STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215283	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Transitional Care Services at Mercy Medical Center	301 Saint Paul Place Baltimore, MD 21202

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interviews, it was determined that the facility failed to ensure the resident/responsible party was offered the opportunity to develop an advance directive for 4 (#18, #2, #12, #13) of 4 sampled residents for advance directives during the annual survey. The findings include:An advance directive is a written statement of a person's wishes regarding medical treatment, often including a living will, made to ensure those wishes are carried out should the person be unable to communicate them to a doctor. It is a legal document in which a person specifies what actions should be taken for their health if they are no longer able to make decisions for themselves because of illness or incapacity.A Maryland MOLST (Medical Orders for Life-Sustaining Treatment) form is used for documenting a resident's specific wishes related to life-sustaining treatments. The MOLST form includes medical orders for Emergency Medical Services (EMS) and other medical personnel regarding cardiopulmonary resuscitation (CPR) and other life-sustaining treatment options for a specific patient.1) On [DATE] at 11:56 AM a medical record review for Resident #18 revealed the resident was admitted to the facility on [DATE] following a revised lumbar decompression. Resident #18 also had diagnoses that included arthritis, asthma, COPD, interstitial lung disease and rheumatoid arthritis. On [DATE] at 11:57 AM an interview was conducted with Staff #4, the unit's chaplain. Staff #4 stated that he always talked to the residents about advance directives and put them in his notes. During a review of Resident #18's medical record on [DATE] at 11:58 AM with Staff #12, it was found that there was no documentation about conversations regarding advanced directives. Review of Staff #4's notes for Resident #18 was void of any advance directives' conversations.On [DATE] at 12:42 PM, during a review of the resident's medical record with Staff #12, the resident's MOLST was located under the advance directives section, but there was no information indicating that an opportunity to formulate an advance directive was provided to the resident. Staff #12 confirmed the findings. 2) On [DATE] at 7:52 AM a medical record review for Resident #2 revealed the resident was admitted to the facility on [DATE] with diagnoses that included, but was not limited to, sickle cell anemia, avascular necrosis of the hips with infection, seizure disorder and SVC syndrome with DVT. During a review of Resident #2's medical record on [DATE], the resident's MOLST was located under the advance directives section, but there was no information indicating that an opportunity to formulate an advance directive was provided to the resident.On [DATE] at 12:50 PM an interview was conducted with Staff #12 who went through the entire chart and confirmed there was no documentation about advance directives that included social worker's notes and the chaplain's notes.3) On [DATE] at 12:22 PM a medical record review for Resident #12 revealed the resident was admitted to the facility on [DATE] with diagnoses that included, but was not limited to, a new diagnosed NET of liver, COPD, hypertension, and ambulatory dysfunction. Liver NET refers to neuroendocrine tumor NET liver metastases, which can originate in the lungs or GI tract and spread to the liver. During a review of Resident #12's medical record on [DATE], the resident's MOLST was located under the advance directives section, but there was no information indicating that an opportunity to formulate an advance directive was provided to the resident. On [DATE] at 12:54 PM (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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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the medical record was reviewed with Staff #12 who confirmed there was no documentation about conversations regarding advanced directives including notes from the social worker and chaplain.4) On [DATE] at 12:23 PM a medical record review for Resident #13 revealed the resident was admitted to the facility on [DATE] following surgery on the left foot for arthritis. Resident #13 also had diagnoses that included end stage osteoarthritis, hypertension, and colon cancer.During a review of Resident #13's medical record on [DATE], the resident's MOLST was located under the advance directives section, but there was no information indicating that an opportunity to formulate an advance directive was provided to the resident.On [DATE] at 12:42 PM the medical record was reviewed with Staff #12 who confirmed there was no documentation about conversations regarding advanced directives which included social work notes and the chaplain's notes.On [DATE] at 12:30 PM the concern was discussed with the Nursing Home Administrator (NHA). The NHA confirmed the surveyor's findings.