STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215340	A. Building B. Wing	07/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Blue Point Healthcare Center	2525 West Belvedere Avenue Baltimore, MD 21215

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interviews and medical record review, it was determined that the facility failed to assess residents for the ability to self administer medication. This was evident during random observations when medications were found at the bedside of 2 residents (Resident #61 and #62). The findings include: During the tour of the 'C' unit of the facility on 6/25/25 at 8:15 AM, this surveyor and another surveyor completing tour observed a medication cup on a bedside table full of pills. There were no residents observed or staff from the doorway. This surveyor knocked and entered the multiple person room. There were 2 people, an individual in the 'b' bed was awake, 'c' bed asleep and the 'a' bed resident sounded to be in the bathroom. The medication cup of pills was at the 'a' bed. There were 7 pills in the cup, 5 white, 1 pink and 1 brown. This surveyor asked the other surveyor to please go get a nurse to assist. LPN #15 arrived at the room and was asked if she passed the medication or who did. She picked up the medication and stated it was not her. At this time Resident # 61 proceeded out of the bathroom and too was asked about the medications. S/he stated that s/he told the nurse s/he had to go to the bathroom, so the nurse left the medication there for him/her. Resident #61 then took the medication from LPN #15 and swallowed all the pills with the water that was also on the bedside table. This surveyor and the other surveyor proceeded up the hall when another resident with pills at the bedside were observed at 8:25 AM. This surveyor asked Resident #62 about the pills on his/her bedside. S/he stated that s/he got distracted working on the computer but will take it now, there were 6 pills in that medication cup. This surveyor then interviewed LPN #14. She was asked about her process for passing medications. She stated that she gives it to the residents and watches them and that there were no narcotics left with either of the identified residents whose pills were reportedly left at the bedside. The records of both individuals were reviewed on 6/25/25 at 8:30 AM. Both residents were recently assessed with a current brief interview of mental (BIMS) status of 15, meaning that they were cognitively intact and were documented as making their own medical decisions. However, there was no current assessment or evaluation in the medical record that determined their ability to self administer medication without the supervision of medical nursing staff. This was reviewed with the current facility NHA and DON on 6/25/25 and again on 6/27/25.

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on medical record review and interview with facility staff, it was determined that the facility staff failed to notify the attending physician when the resident was refusing their medications. This was evident during the review of 1 of 3 residents administered Narcan (Resident #11) The findings include: The medical record for Resident #11 was reviewed on 6/23/25 at 10:51 AM related to a facility reported incident where Resident #11 was administered Narcan secondary to a suspected overdose occurring on 2/3/25. Further review at this time of Resident #11's medical record revealed admission to the facility for a minimal 6-week course of intravenous antibiotics for septic wounds on the leg and abdomen from suspected drug use and related endocarditis (inflammation of the heart due to an infection). Resident #11 was ordered Suboxone as part of his/her substance use disorder treatment. According to his/her medication administration record (MAR), Resident #11 refused 9 doses for the month of January and 5 of 8 doses for February 2025. Surveyor interviewed physician staff #35 on 6/25/24 at 10:12 AM regarding a note from 1/31/25 that referred to Resident #11 appearing high. She was asked about interventions related to this and she stated that that is why [resident] is on suboxone and followed by mental health. This surveyor asked who would have been responsible for letting mental health know that there was a concern that Resident #11 had an incident where s/he could have relapsed and she stated that it would have been her or the nursing staff. Concurrent review of the record with Staff #35 revealed there was no report to mental health or a meeting with any other discipline than her after this occurrence prior to the overdose incident. She was also asked if she had been notified of the numerous refusals of the Suboxone in January and for February 2025 and she reported no. The concern about the notification was reviewed with the current DON and NHA throughout the survey and again on 6/27/25.