident #8's plan of care and to allow for the resident's representative to participate in plan of care decision making. The findings include: The facility's policy and procedure titled Assessment of Resident: Comprehensive Care Planning Process, (last revised June 2024), read in part that the purpose of the policy is to ensure that the best approaches to provide for the quality of care for each resident were developed, implemented and evaluated and to assure that care planning was performed in a timely manner. Participants in the care planning process were to include the resident and their representative (if they chose to attend), direct care givers, representatives from each clinical discipline and representative from the facility administration, clergy and ombudsman if appropriate. An initial planning conference was to be scheduled within one week of the completion of the admission Minimum Data Set (MDS) assessment. Subsequent care planning conferences were to be scheduled within one week of the resident 's quarterly MDS assessment or within one week after the completion of a significant change MDS assessment. The resident and their representative/family member were to be notified of the care planning process upon admission and notified in advance of each care planning conference. Resident #8 was admitted to the facility with diagnoses which included type II diabetes mellitus with unspecified complications, unspecified dementia with behavioral disturbance, adjustment disorder with anxiety, and major depressive disorder. The Minimum Data Set (MDS) dated [DATE] documented Resident #8 had a Brief Interview for Mental Status (BIMS) score of 0/15 which was indicative of severe cognitive impairment. A Social Services Note, dated 6/13/24, documented the facility held a care plan conference for Resident #8 during which the resident's family member/ power of attorney attended on their behalf. Resident #8 was documented to have had a BIMS assessment completed 3/13/24 and scored a 14/15 which was indicative of intact cognition. Resident #8 was documented to have been experiencing audio and visual hallucinations and refusing care at times. (continued on next page)

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

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #8's Electronic Health Record (EHR) revealed that no subsequent care plan conferences had been held for Resident #8 since 6/13/24. The record documented the resident had a cognitive decline with their BIMS score assessed as 14/15 (intact cognition) on 3/13/24 to 0/15 (severe cognitive impairment) on 10/29/24. During an interview on 1/23/25 at 12:13 PM, Resident #8's representative stated Resident #8 had not had a care plan conference scheduled since June of 2024, despite requesting that a conference be scheduled by the facility multiple times. They stated when they had made requests for a conference to be held, the facility staff would respond that they would inform the Director of Social Work (DSW), however, no one would ever follow-up with them. During an interview on 1/29/25 at 1:58 PM, the DSW stated they had started working at the facility in November 2024. The DSW stated prior to November 2024, the facility had been without a Director of Social Work for several months. They stated the social services department was responsible for facilitating care plan conferences and they had noticed that many residents had gone for an extended period of time without having a care plan conference scheduled. They stated they did not believe that any other facility staff stepped in to facilitate care conferences while the Director of Social Work position was vacant. The DSW stated Resident #8 last had a care plan conference in June of 2024 and therefore should have had conferences scheduled in September and December of 2024. During an interview on 1/31/25 at 12:00 PM, the Nursing Home Administrator (NHA) stated care plan conferences should be scheduled upon admission, quarterly and following any significant change for a resident. They stated that care plan conferences were an opportunity for residents/their representative to provide their input on the resident's plan of care. They stated the DSW was the primary person responsible for scheduling care plan conferences for long term care residents. They stated Resident #8 had been due for care plan conferences in September and December 2024. The NHA stated the intent of holding care plan conference was to provide an overall and multidisciplinary clinical update on the resident' s status and review any changes. They stated resident representatives should be invited and given advance notice of when a care plan conference would be held.The NHA concurred that the facility had failed to schedule care plan conferences for Resident #8 in September and December of 2024.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41274 Based on observations, record review, and interviews during a complaint survey the facility failed to ensure the resident environment remained free of accident hazards and adequate supervision was provided to prevent accidents for one resident (Resident #10) out of five residents reviewed for accidents/hazards. Specifically, for Resident #10 the facility failed to ensure the following: new interventions were implemented to prevent accidents after the resident had a fall on 2/3/2022 and sustained a laceration to their head; fall care plan was followed; was not left unattended on their side while they were being changed which resulted in a fall; and the behavioral care plan was followed for staff to not leave plastic items within reach of the resident; this created an environmental hazard due to the resident ' s behavior of eating plastic. The findings include: The facility ' s Fall Prevention/ Management Program and Incident/ Accident Management Policy, last revised June 2005, documented once a resident experienced a fall in the facility, with or without injuries resulting, the facility would initiate a prompt assessment of the cause of the fall and implement additional interventions to prevent recurrence based on an interdisciplinary approach. Licensed nurses were to complete a Fall Risk Identification Tool and additional members of the interdisciplinary team (IDT) were to participate in the identification of potential or actual problems, possible interventions and ongoing monitoring. Resident #10 was admitted to the facility with diagnosis which included epilepsy, vascular dementia and psychotic and mood disturbances. The Minimum Data Set (MDS) dated [DATE] documented the resident was assessed with a Brief Interview for Mental Status (BIMS) score of 9/15 which was indicative of moderate cognitive impairment. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #10 ' s Care Plan, initiated 6/8/2020, revealed Resident #10 was at risk of falls related to diagnoses of Parkinson ' s Disease, a history of falls and a belief that they could still ambulate. Interventions included that the resident ' s bed should remain in the lowest position when in bed and for staff to anticipate the resident ' s needs. An Incident Investigation Form dated 2/3/2022 documented at 8:30 PM, Resident #10 was found on the floor with their head on the ground, near their bedside table. The resident was noted with an injury to their right eyebrow and was transported to the hospital via emergency services. The investigation concluded that the resident attempted to get out of their bed unassisted, fell and hit their head on the bedside table. Resident #10 was documented as having floor mats on the side of their bed at the time of the fall. The factors related to the incident were documented as patient overestimates their limits. The corrective action plan was documented as redirect to safety as needed. The facility investigation did not include/document any IDT conference notes, evaluation, or new interventions implemented to prevent recurrence. A Nurse Progress Note dated 2/4/2022 documented Resident #10 returned from hospital at approximately 3:00 AM, following their fall. Resident #10 returned from the hospital with dissolving stitches on their right eyelid and swelling was noted to the right side of their face. An Incident Investigation Form dated 8/26/24 documented Resident #10 was observed on the floor of their room with Geriatric Nurse Aide (GNA) #15 also present in the room. GNA #15 was documented to have stated they were trying to change the resident when they rolled onto the floor. Upon assessment, the resident was found to have a hematoma on the left side of their forehead and a broken tooth. Resident #10 was sent to the emergency room for further evaluation. During interview at the time of the investigation, GNA #15 stated they turned the resident toward the window to remove their soiled brief. They turned around to place the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	soiled brief in the trash can and when they turned back, Resident #10 had rolled onto the floor. During an observation on 1/24/25 at 11:45 AM, Resident #10 was sleeping in their bed. The head of the resident's bed was in an elevated position and the height of the bed was not in a lowered position. During an interview on 1/24/25 at 11:50 AM, Licensed Practical Nurse (LPN) #3 stated Resident #10 typically required two people to transfer and reposition them. They stated the resident was heavy and did not move well in bed. During an interview on 1/29/25 at 10:29 AM, Resident #10 ' s representative stated the resident had multiple falls while at the facility and had sustained injuries. They stated they were unaware of anything being done differently by the facility to prevent the resident ' s falls. They stated they thought the resident was supposed to have their bed in a lowered position and that fall mats were be placed on the side their bed, however, during visits with the resident they had observed that the bed would not be in a lowered position and they would not see fall mats. During an interview on 1/29/25 at 12:40 PM, GNA #15 stated while they were changing Resident #15 ' s brief on 8/26/24 they turned the resident on their side, removed the soiled brief and stepped away to dispose of the soiled brief. They stated when they turned back, the resident had rolled from their side onto the floor. They stated the resident ' s care plan documented the resident required one person to perform care, however, added it would be good to have two people assisting due to the resident ' s size. GNA #15 stated they received education after the incident on how to perform the resident ' s care without stepping away from them. During an interview on 1/31/25 at 11:52 AM, the Regional Nurse Consultant (RNC) stated they were the acting Director of Nursing (DON) at the facility. They stated when a resident experienced a fall, the facility should assess the resident for injuries, conduct an investigation (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and perform a root cause analysis to identify what factors contributed to the fall. The RNC stated based on what occurred with a fall multiple interventions could be implemented which may include more frequent rounding on the resident, evaluation of the resident ' s medication regime, and referral to therapy services. The RNC stated new interventions should be implemented and documented in the resident ' s care plan. They stated Resident #10 ' s bed should be in the lowest position when the resident was lying in bed, per the resident's care plan. They stated GNA #15 should not have stepped away from Resident #10 during care and was provided with reeducation on how perform to activities of daily living (ADL) care safely for the resident. The Policy and Procedure titled, Incident/Accident Management, last revised June 2005, read in pertinent part the facility would investigate and manage the risk of accidents and incidents. Examples of accidents/ incidents provided included environmental hazards and ingestion of dangerous substances. Review of Resident #10 ' s Behavioral Care Plan, initiated 6/16/2020 documented Resident #10 had ineffective impulse control related to the behavior of eating paper and plastic. On 9/30/21, the care plan was updated to include that Resident #10 should not be provided with plastic utensils on their meal trays. On 11/27/24, the resident ' s care plan was updated to include that no plastic object should be left within reach of the resident. Resident #10 was also documented to be at risk for aspiration due to their history of stroke; interventions included the resident was not to be provided with straws. During an interview on 1/29/25 at 10:49 AM, Resident #10 ' s representative stated that Resident #10 had the behavior of eating plastic and had been found with diabetic testing equipment in their mouth. They stated it was brought to the facility ' s attention and staff were instructed that plastic items should not be left within reach of the reach of the resident, however, during (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	subsequent visits they had continued to see the resident with plastic items left at bedside. During an observation on 1/30/25 at 11:37 AM, Resident #10 was lying in their bed; a small, clear plastic cup was tucked in the resident ' s right arm. The cup was crumpled up and had bite/teeth marks around the rim of the cup and other areas. On the resident ' s over-bed table was a clear plastic cup with a lid and a plastic straw. During an interview and observation on 1/30/25 at 11:41 AM, GNA #18 stated they were assigned to Resident #10 ' s care that day. When asked whether they were aware of any behavioral/environmental safety interventions for Resident #10, they stated they were not aware of any. GNA #18 entered Resident #10 ' s room, observed the clear plastic cup that had been in the resident ' s possession and stated that it appeared that there were bite/teeth marks on the cup. They stated the plastic cup appeared to be the same kind used by the nurses when passing medications. During an interview on 1/31/25 at 12:02 PM, the Nursing Home Administrator (NHA) stated Resident #10 had a safety care plan in place which included interventions to prevent falls as well as interventions related to the resident ' s behaviors. They stated plastic items were not to be left where the resident could reach them due to the behavior of placing plastic items in their mouth and chewing on them. They stated the resident had previously been noted with a plastic piece of diabetic testing equipment in their mouth. They stated plastic cups, utensils and straws should not be left on the resident ' s bedside table.