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, it was determined the facility staff failed to ensure Minimum Data Set (MDS) assessments were accurately coded. This was evident for 2 (Residents #12, #9) of 4 residents reviewed for nutrition during the annual survey. The findings include: The MDS is part of the Resident Assessment Instrument that was Federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned based on those individualized needs, and that the care is provided as planned to meet the needs of each resident. 1) On 11/19/25 at 12:44 PM Resident #12's medical record was reviewed and revealed the resident was admitted to the facility on [DATE] with a weight of 90.5 lbs. There was also a weight of 104 lbs. documented in the medical record from 10/28/25, the date of discharge from the acute care setting. There were no other weights documented in Resident #12's medical record. Review of Resident #12's admission MDS with an assessment reference date (ARD) of 11/4/25, section K0300, weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months, was coded, no. This was an error as there was a 13.5 lb. weight difference which was 13 percent. On 11/21/25 at 10:07 AM an interview was conducted with the MDS Coordinator. The MDS Coordinator reviewed the admission MDS with the surveyor and she stated that Section K0300 should have been coded, yes and that a re-weight should have been done. 2) Review of Resident #9's medical record on 11/19/25 revealed the Resident was admitted from the hospital to the facility on [DATE] and the facility staff documented the Resident's weight to be 169 pounds. Further review of Resident #9's medical record revealed the Resident had a documented weight from the hospital on [DATE] of 186 pounds, indicating a 17-pound weight loss or 9%. Review of Resident #9's 11/9/25 admission MDS assessment Section K Swallowing/Nutritional Status revealed the facility staff coded the Resident in Section K0300 Weight Loss as No for Loss of 5% or more in the last month. Interview with the MDS Coordinator on 11/21/25 at 10:05 AM confirmed the facility staff should have coded Resident #9 as Yes in Section K0300 Weight Loss.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview it was determined that the facility staff failed to ensure a resident had a baseline care plan created and initiated within 48 hours of admission to the facility. This was evident for 1 (Resident #12) out of 12 residents reviewed during the annual survey. The findings are:The baseline care plan is given to residents within 48 hours of their admission and details a variety of components of the care that the facility intends to provide to that resident. In addition to the baseline care plan, residents are also expected to receive a list of their admission medications. This allows residents and their representatives to be more informed about the care that they receive.On 11/20/25 at 1:04 PM a review of Resident #12's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included, but were not limited to, a new diagnosed NET of liver, COPD, hypertension, and ambulatory dysfunction. Liver NET refers to neuroendocrine tumor NET liver metastases, which can originate in the lungs or GI tract and spread to the liver. Further review of Resident #12's medical record revealed there was no evidence in the medical record of a baseline care plan that was created, reviewed, and given to Resident #12.The medical record review failed to reveal evidence that the facility offered the Resident and their representative a summary of the baseline care plan that included initial goals, physician orders, therapy services, dietary services, and social services within 48 hours of the resident's admission to the facility.On 11/21/2025 at 8:48 AM the Nursing Home Administrator (NHA) reviewed the medical record with the surveyor. The NHA could not find a baseline care plan or documentation that the baseline care plan had been given and discussed with the resident along with a list of medications that the resident was prescribed.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, the facility staff failed to thoroughly assess and monitor residents at risk for weight loss. This was evident for 3 (Resident #9, #36, #12) of 4 residents reviewed for nutrition during an annual survey.The findings include: 1) Review of Resident #9's medical record on 11/19/25 revealed the Resident was admitted to the facility on [DATE] and the facility staff documented the Resident's weight to be 169 pounds. Further review of Resident #9's medical record revealed the Resident was assessed by Dietitian #1 on 11/4/25 and documented the Resident had Nutrition Diagnosis #1 Moderate acute disease or injury related to malnutrition and Nutrition Diagnosis #2 Inadequate oral intake. Dietitian #1 documented the Resident will be High and re-evaluated every 5-7 days. At that time Dietitian #1 recommended supplements. Further review of Resident #9's medical record revealed Dietitian #1 assessed the Resident on 11/7/25 and recommended adding some preferred foods to the Resident's meals. Dietitian #1 documented Team member reported that patient's intake remains poor. Further review of Resident #9's medical record revealed on 11/13/25 the Resident was seen by Dietitian #1 who documented no improvement in the Resident's intake