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview; it was determined that the facility failed to protect a resident (Resident #43) from misappropriation of personal funds by failing to provide the resident with way to secure the resident's valuables from theft. This was evident for 1 of 67 residents reviewed during the complaint survey. The findings include: The surveyor reviewed a facility reported incident (MD00217424) sent to the State of Maryland ' s Office of Health Care Quality alleging that Resident #43's money was stolen from his/her room. Medical record review for Resident #43 on 6/24/25 at 1:28 pm revealed the facility documented a change on condition which reported that the resident alleged that his/her money ($110.00) was stolen from the resident's room. On 6/24/25 at 1:40pm, the surveyor reviewed the facility investigation of the reported incident. The investigation contained a concern form dated 4/28/25 which reported that the resident was given a lock box to secure his/her valuables. On 6/25/25 at 8:30am, the surveyor interviewed Resident #43 in his/her room. The resident stated that he/she did not have a lock box at the time of the interview. The resident stated that his/her valuables were in a drawer unsecured. The resident also stated that he/she was transferred to his/her present room on 6/20/25. Interview with the Director of Nursing (DON) on 9:40am confirmed that the resident was transferred from room [ROOM NUMBER]C to 305C on 6/20/25. The surveyor informed the DON that the facility failed to provide the resident with a locked box to secure his/her valuables. The DON confirmed that the locked box was not the new room.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, it was determined the facility staff 1) failed to provide written notice to the resident and resident representative of the transfer to a local hospital for evaluation on 12/17/24. (Resident # 38). This was evident in 1 of 67 residents reviewed during a complaint survey; and 2) failed to ensure that hospital transfers were documented in the residents' medical records and that appropriate information was communicated to the receiving health care institution. This was evident for 1 (Resident #14) of 67 residents reviewed. Findings include:1) On 6/25/25 at 12:00pm, the surveyor reviewed complaint MD00212839 that was sent to the State of Maryland's Department of Health Care Quality alleging that the facility failed to recognize Resident #38's change in status resulting in the resident's family calling for emergency assistance to have the resident transferred to the local hospital on [DATE]. Review of Resident #38's medical records on 6/25/25 at 12:29pm revealed that the resident was treated for abnormal laboratory results by his/her primary provider on 12/17/24. Further review of the resident's medical record revealed that nursing staff documented that the resident was hospitalized as of 12/18/24. There was no evidence that the facility documented the resident's change of condition nor transfer of the resident for treatment prior to the hospitalization documentation.During an interview with the Director of Nursing (DON) on 6/25/25 at 1:36pm confirmed that that nursing staff failed to create a transfer for treatment documentation prior to the resident being transferred to the local hospital. The DON also confirmed that the facility was unable to confirm that this transfer document was given to the resident or the resident representative prior to the resident being transferred to the local hospital. 2) Resident #14's medical record was reviewed on 6/30/25 at 8:24 AM. S/he was admitted to the facility on [DATE]. The census record indicated that the resident was discharged 2 days later on 1/30/24. A Nursing progress note dated 1/30/24 16:03 (4:03 PM) Stated Resident called 911. Upon request resident transported to emergency room. Further review of the record failed to reveal the location of the transfer, the reason for the transfer, that the required information was provided to the receiving health care institution including but not limited to advance directive information, diagnoses and allergies, medications, most relevant labs other diagnostic tests, all special instructions and/or precautions for ongoing care, and care plan goals; there was no evidence that the resident was provided with a written discharge notice nor the facility's bed hold and return notice. There was no documentation in the record regarding the resident's orientation or that the physician was notified. On 6/30/25 at 9:50 AM the DON (Director of Nursing) was made aware of the above concerns and asked to provide all additional documentation pertaining to the residents hospital transfer on 1/30/24 including but not limited to change in condition, assessment and hospital transfer. He returned at 10:21 AM on 6/30/25 and confirmed that the only documentation related to Resident #14's hospital transfer was the nurses note which indicated the resident called 911. He indicated he was unable to locate any additional documentation. These findings were reviewed with the Administrator and Director of Nursing on 7/2/25 at 1:15 PM.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record reviews, the facility failed to have individualized care plans in place for Resident #32, #36, and #37 who have SUD (substance use disorder). This was evident for 3 out of 5 residents reviewed for care planning who had SUD.Findings include:1. On [DATE] at 10:55 AM, a medical record review revealed Resident #37, who had a diagnosis of SUD (Substance Use Disorder) and a BIMS score of 15/15, indicating intact cognition. On [DATE], GNA (Geriatric Nursing Assistant) called the Nurse into the room. The Nurse entered the room and found the resident unresponsive with no respirations and no pulse and no response to any verbal or tactile pain stimuli. A STAT (immediate) Code was called and all life-saving measures were given including CPR (cardiopulmonary resuscitation), Narcan x 4 administered and use of AED (automated external defibrillator) until emergency services staff arrived. Continued review of the record revealed Behavior Health saw resident on [DATE] where he/she described mood as 5/10 being depressed in the morning. Resident denied drug use and participated in SUD group activities. Review of the care plan only indicated to administer medications as ordered and evaluate resident for the following symptoms such as nodding