STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215356	A. Building B. Wing	07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Nursing and Rehab Center at Stadium Place	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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on administrative record review and interviews with the residents, family and facility staff, it was determined the facility staff failed to provide an environment that promotes dignity and respect for residents who require assistance with their daily care. This was found to be evident for 1(Resident #49) of 5 residents reviewed for abuse allegations during the survey.The findings include:Intake #331013 was reviewed on 7/21/25 at 11:00AM for allegations of resident abuse to Resident # 49. The abuse allegations were unsubstantiated.Resident #49 was admitted to the facility with the following but not limited diagnosis: Osteoarthritis (Degenerative Joint Disease) Right Hip and Muscle Weakness.An interview was conducted with Resident #49 on 7/22/25 at 10:59AM and the resident was asked about the care that s/he received while at the facility. The resident went on to say that a few months ago while in the facility a nurse (Staff #21) did not provide assistance when requested. The resident stated that the nurse questioned why s/he did not ask the aide for assistance. The resident stated s/he called their daughter, and their daughter wrote down the date and the staff name.During an interview with the resident daughter on 7/23/25 at 11:10AM she stated that she received a call from Resident #49 and the resident explained to her what happened. She stated that she wrote down the nurse name (Staff #21) and the date, which was 4/25/25 and she immediately spoke with the facility administration and reported this to the state office.Review of Staff #21's employee file had a corrective action form dated 4/25/25 which indicated the employee conduct during an interaction with a resident was inappropriate and did not reflect the respectful, compassionate and patient-centered care that the facility was committed to providing, and the disciplinary action includes termination.During an interview on with the DON with the Administrator present on 7/23/25 at 1:04 PM they explained to the survey team that the corrective action form was a result of the interaction regarding Resident #49 and the nurse (#21). The DON went on to explain that it was reported to her that while the nurse was in the resident room, the resident asked the nurse to give him/her the TV remote, and the nurse told the resident that s/he could have asked the aide to get it. The DON went on to explain that this behavior is unacceptable and that the nurse was to assist the resident. The DON explained that everyone is responsible for assisting the resident and the resident was not treated with respect and the nurse was terminated.All concerns were discussed with the administration team at the exit conference on 7/23/25 at 4:00PM.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interviews with facility staff, it was determined the facility failed to ensure that a resident and /or the resident representative (RP) received notice in a timely manner regarding notification and explanation of their rights pending discharge from Medicare. This was found to be evident for 1 (Resident # 67) of 4 residents reviewed regarding liability notices during the survey.The findings include:Notice of Medicare Non-Coverage (NOMNC) is notification to residents and/or their representative (RP) regarding the end of their Medicare coverage. Notification is required to be minimally 48 hours prior to the scheduled effective date that coverage will end, therefore, affording the resident an opportunity to appeal the decision or to prepare for discharge.During a medical record review on [DATE] at approximately 11:30AM for Resident # 67 for discharge, the facility provided the survey team with the non-medical coverage documentation. The form indicated that the resident services were going to expire on [DATE]. The notice was signed by the resident on [DATE].An interview was conducted with the Business Office Manager (BOM) on [DATE] at 12:02 PM and she was asked to explain why the resident was provided with the non-medical coverage form after the services expired and she stated the following:Resident # 67 did not discharge from the facility until [DATE] and that the resident should have been provided with the notice two days before the date the services were due to expire. She went on to say that she recognized that this was an error and submitted that the resident cost be wiped out as the resident was billed.During a subsequent meeting with the survey team, the BOM provided an activity report of the resident account that showed a note dated [DATE] as follows: an amount submitted for potential write off. Prior days used removed from census. Exhausted Medicare A days. Facility responsibility. She confirmed that the resident should have been provided with the notice 48 hours prior to the date that the services were due to end and that the resident should not have been charged. All concerns were discussed with the Administration team on [DATE] at 4:00PM at the exit conference.