and spoke with family about appetite stimulant-they expressed interest. Review of Resident #9's medical record on 11/20/25 revealed no appetite stimulant has been ordered and no further weights have been obtained by the facility staff to assess if the Resident has lost weight due to the poor intake. Interview with the Clinical Nutrition Manager, who oversees Dietitian #1, on 11/20/25 at 1:30 PM confirmed there are no weights in the Resident's medical record since the admission weight on 11/3/25 to determine the Resident's weight loss. Interview with the Administrator on 11/21/25 at 7:15 AM confirmed the facility staff failed to reweigh Resident #9 to determine if and how much weight the Resident was losing. During interview with the Clinical Nutrition Manager on 11/21/25 at 10:00 AM, she stated she will be placing all the residents on weekly weights on admission to assess for weight loss. 2) Review of Resident #36's medical record on 11/19/25 revealed the Resident was admitted to the facility on [DATE] and the facility staff documented the Resident's weight to be 125 pounds and 8 ounces. Further review of Resident #36's medical record revealed Dietitian #2 assessed the Resident on 11/9/25 and documented the Resident to have Nutrition Diagnosis #1 Severe chronic disease or condition related to malnutrition, Nutrition Diagnosis #2 Increased nutrient needs and Nutrition Diagnosis #3 Inadequate oral intake. Dietitian #2 documented the Resident as Low and will be re-evaluated every 10-14 days. The Resident was assessed by Dietitian #1 on 11/18/25 who documented for weight change: patient (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	guessed that he/she had 5-pound weight loss over 1 week due to stress and decreased intake/appetite. Further review of the Resident's medical record on 11/20/25 revealed no weights documented since the Resident's admission on [DATE] to determine an accurate weight loss. Interview with the Clinical Nutrition Manager, who oversees Dietitian #1 and #2, on 11/20/25 at 1:30 PM confirmed there are weights in the Resident's medical record since the admission weight on 11/8/25 to determine the Resident's weight loss. The Clinical Nutrition Manager also stated the Resident should have been assessed as High not Low and should have been reevaluated weekly. Interview with the Administrator on 11/21/25 at 7:15 AM confirmed the facility staff failed to reweigh Resident #36 to determine if and how much weight the Resident was losing. During interview with the Clinical Nutrition Manager on 11/21/25 at 10:00 AM, she stated she will be placing all the residents on weekly weights on admission. 3) On 11/20/25 at 12:22 PM a review of Resident #12's medical record revealed Resident #12 was admitted to the facility on [DATE] with diagnoses that included, but was not limited to, a new diagnosed NET of liver, COPD, hypertension, and ambulatory dysfunction. Liver NET refers to neuroendocrine tumor NET liver metastases, which can originate in the lungs or GI tract and spread to the liver. Review of the vital sign section of the medical record revealed an admission weight of 90.4 lbs. It was noted that on 10/28/25, prior to Resident #12 being discharged from the hospital, the resident's weight was documented as 104 lbs. Review of the initial nutrition assessment dated [DATE] documented Resident #12's weight as 90 lb. 9.7 oz. It was documented, weight change: underweight for age. Pt. endorsed too much weight loss but unable to recall time period, likely 2/2 (secondary) to reported po (by mouth) intake. Chart review: 6.124 kg (13%) severe weight loss x 1 day – question accuracy of weight. The nutrition PES statement documented, nutrition diagnosis #1: Severe acute disease or injury related malnutrition related to inadequate energy intake as evidenced by visual loss of muscle mass, visual subcutaneous fat loss, less than or equal to 50% of estimated energy requirement for greater than or equal to 5 days. Per nutrition standards of care, this patient will be re-evaluated every TCU High (5-7 days) and prn (when needed). Further review of Resident #12's medical record revealed there was no re-weight as of 11/21/25. Resident #12 continued on a regular diet, had an appetite stimulant, received ensure vanilla twice per day for wound healing and continued vitamin supplements. Continued review of Resident #12's medical record revealed Dietitian #1 assessed the Resident on 11/6/25, 11/11/25, and 11/18/25 and documented the same weight and wrote, no new weights since previous nutrition evaluation. The end of the assessment documented, check weight monthly. On 11/20/25 at 1:30 PM an interview was conducted with the Clinical Nutrition Manager, who oversees Dietitian #1, who confirmed that there were no follow-up weights in the medical record and that the resident should have been reweighed. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Administrator on 11/21/25 at 7:15 AM confirmed that the facility staff failed to reweigh Resident #12 to determine if and how much weight the Resident was losing or if the nutritional supplements were effective. The Administrator also confirmed that she did not have a policy related to weights.