off, stumbling, incoherent speech and anything that might indicate drug use. The Care plan failed to list interventions such as SUD group meetings, 1:1 if needed, and SUD mental health and recovery services which participated on [DATE], and [DATE], 5/27, and [DATE]. Resident #37 was required to take urinalysis for drug use and also comply with policies of the facility. There were no notes from the social worker and nothing noted in the QA book suggesting they discussed what interventions were put in place for the resident. Interview with DON, Administrator and Clinical Director of operations on [DATE] at 10:17 AM about concern with care plans and they offered no response.2. On [DATE] at 9:31 AM, a medical record review revealed Resident #36 had a diagnosis of SUD (substance use disorder). On [DATE] Resident #36 was observed sitting on the floor of the courtyard next to his/her walker unresponsive to tactile and verbal stimuli, respirations were slow and shallow. Narcan was given x 2 and the resident woke up. No other substances were found in the resident's room and resident denied taking any drugs. Police were called but did not respond because the resident was transported to the hospital. Review of the Care plan documented to approach in a calm manner, redirect behavior and monitor for the safety of others. The Care plan failed to include interventions such as SUD group meetings, 1:1 if needed, and SUD mental health services and recovery services if needed which the resident was receiving. Interview with the DON, Administrator and Clinical Director of operations on [DATE] at 10:17 AM regarding Care plans and they offered no response. 3. On [DATE] at 8:45 AM a medical record review was conducted for Resident #32 who had a diagnosis of SUD (substance use disorder) with a known history of opioid use and had been administered 2 doses of Narcan by staff after a change in condition. Resident had refused transport to the Emergency Department for further evaluation and stated that someone gave him/her the drugs, however the care plan was not updated to show behavior health was contacted to see resident. Review of the Care Plan only documented to administer medication as ordered and evaluate for the following symptoms: slurred speech, sleepy, erratic behavior. There was no care plan for 1:1, Behavioral contract that had been issued to the resident, or reference to seeing SUD abuse Nurse Practitioner or attending SUD groups. Interview with the DON, Administrator and Clinical Director of operations on [DATE] at 10:17 AM regarding Care Plans and they said nothing.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review, it was determined that the facility 1) failed to intervene when a resident that was admitted with a known history of substance use disorder was showing signs and symptoms of potential use and abuse of those substances. This was evident during the review of 1 of 3 residents administered Narcan (Resident #11); and 2) failed to ensure hospital instructions for surgical wound care were addressed upon the resident's admission to the facility. This was evident for 1 (Resident #14) of 10 residents reviewed for neglect.The findings include:1) Review of the facility reported incident on 6/23/25 at 10:51 AM for Resident #11 revealed that on 2/3/25 Resident #11 was observed on the ground outside appearing non-responsive, two doses of Narcan were administered with a positive response from the resident and s/he became alert and responsive to staff who had gathered to assist. Continued record review revealed that Resident #11 was admitted to the facility post hospitalization for septic wounds on the leg and abdomen from suspected drug use and related endocarditis (inflammation of the heart due to an infection) requiring minimally 6 weeks of intravenous antibiotics with a follow up with infectious disease to determine what further course is needed. For Resident #11's initial hospitalization s/he was observed injecting a substance into the central catheter, therefore the catheter was removed prior to discharge, however, the resident was readmitted to the hospital for worsening symptoms and discharged to this nursing facility with a central catheter intact. According to progress notes on 1/31/25 Resident #11's peripherally inserted central catheter was reported by the resident to staff to be dislodged. According to the physician, staff #35's encounter note completed on 1/31/25 also documented that staff had reported the resident to be high earlier that day. Further progress notes reported that for medications and wound care Resident #11 was unavailable on 2/1/25 and 2/2/25. The subsequent progress notes that were available were on 2/3/25 when Resident #11 were observed in the courtyard unresponsive. An additional review of the resident's medication administration record (MAR) revealed that his/her ordered Suboxone for opioid withdrawal was refused multiple times in January and every day in February 2025. Surveyor interviewed physician staff #35 on 6/25/24 at 10:12 AM regarding the note from 1/31/25 that referred to Resident #11 appearing high. She was asked about interventions related to this and she stated that that is why [he] is on suboxone and followed by mental health. This surveyor asked who would have been responsible for letting mental health know that there was a concern that Resident #11 had an incident where s/he could have relapsed and she stated that it would have been her or the nursing staff. Surveyor and Staff #35 concurrently reviewed the record and there was no report to mental health or a meeting with any other discipline than Staff #35 after this occurrence prior to the overdose incident. She was also asked if she had been notified of the numerous refusals of the suboxone in January and for all of February 2025 and she reported no.These collaborative concerns were reviewed with the facility current DON and NHA throughout the survey and again on 6/27/25. 