

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215356	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/14/2026
NAME OF PROVIDER OR SUPPLIER The Nursing and Rehab Center at Stadium Place		STREET ADDRESS, CITY, STATE, ZIP CODE 1010 East 33rd Street Baltimore, MD 21218	
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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on record review and staff interview, it was determined that the facility failed to ensure there was a Registered Nurse working at least 8 hours a day. This was evident in 3 out of 14 days reviewed during the Staffing task in the recertification survey. The findings include: On 7/10/2026 at 9:16 AM, a review of the staff assignment sheets for 6/25/2026 to 7/9/2026 were reviewed. The facility did not have a Registered Nurse (RN) working for any shift on 6/30/2026, 7/4/2026, and 7/5/2026. On 7/10/2026 at 9:44 AM, an interview with the Director of Nursing was conducted. When asked if they were aware that the facility did not have Registered Nurses on 6/30/2026, 7/4/2026, and 7/5/2026, they stated that they were aware. When asked what is being done to ensure they are meeting staffing requirements, the DON stated that they are working on hiring more staff.		

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on resident interview, observations, and staff interview, it was determined that the facility failed to maintain a functional and comfortable environment. This was evident on 4 out of 4 units reviewed for environment. The findings include: 1. On 7/7/2026 at 12:22 PM, The 1st floor shared bathroom's walls were bubbled with unpainted repairs on the opposing walls. When asked what was being done to repair the walls, Staff #1 stated that repairs have been completed for the 2nd and 3rd floor. Staff #1 stated that he will be repairing the 1st floor shared bathroom next. Staff #1 stated that he made administration aware that paper towels were causing the pipes to clog resulting in leaks and damaging the walls of the lower bathrooms. The maintenance director stated that paper towel dispensers were replaced with an air drying system in the bathrooms. 2. On 7/6/2026 at 9:12 AM, Interview with Resident #1 was conducted. When asked if the temperature in the facility was comfortable, Resident #1 stated that it was fine at the moment but the weekend was rough. When asked what was rough about it, Resident #1 stated that it was too hot. On 7/7/2026 at 12:46 PM, an interview with Staff #1 was conducted. When asked about why there were portable air units in the main hallways, the maintenance director stated that the A/C unit has been under repair since his arrival to the facility. Stated he arrived about a year ago. When asked what is being done to permanently fix the main A/C unit, Staff #1 stated that the Air Conditioning system is running at its highest capacity and only maintenance is required at this time. When asked what needs to be done for the facility temperature to be maintained without portable units, Staff #1 stated that the A/C unit would have to be replaced or upgraded. On 7/10/2026 at 11:05 AM, an interview with the Administrator was conducted. When asked how long the main A/C had needed portable A/C units to maintain facility temperature, the Administrator stated that the portable A/C units have been supporting the main units since their arrival in the beginning of June 2026.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on interviews, record reviews, and observations, it was determined that the facility failed to promote and maintain resident dignity by failing to answer residents' call lights promptly to address residents basic care needs. This was evident for 4 (Resident #17, #2, #60 and #22) out of 8 residents reviewed for dignity during the recertification survey. The findings include: On 07/06/2026 at 9:34 AM, an interview with Resident #17 was conducted. They reported that it took too long for call bells to be answered, so they avoided going to the bathroom a lot therefore avoiding the need to call a staff member to change their brief. When asked for a specific date or time, they responded that it happened frequently and on various shifts. On 07/06/2026 at 10:06 AM, an interview with Resident #2 was conducted. They reported that when their colostomy bag got full and called the facility staff for help, it took them too long to respond to the call bell. They added that at times when they pressed the call bell, no staff came to check on them. On 07/07/2026 at 1:14 PM, an interview with Resident #22 was conducted. They reported that it was easier to call 911 and get help than to press the call bell for assistance. The resident called for help at 1:14 PM, and the surveyor observed the call bell light was on. No staff responded to the call until 1:54 PM. On 07/13/2026 at 8:06 AM, a review of Complaint #2966643 submitted to the Office of Health Care Quality (OHCQ) was conducted. Resident #60 alleged that residents waited for an hour for call bells to be answered. On 07/09/2026 at 10:01 AM, an interview with the Director of Nursing (DON) was conducted. She reported that when a resident calls for help, nursing staff have a pager which alerted the staff to which resident needed help. The pager would sound or buzz within 5-10 seconds of a resident calling for staff assistance and the call could only be turned off once the staff checked on the resident. When asked what the expectation was to respond to residents' call bell, DON stated as soon as possible and not more than 15- 20 minutes. On 07/09/2026 at 1:03 PM, the surveyor reviewed the call audit report for Resident #17 with the DON. On 7/5/2026, the report indicated that the resident called for assistance twice and waited for 48 minutes and 59 minutes. DON reported that she was not aware of any staffing shortage that day and is unsure why the resident had to wait for that long. Further review of the call bell system audit for 3rd and 4th floor revealed that 58 out of 221 calls were answered with a wait time of 15 minutes or longer.		