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review, it was determined that the facility failed to maintain documentation related to an allegation of abuse. This was evident for 2 of 6 facility reports reviewed during the annual recertification survey.The findings include: 1.) On 07/18/2025 at 11:45 AM, the surveyor requested information related to an abuse allegation reported by the facility to the State Agency on 2/23/23. The Director of Nursing stated that the facility had no records related to the report. On 07/21/2025, the surveyor requested additional information from the State Agency. The initial report and 5-day report were reviewed and indicated that the investigation had been completed in a satisfactory manner, and reporting appeared to have occurred within the required 2-hour timeframe. However, exact incident times were not documented, and the facility failed to retain required records of the incident investigation or reporting process. 2.) On 07/17/25 at 1:10 PM the surveyor reviewed the change in condition report dated 01/03/2023 which was located in the electronic medical record (EMR). There was a late entry created by the current DON which documented the statements made by the resident and the actions of the DON. Per the documentation in the EMR on 01/02/2023, on the night shift, Resident # 63 stated that a geriatric nursing assistant (GNA) tried to fight him/her and refused to help him/her put on a pull up. The resident stated that he/she feels safe here and this was the first time this had happened. Police were called and an investigation was initiated. Resident was followed by psych services. The resident reported to nursing staff that she/he was concerned about her/his daughter not visiting. Resident #63 stated that she/he did not like the way the GNA spoke to him/her. Resident admitted to being the person who asked the GNA if she/he wanted to fight. Resident #63 continued to be followed by psych services after the incident on 01.02.2023. The change in condition report revealed that the alleged perpetrator/employee/GNA was immediately suspended and did not return to work until after the investigation was completed. According to the intake information, the facility determined there was insufficient evidence to support the allegations of abuse. On 07/17/25 at 1:15 PM the surveyor requested a copy of the FRI for this Resident #63. As of 2:37 PM the surveyor had not received the FRI for review. On 07/17/2025 2:41 PM Resident #63's hard copy facility incident report had not be received from the DON. On 07/18/25 at 09:44 AM the administrator stated that the DON was unable to locate the hard copy of the facility report for the incident that allegedly occurred on 01/02/2023. On 07/18/2025 at 09:47 AM the administrator stated in the presence of two other surveyors that the DON stated that she could not locate any electronic and/or hard copy documentation of the FRI related to the alleged incident that occurred on 01.02.2023.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview with staff, it was determined that the facility failed to ensure a resident's person-centered care plan was reviewed and revised to reflect the resident's current code status. This was evident for 1 (Resident #68) out of 2 residents reviewed for care planning during the survey.The findings include:A care plan is used to summarize a person's health conditions, specific care needs, and current treatments and outlines what needs to be done to plan, assess, and manage care. Care plans are developed, reviewed, and/or revised by the IDT after the completion of a comprehensive MDS assessment (Admission, Annual, Quarterly, Significant Change) to help to evaluate the effectiveness of the resident's care while in the facility.Do Not Resuscitate (DNR) is an order placed in a person's medical record by a doctor informs the medical staff that CPR should not be attempted.Do Not Intubate (DNI) is an order placed in a person's medical record by a doctor informs the medical staff that chest compressions and cardiac drugs may be used, but no breathing tube will be placedMaryland Medical Orders for Life-Sustaining Treatment (MOLST) is a form which includes medical orders for emergency medical services or other medical personnel regarding CPR (cardiopulmonary resuscitation) and other life-sustaining treatment options.On [DATE] at 7:40AM, during a review of Resident #68's electronic medical record, the Surveyor discovered a physician's Medical Visit note created on [DATE] which identified the resident's code status as DNR/DNI with all other interventions under the Advance care planning section.Further review revealed a MOLST form, signed and dated [DATE] by the physician, which stated that Resident #68's code status of No CPR, DNR/DNI.A full code provides full support, including CPR, and allows all interventions needed to restore breathing and/or heart functioning.On [DATE] at 7:51AM, during a review of Resident #68's active physician's orders, the Surveyor noted an order for Full Code created on [DATE].An additional review of the electronic medical record revealed a care plan created on [DATE] with a focus stating, The resident has an advanced directive of Full Code.On [DATE] at 8:44AM, during an interview conducted with the Director of Nursing (DON), the Surveyor expressed the concern that the resident's care plan had not been revised to reflect the resident's current code status of DNR/DNI. The DON confirmed the Surveyors' findings and stated that the resident's care plan will be reviewed and revised to reflect the resident's current code status of DNR/DNI.On [DATE] at 9:51AM, the Surveyor was informed that Resident #68's care plan was revised to reflect the resident's code status of DNR/DNI.