2) Resident #14's medical record was reviewed on 6/30/25 at 8:24 AM. S/he was admitted to the facility with hospital discharge diagnoses which included: Motor vehicle accident injuring pedestrian, Cardiac Contusion, bladder rupture, closed fracture of left distal tibia (lower leg), multiple fractures of pelvis and closed compression fracture of L4 lumbar vertebrae (lower back). The hospital Discharge summary dated [DATE] included: instructions to schedule 2 week follow up appointments with providers for spine injuries, pelvic injuries and bladder injuries, it included the providers' contact information; and Wound/Ostomy/Drain Care: Dressing Instructions (specific): keep surgical dressings intact unless soiled until follow up in clinic. Should the dressings need to be changed, clean the incision with normal saline and apply a dry dressing secured with tape. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #14's admission nursing assessment dated [DATE] 16:30 (4:30 PM) did not identify the presence and location of the resident's surgical wounds. A TAR (Treatment Administration Record) is a tool used to record the physicians' orders for treatments. It is initialed by the nurse each time the prescribed treatment has been provided. It provides verifiable documentation of what treatments a patient has received. Resident #14's TAR (Treatment Administration Record) did not include wound care. Further review of the record revealed there were no physicians' orders for the care of Resident #14's wounds including the instructions provided in the hospital Discharge Summary. A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess and evaluate the effectiveness of the resident's care. A Plan of Care for Impaired Skin integrity was developed for Resident #14 related to prevention of pressure ulcers. However, it did not include Resident #14's surgical wounds nor their care. No other plan of care was developed to address Resident #14's surgical wounds. An interview was conducted with the DON (Director of Nursing) on 6/30/25 at 10:21 AM. He was made aware of the above concerns. He confirmed that there should have been some type of order on admission regarding the wound care identified in Resident #14's hospital discharge instructions. He indicated that he would reach out to the wound care nurse to see if she could locate any additional documentation regarding Resident #14's wounds. However, no further information was provided to the surveyor prior to the end of the survey. These findings were reviewed with the Administrator and Director of Nursing on 7/2/25 at 1:15 PM.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on a review of medical records, facility reported incidents, Controlled Medication Utilization Record sheets, Medication Administration Record (MAR), and interviews with staff, it was determined that the facility failed to consistently document address residents' pain, ensure prescribed medications had adequate parameters, ensure non-pharmacological interventions were attempted prior to the administration of narcotic pain medication, document assessment of pain and administration of an as-needed (PRN) pain medication on the electronic MAR and further monitor the resident's pain level and efficacy of the medication. This was evident for 3 of 5 residents reviewed for pain Resident #48, #5, #16 The findings include: A review of complaint MD00211655, revealed the following: 1. On 6/27/25 at 8 AM a review of Resident #48's clinical record revealed that the resident's primary physician on 10/25/24 ordered Dilaudid (Hydromorphone) Oral Tablet 4 MG, give 1 tablet by mouth every 6 hours as needed for Pain. This medication is used to help relieve moderate to severe pain. Dilaudid (Hydromorphone) belongs to a class of drugs known as opioid analgesics. A review of October and November 2024, Control Medication Utilization Record revealed Dilaudid (Hydromorphone) on the following days and times was removed from the controlled lock box on 10/28/24 at 5:30 AM, 10/29/24 at 12 PM, 10/30/24 at 1 PM and 7 PM, and 10/31/24 at 11:48 AM and 7 PM, 11/1/24 at 8 AM, 11/2/24 at 9 AM and 11:20 PM, 11/3/24 at 5 PM, 11/05/24 at at 11 AM, 11/7/24 at 6 PM, and 11/8/24 at 7 AM. Further review of the resident's clinical records revealed that the resident's October and November 2024, Medication Administration Record (EMAR) revealed that the Dilaudid (Hydromorphone) medication on the stated date was not documented as given to the Resident and the resident's pain level and efficacy of the medication was not monitored. The facility staff failed to administered pain medication as ordered by the physician. Interview with the Director of Nursing on 06/27/25 at 9 AM confirmed the facility staff failed to ensure Resident #48's, was administered pain medication as ordered by the physician after reviewing the EMR and Controlled Medication Utilization Record sheets. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) Pain medications written on a PRN (as needed) basis are given for unpredictable changes in a resident's pain level. Part of the nursing process is to obtain a pain level from the resident prior to administration (to indicate what level of pain is being treated) and after administration (to assess the effectiveness of the pain medication). Furthermore, good nursing assessment identifies the quality, the source, the location, and duration a of pain, not only to ensure that a medication is effective, but also to help the interdisciplinary team adjust the resident's medication and plan of care to best address their pain management needs.The pain level scale, where a resident reports their level of pain from 0 (no pain) to 10 (worse pain imaginable). When administering as-needed pain medication, an evaluation of the effectiveness of the medication is determined by asking a resident's pain level score prior to administration of the pain medication and their pain level after receiving the medication.Acetaminophen (Tylenol) is a non-opioid analgesic used to treat mild to moderate pain and fever.Tramadol is an opioid analgesic, also known as a narcotic. Narcotic pain medications are potent and effective at managing moderate to severe pain but have significant side effects and the potential for abuse.On 6/24/25 at 12:20 PM, review of complaint #MD00204000 alleged the facility was not administering medication to Resident #5 properly, that the resident was in pain and moaning all day. A review of the resident's medical record revealed Resident #5 resided in the facility for long term care since February 2018 and had diagnosis which included dementia, a history of a right hip fracture with right hip pain and chronic pain syndrome. A) Review of Resident #5's June 2025 MAR (medication administration sheet) revealed a 8/2/24 order for Acetaminophen (Tylenol) Extra Strength oral tablet by mouth every 8 hours for pain and a 5/13/25 order for Tramadol tablet by mouth every 12 hours as needed for pain. The orders failed to have adequate parameters to indicate when to administer which medication as needed for pain.B) The MAR documented Resident #5 was administered Acetaminophen by mouth on 6/20/25 at 6:49 PM for pain level 5. Review of Resident #5's eMar (electronic medication administration record) - Medication Administration Note (eMar note) dated 6/20/25 at 10:01 PM documented the resident's follow-up (f/u) pain scale was 0; PRN administration was effective. There was no documentation in the medical record to indicate the location or source of Resident #5's pain, or that an assessment of the resident's pain had been completed and non-pharmacological interventions had been attempted prior to the administration of the pain medication C) The MAR documented Resident #5 was administered Tramadol by mouth for pain 4 times in June 2025:- Resident #5 received Tramadol on 6/7/25 at 6:30 PM for pain level 8. An eMar note on 6/7/25 at 8:10 PM, documented f/u pain scale was 0, PRN administration was effective. There was no documentation to indicate the location of the pain or that an assessment of the resident's pain had been completed and non-pharmacological interventions had been attempted prior to the administration of the pain medication- Resident #5 received Tramadol by mouth on 6/8/25 at 5:00 PM for pain level 7. An eMar note on 6/8/25 at 5:42 PM documented f/u pain scale was 1, PRN administration was effective. There was no documentation to indicate the location of the pain or that an assessment of the resident's pain had been completed and non-pharmacological interventions had been attempted prior to the administration of the pain medication- The Resident #5 received Tramadol by mouth on 6/17/25 at 2:16 AM for pain level 8. An eMar note on 6/16/25 at 2:16 AM documented Resident #5 was medicated for left jaw pain (Parotitis) (inflammation of the parotid (salivary) gland(s)). An eMar note on 6/17/25 at 4:48 AM documented f/u pain scale was 0, PRN administration was effective. There was no documentation to indicate non-pharmacological interventions had been attempted prior to the administration of the narcotic pain medication- Resident #5 received Tramadol on 6/22/24 at 9:09 AM for pain level 6. An eMAR note on 6/22/25 at 10:43 AM, documented the resident's f/u pain scale was 0, PRN administration was effective. There was no documentation to indicate the location or source of the pain, that an assessment of the resident's pain had been completed and non-pharmacological interventions had been attempted prior to the administration of the pain medication.The above concerns were discussed with the Director of Nurses (DON) on 6/26/25 at 3:16 PM. The DON acknowledged the concerns, and no further comments were offered at that time. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3) Review of the medical record for Resident #16 related to an injury of unknown origin on 6/24/25 at 8:20 AM revealed that on 3/23/24 Resident #16 was noted with a change in condition to their arm with noted tenderness and pain upon movement. Further review noted that a telehealth notification was sent to the on-call provider overnight reporting that Resident #16 had a right humeral fracture and was 'in excruciating pain'. Screaming out and inconsolable. The right arm is 'swollen.' Concurrent comparison with the resident's medication administration record (MAR) failed to reveal the administration of any scheduled or as needed pain medication at this time frame. Resident #16 was ordered to be sent to the emergency room secondary to the fracture and pain, however, pain was not documented in the record or the MAR as treated prior to the transfer except for 1 time at 6:05 PM. There was no documentation of any Tylenol administered after that dose although the order stated the Tylenol could be administered again every 6 hours.The concern Resident #16 was documented as being in excruciating pain and no further documentation of a pain intervention was reviewed with the current facility DON (Director of Nursing) and NHA (Nursing Home Administrator) on 6/24/25 and again on 6/27/25.