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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 staff interviews, it was determined that the facility failed to maintain a clean and homelike environment. This was evident in 4 out of 4 units observed for environment. The findings include: 1. On 7/06/2026 at 9:12 AM, an observation of Resident #1's room was conducted. The carpet in the room was sticking to the surveyors shoes. 2. On 7/07/2026 at 12:16 PM, observations of 1st, 2nd, and 3rd floor and interview with the Maintenance Director (Staff #1) were conducted. Multiple windows in resident rooms bottom rails are separating from the glass. This was observed in rooms [ROOM NUMBER]. When asked if the facility was aware of the windows, Staff #1 stated that they were aware and the only solution they have at the moment is duct taping the gaps in the windows. When asked what can be done to fix the windows, Staff #1 stated that because of the age of the windows the only solution is to replace the windows. 3. On 7/07/2026 at 12:20 PM, The 1st floor carpet in the hallway between room [ROOM NUMBER] and the kitchen door had a strong smell of urine. When asked if he was aware of the smell, Staff #1 stated that he was not aware. Staff #1 stated that the smell is a combination of the built-up urine in the carpet and the high humidity and temperatures over the weekend. When asked what can be done to eliminate the odor, Staff #1 stated that the only way is to replace the carpet.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interviews and record reviews, it was determined that the facility failed to administer medications in accordance with professional standards. This was evident for 5 (Resident #46, #2, #60, #59 and #64) out of 5 residents reviewed for medication administration. The findings include: 1. On 07/06/2026 at 9:06 AM, an interview with Resident #46 was conducted. They reported that the medications are administered late. On 07/09/2026 at 9:58 AM, a review of Resident #46's Medication Administration Review (MAR) audit was conducted. A review of July 1st to July 8th medication administration times revealed that the resident received medications late on 8 out of 8 days on various shifts. 2. On 07/06/2026 at 11:24 AM, an interview with Resident #2 was conducted. They reported that the medications were constantly given late. On 07/08/2026 at 12:34 PM, a review of Resident #2's Medication Administration Review (MAR) audit was conducted. A review of July 1st to July 8th medication administration times revealed that the resident received medications late every day and on various shifts. 3. On 07/13/2026 at 8:06 AM, a review of Complaint #2966643 submitted to the Office of Health Care Quality (OHCQ) was conducted. Resident #60 alleged that medications were not administered as prescribed. On 07/08/2026 at 2:11 PM, an interview with the Director of Nursing (DON) was conducted. She stated that residents should be given medications as prescribed and to be administered within 1 hour before or after the ordered time. Additionally, facility staff were expected to sign off medications at the time of administration. At this time, the surveyor reviewed Resident #46, #2, and #60 medication administration audits with the DON who confirmed that medications were administered late and others were not administered. 4. On 7/13/2026 at 9:39 AM, a review of Complaint 2974726 was conducted. The complainant (Resident #59) stated that they were receiving their medication late. On 7/13/2026 at 1:47 PM, a review of the Medication Administration Audit report for Resident #59 for the month of April was conducted. Resident #59 received the following medications late:-Jardiance (a medication used to treat diabetes) late 4 times-Carvedilol (a medication used to regulate blood pressure) late 10 times-Dolutegravir (an antiretroviral drug) late 3 times-Bupropion (a medication used to help with anxiety) late 3 times-Losartan (an antihypertensive medication) late 3 times-Clonidine (an antihypertensive medication) late 1 time 5. On 7/09/2026 at 2:32 PM, a review of Complaint 3073715 was conducted. The complainant stated that Resident #64 did not administer the medications as ordered. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/09/2026 at 2:56 PM, a review of the Medication Administration Audit report for Resident #59 for the month of July was conducted. Resident #64 received the following medications late:-Carvedilol Oral Tablet 3.125 MG (Carvedilol) 5 times-Senna-Plus Oral Tablet 8.6-50 MG (Sennosides-Docusate Sodium) 4 times-Bumetanide Oral Tablet 2 MG (Bumetanide) 2 times On 7/13/2026 at 2:48 PM, an interview with the DON was conducted. When asked about the expectation for the medication documentation and administration, the DON stated that the medications should be documented at the time the medication is administered. When asked what time frame the medication should be given from the ordered time, the DON stated that the medication should be given between 1 hour before and 1 hour after the ordered administration time. This surveyor made the DON aware of Resident #59 and #64 receiving medications late, and the DON confirmed the surveyor's findings.		

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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** Based on record review, observations, and staff interview, it was determined that the facility failed to supervise a resident (#49) to prevent them from hazards. This was evident for 1 out of 3 residents reviewed for accidents and supervision. The findings include: On 7/10/2026 at 8:45 AM, a review of facility reported incident #3067330 was conducted. The incident was reported to the state agency after Resident #49's representative reported that the resident had cuts and bruises from an unknown origin. A Nursing Investigation form created on 7/1/2026 stated that the resident had been admitted with bruises on both arms and a skin tear on the right elbow at the time of admission. The Nursing Investigation form stated that Resident #49 had additional bruises and a skin tear from striking a nurse on an attempt to elope through the rehab window on 6/28/2026. On 7/10/2026 at 11:23 AM, a review of Resident #49's progress notes. A Behavior note written by Staff #10 on 6/28/2026 stated: Type of Behavior: upon resuming my shift at 11:15pm the resident was in bed during my rounds. At 12am I went to the 2nd floor to give medication and came back to the 1st floor, my GNA made me aware the resident was not in his room, after searching all the rooms and the toilets in the building 911 was called. The writer opens the PT room and finds the resident at the back of the [Physical Therapy] room using a [NAME] to cut the fence in order to elope the writer was trying to stop [them], [s/he] was combative, and [s/he] used the [NAME] to hit the nurse several times. The on-call order for [them] to be transferred to the hospital but the [Representative] declined and said [they] will stay with [them] over the night. The policemen said it is part of [their] diagnosis and [s/he] should not be sent out also blaming the facility for allowing [them] to have access to the [NAME]. On 7/10/2026 at 11:40 AM, an observation of the Screened-in porch and therapy room was conducted with the Director of Nursing (DON). The therapy room was observed to have a lock at the bottom of the door. When asked if the lock on the door is new, the DON stated that the lock has been there even prior to the incident. A keypad locked door knob was observed on the door leading out to the screened-in porch. The DON stated that this was added to the door after the incident. The screen on the porch was observed to have 2 - 1 foot long tears and 1 screen detached from the bottom of the section. On 7/10/2026 at 12:08 PM, an interview with DON was conducted. When asked how the resident was able to access the incident of 6/28/2026, the DON stated that they did not know. When asked when the facility staff was able to locate the resident, the DON stated 1:13 AM. When asked if the resident was reassessed for elopement risk after the incident, the DON confirmed that the resident is not a low elopement risk now but there was no reassessment completed for elopement risk after the incident.		