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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. Based on observations, record review, and interviews with residents and staff, it was determined that the facility failed to ensure a physician's order for tube feeding was accurately followed (Resident #12) who was reviewed for tube feeding. The findings include:On 7/15/2025 at 8:53AM, during an interview with Resident #12, the Surveyor observed the resident's tube feeding running at 75ml/hour and the flush bag was not labeled.On 7/15/2025 at 10:30AM, a review of Resident #12's electronic medical record revealed an active physician's order for Jevity 1.5kcal Up : 5 pm Down : 3 am TV : 75 mL/hr x 10 hrs.During an interview with the Director of Nursing on 7/21/2025 at 12:45PM, the Surveyor was informed that Resident #12's order for the tube feed to be started at 5PM and ended at 3AM. The tube feed should be labeled with the resident name, room number, name of the formula, formula rate, the date and time hung, and nurse initials. The flush bag should also be labeled with the resident name, flush rate, date and time hung, and the nurse initials. The Surveyor expressed the concern that Resident #12's tube feed was running on 7/15/2025 at 8:53AM and the flush bag was not labeled.

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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. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on reviews of medical records, interviews with residents, and interviews with facility staff, it was determined that facility staff failed to document administration of as needed (PRN) pain medications in a resident's medication administration record. This was evident for 1 (Resident #66) of two residents reviewed for pain management during the survey.The findings include:Resident #66 was diagnosed with displaced closed fracture of the left tibia and admitted to the facility on [DATE].On 07/16/2025 at 11:24 AM Resident #66 stated that right leg pain occurs regularly and there had been a delay in the staff responding to the call bell which meant the resident was in pain for longer periods of time. The resident's spouse stated that he/she spoke to nursing staff regarding the delay in the delivery of pain medication and some improvements occurred, but the delays in the staff's response to the call bells still occur routinely. Resident # 66's spouse explained that the staff response to the call bell would sometimes be between thirty minutes to an hour.On 07/18/2025 at 9:10 AM Resident #66 's care plan and medication administration record (MAR) was reviewed by the surveyor via the electronic medical record. On 07/18/2025 at 1:39 PM Resident #66's hard copy MAR was reviewed by the surveyor. Specific instructions regarding the order of and use of a Pain Assessment using a 0-10 scale or non-verbal scoring tool every shift had an order date of 07/02/2025 on the resident's medication administration record. On 07/21/2025 at 12:48 PM the surveyor interviewed the Resident # 66's spouse and the resident. Resident #66 stated that she/he wanted to leave the facility. Stated that over the weekend there were terrible problems to the evening staff answering the call bells in a timely manner. The resident's spouse stated that he/she had to return to the facility on July 19th, because Resident #66 was upset because his/her pain medication and bedtime medications were not delivered in a timely manner. On 07/21/2025 at 1:48 PM the surveyor interviewed the DON regarding Resident # 66's concerns with untimely delivery of pain and bedtime medications to the resident in a timely fashion on evening shift as well as the delayed response of staff to the call lights on evening shift this past Saturday and Sunday, July 19th and 20th. The surveyor also requested a copy of the medication reconciliation review document located in the Point Click Care electronic medical record (EMR). The surveyor, upon review of the medication administration review form electronically, found that there was no documentation of the Resident #66 receiving Tylenol 650 mg po for pain during the evening shift on 07/19/2025 and 07/20/2025.On 07/21/2025 at 2:48 PM the surveyor informed the DON of the results of the surveyor's review of the EMR related to Resident #66's medication administration record for July 19, 2025, and July 20, 2025 evening shift. On 07/21/2025 at 2:58 PM the surveyor requested a copy of the Medication Administration Record (MAR) for the dates of July 19th and 20th, 2025 related to Resident #66's evening pain and bedtime