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	215340	A. Building B. Wing	07/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Blue Point Healthcare Center	2525 West Belvedere Avenue Baltimore, MD 21215

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interviews, and review of facility investigation documents, it was determined that the facility failed to effectively communicate with the Substance Abuse Disorder (SUD) team, the physician and direct care staff regarding residents in order to develop and maintain a comprehensive plan of care to address residents substance abuse disorders and treatment plans. This was evident for 1 of 11 residents (Resident #56) reviewed during the complaint survey.As a result of this deficient practice, an Immediate Jeopardy was identified on [DATE] at 12:15 PM and an IJ summary tool was provided to the facility. The removal plan was accepted by OHCQ on [DATE] at 9:20 PM after 5 initial plans were submitted to the surveyors at 3:40 PM, 4:45 PM, 7:45 PM, 7:48 PM and 8:45 PM. After removal of the immediacy, the deficient practice remained with a scope and severity of E. The Immediate Jeopardy was removed on [DATE] at 10:45 AM after on-site confirmation of the completion of the facility's plan of removal.The findings include:Substance Use Disorder is a treatable mental disorder that affects a person's brain and behavior, leading to their inability to control their use of substances like legal or illegal drugs, alcohol, or medications. Suboxone: is part of a family of medications used in Medication Assisted Treatment (MAT).Medication Assisted Treatment (MAT): is an addiction recovery treatment plan that includes medications designed to treat opioid use disorders.Narcan: A medication given to help reverse an opioid overdose.A list of residents provided by the Director of Nursing (DON) and reviewed on [DATE] at 10:32 AM revealed that 94 out of 111 residents who resided in the facility had diagnoses which included but were not limited to Substance Use Disorder (SUD). On [DATE] at 8 AM, the surveyor reviewed Resident #56's medical record which revealed a change in condition report on [DATE], that the resident was observed with decreased responsiveness with limp body, decreased respiration and decreased heart rate. The resident was given 2 doses of Narcan and transported to the hospital. The resident returned to the facility on [DATE]. Further, review of the medical record failed to identify the overdose. The resident was seen by the SUD staff on [DATE] and the assessment failed to identify the overdose on [DATE] and documented that the resident admitted to occasional craving and thoughts, however, denied desire to use at this time.A review of the SUD staff assessment dated [DATE] revealed that the resident disclosed an incident where he/she unknowingly ingested heroin given to him/her by someone else, leading to an overdose that required Narcan administration. The resident mentioned being on Suboxone and stated that no adjustments were needed. However, he/she reported experiencing cravings.Further, a review of the SUD assessments revealed:1. That on [DATE], Resident #56 reported experiencing cravings.2. On [DATE], the client disclosed having last used illicit drugs yesterday, stating he/she liked using drugs even if on Suboxone.3. On [DATE] progress notes revealed that Resident #56 last used 2 days ago.4. On [DATE] and [DATE] Resident # 56 admitted occasional craving and thoughts of using drugs.5. On [DATE] Resident #56 disclosed to SUD staff having used drugs a week ago. All of the above information on the SUD assessments was not communicated to the facility staff.A review of the electronic medical record revealed that that Resident #56 refused his/her suboxone from [DATE] - [DATE]. On [DATE] Resident #56 was observed slumping down in his wheelchair in the hallway. Prior to finding the resident slumped down, the resident was self-propelling in his wheelchair. The resident was assisted into the bed. The resident was assessed as follows: Slow shallow breathing and faint pulse. Narcan was given x 2, due to resident drug history without positive results. CPR was initiated, 911 called and one shock by AED was given. The Resident was pronounced dead on [DATE] at 0446 in the facility.On [DATE] @ 1:15 PM an interview with LPN #33 stated that he did not inform the physician or the SUD team of Resident #56's refusal of suboxone. LPN #33 also said that he does not communicate with the SUD team, only the physician.On [DATE] @ 9:17 AM an interview with the Unit Manager #6 revealed that if a resident refuses medications that the Physician is made aware and a note is written in the resident's medical record. The Unit Manager #6 stated that he/she did not communicate with the SUD team or physician. The Unit Manager confirmed that she/he attends the care plan meeting, but the SUD staff does not.The SUD program NP, Staff #36, was interviewed on [DATE]. She indicated that she had worked in the facility since [DATE]. She revealed that she does not develop SUD care plans nor attend the care plan meetings for the residents in the SUD program. She also indicated that a resident who has used and overdosed is at high risk and she would expect a change in the care plan to find out the reason, whether it's a personal event, pain or a need for medication changes When asked how staff would know how to assist the residents if they are

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F 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview with facility staff it was determined that the facility failed to ensure that a radiology report was timely accessible to the attending physician. This was evident during the review of 1 of 3 fractures (Resident #13)The findings include:Revie of the medical record for Resident #13 on 6/24/25 at 11:17 AM for an injury of unknown origin revealed an x-ray was ordered for this resident on 11/6/24 and completed on 11/6/24 at 2:13 PM. This report was then reported back to the facility on [DATE] at 6:32 PM stating that Resident #13 had a fracture of the right femoral neck and recommended further imaging of the right hip. This report was not responded to or followed up on by the facility attending physician until 11/7/24 at 12:12 PM. The current facility DON was interviewed on 6/24/25 at 1:56 PM and was notified of the findings. There was no further information provided prior to exit regarding the delay in reviewing the x-ray by the attending physician.

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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 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Based on record reviews and interviews, it was determined that the facility failed to use the Quality Assurance Performance Improvement (QAPI) process to track, review, and analyze residents at risk for illicit drug use/overdoses. This was evident during review of the facility's QAPI process after 11 residents (#56, #8, #4, #45, #31, #11, #33, #32, #7, #36 and #37) were reported by the facility to the state agency for suspected drug overdoses in the past 13 months and has the potential to affect all residents with Substance Use Disorders. As a result of this deficient practice, an Immediate Jeopardy was identified on 7/2/2025 at 10:00 AM and an IJ summary tool was provided to the facility. The removal plan was accepted by OHCQ on 7/2/25 at 9:20 PM after 5 initial plans were submitted to the surveyors at 3:40 PM, 4:45 PM, 7:45 PM, 7:48 PM and 8:45 PM. After removal of the immediacy, the deficient practice remained with a scope and severity of F.The Immediate Jeopardy was removed on 7/7/25 at 10:45 AM after on-site confirmation of the completion of the facility's plan of removal. The findings include:The Centers for Medicare and Medicaid Services (CMS), defines Quality Assurance (QA) and Performance Improvement (PI) as a systematic, comprehensive, and data-driven approach to maintaining and improving safety and quality in nursing homes while involving all nursing home caregivers in practical and creative problem-solving. Narcan is a medication that rapidly reverses an opioid overdose. A list of residents provided by the Director of Nursing (DON) and reviewed on 6/27/25 at 10:32 AM revealed that 94 out of 111 residents who resided in the facility had diagnoses which included but were not limited to Substance Use Disorder (SUD). Between 5/23/24 and 6/2/25 the facility reported 11 incidents to the state agency involving suspected resident drug overdoses: 1. Resident #56 overdosed on 5/23/24, passed away2. Resident #8 overdosed on 9/4/243. Resident #4 overdosed on 10/2/244. Resident #45 overdosed on 12/27/245. Resident #31 overdosed on 12/31/246. Resident #11 overdosed on 2/3/257. Resident #33 overdosed on 3/3/25 8. Resident #32 overdosed on 4/10/259. Resident #7 overdosed on 4/15/25, passed away10. Resident #36 overdosed on 5/23/2511. Resident #37 overdosed on 6/2/25, passed away Review of Resident #56's record on 6/30/25 at 8:00 AM revealed the resident had a prior overdose on 2/23/24. During an interview on 6/27/25 at 12:10 PM the Director of Nursing identified that the SUD program was overseen by an outside contracted service provider that provided psychiatric services in the facility. 1 Nurse Practitioner (NP), Staff #36, oversaw the SUD program and another NP provided other psychiatric services. The SUD program NP, Staff #36, was interviewed on 7/1/25. She indicated that she had worked in this facility since April 2025. She revealed that she did not develop SUD care plans nor attend the care plan meetings for the residents in the SUD program. She also indicated that a resident who has used and overdosed is at high risk, and she would expect a change in the plan of care to find out the reason, whether it's a personal event, pain or a need for medication changes. When asked how staff would know how to assist the residents if they voiced or expressed symptoms such as cravings, she indicated, that would be up to the nursing staff. When asked if she attended QAPI meetings she indicated she had in the past, in other facilities but not in this facility. Review of QAPI meeting records for the past year revealed the facility included Quality Measures for: Behavior Affecting Others - with the Action Plan: Continue to partner with [Contracted psychiatric services provider] and insert appropriate interventions as needed; and, Depressive Symptoms - with the Action Plan: Continue to partner with [Contracted psychiatric services provider] and insert appropriate interventions as needed. Facility has a high admission rate of residents admitted with depression diagnoses due to prior history and/or possible substance abuse. However, the QAPI process did not include measures to track and analyze illicit drug use and/or overdoses in the facility. In an interview on 7/1/25 11:02 AM the Administrator and DON were asked if the facility developed and conducted performance improvement activities for drug overdoses. The Administrator indicated, no, that they did not determine that there was a break in their system. She indicated that they investigated all the overdoses and determined during their investigations that processes were followed, that some overdoses were out of their control even though the facility's processes were followed. She indicated that the facility would QAPI if they determined the overdoses were a break in their system. However, there was no evidence that the overdose incidents were systemically tracked, reviewed or analyzed in the aggregate to identify trends or systemic issues. The provision of the plan to remove the Immediate Jeopardy immediacy had a completion date of 7/7/2025 and included the following:QAPI Governing body to be educated on monitoring and tracking/trending Narcan administration by Regional clinical team by 7/3/25 SUD NP to attend monthly QAPI meetings DON to track Narcan administration and

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on record review and interview with staff it was determined the facility staff failed to ensure that the resident's appointed decision maker was provided education and opportunity to consent or decline the COVID-19 vaccine booster on the resident's behalf. This was evident for 1 (#21) of 67 residents reviewed during the complaint survey. The findings include: A complaint reviewed on 6/23/25 at 1:15 PM alleged that Resident #21, a resident who was incapable of making decisions for him/herself received a COVID-19 vaccine booster on 1/16/24 without the consent of his/her guardian. Resident #21's medical record confirmed the resident had a court appointed guardian since 2017. The Resident's immunization record revealed 2 electronic consent forms which indicated 2023-2024 COVID-19 Moderna. One was dated 1/30/24 and the other 4/26/24, both indicated education was provide and Resident Refused. The documentation did not indicate that the resident's court appointed guardian was contacted, provided education and either declined or consented for the resident to receive the vaccine. On 6/24/25 at 11:23 AM the DON (Director of Nursing) was made aware of these findings. He indicated that unfortunately the facility had gone to electronic documentation. He was made aware that the electronic documentation indicated the resident refused and did not reflect that his/her guardian was contacted as required. The facility's current IP (Infection Preventionist) Staff #21 was interviewed on 6/24/25 at 12:25 PM. She indicated that she had been the IP for 1 month and that the IP identified on the consent forms dated 1/30/24 and 4/26/24 no longer worked in the facility. She identified the Assistant Director of Nursing Staff #13 as a former IP at the facility. Staff #13 was interviewed on 6/24/25 at 12:30 PM. She confirmed that she was the IP in 2021. She was asked to explain the facility's process for offering COVID-19 or any vaccines to residents with guardians. She indicated call the guardian, let them know, provide education and get consent/declination - either verbally, or some wanted to consent in writing. She indicated the consent form would be sent by mail or email or given to them in person and returned to the facility after signing. When asked if staff were able to specify in the electronic system whether the resident or a guardian consented or declined, she indicated yes, that she had the ability to identify the name of the guardian/representative. She confirmed that if the electronic consent form indicated Resident then it would mean that the resident either consented or refused. These findings were reviewed with the Administrator and Director of Nursing on 7/2/25 at 1:15 PM.