medications.On 07/21/2025 at 3:02 PM the surveyor received a copy of the Resident #66's MAR that reflected the LPN assigned to administer medications did not sign off that the PRN pain medication was given on evening of July 19th or the evening of July 20, 2025. On 07/21/2025 at 3:10 PM the DON stated that she had spoken with Resident #66 and the resident's spouse. The DON stated that she informed the couple that the medication administration time for the 1st floor was 8:00 PM and that the physician would need to be contacted to change the administration of Resident #66's evening shift pain medication and bedtime (HS) medication in order for them to be given at the same time as requested by the resident.On 07/22/2025 at 08:52 AM the surveyor requested that the administrator provide a copy of the staffing assignment sheet for the evening shifts on July 19th and 20th for Resident #66. On 07/22/2025 at 09:38 AM the surveyor reviewed the staffing assignment sheets for evening shift LPNs for 07/19 and 07/20, 2025. Resident #66's assigned LPN for both days 7/19 and 7/20 was LPN # 13. The surveyor's review of the MAR revealed, LPN #13 did not document in the electronic MAR that Resident # 66 received his/her pain medication on the evening shift on both days. The review of the Resident # 66's MAR revealed that the PRN Tylenol Extra Strength Oral table 500mg (2 tablets) by mouth every 8 hours as needed (ordered on 07/02/25) was not documented as given on 07/19 and 07/20/2025 the evening shifts (3PM-11:00PM). Both the Resident #66's and the Resident # 66's spouse stated the Tylenol for pain was received 30 to 60 minutes after requested on these two dates. The potential deficit practice was discussed with the administrator and DON prior to and during the exit conference on July 23, 2025.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, observations, and interviews it was determined that the facility failed to perform bed rail assessments and obtain resident consent for bedrails. This was evident for 4 (Resident #17, # 21, #68, and #64) out of 5 residents reviewed for bedrails during the survey. The findings include: Bedrails, also known as side rails, are adjustable bars that attach to the bed. They vary in size, including full, half, and quarter lengths depending on their intended purpose. They can be used to prevent falls, help assist residents with movement, and provide a feeling of security. Bed rails also have potential risks associated with them, such as suffocation, entrapment, and psychological risks. A Resident or Resident's Representative should be provided with the risks and benefits along with a signed consent obtained before the use of bedrails. 1. On 07/14/2025 at 08:35 AM the surveyor observed Resident # 64 was in bed with bilateral bed rails and the bed was in the high Fowler position. On 07/15/2025 at 10:45 AM the surveyor reviewed the electronic medical record and found the resident did not have a bed rail assessment form present in the chart and the resident was admitted on [DATE]. On 07/16/2025 at 09:30 AM the surveyor interviewed Resident # 64 who stated the staff had not discussed the bedrails with him/her. The resident stated the bedrails did assist him/her with mobility while in the bed and with exiting the bed. On 07/16/2025 at 12:30 PM the surveyor reviewed the electronic medical record and there was no documentation of a completed bed rail assessment. On 07/16/2025 at approximately 1:30 PM the surveyor interviewed the DON and asked whether the facility had a bed rail assessment policy and if the resident and /or resident representative would normally consent to the bedrail placement. The DON stated yes. The surveyor informed the DON that a bed rail assessment was not present in the electronic medical record for Resident #64. On 07/17/ 2025 at 2:30 PM the DON provided the surveyor with a hard copy of Resident # 64’s bed rail assessment and consent with a completion date of 07/17/2025 at 13:40 PM. This deficient practice was also reviewed with the DON and administrator during the exit conference on 07/23/2025. 2. On 7/15/2025 at 9:15AM, the Surveyor observed Resident #17 laying in bed sleeping. The head of the bed was raised to about 30 degrees and the resident was facing the left side towards the window. There were half bedrails on each side of the bed and the bedrail on the left side was raised. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/16/2025 at 9:30AM, the Surveyor observed Resident #17 lying in bed with the head of the bed at about 30 degrees facing the left side. The left bedrail was raised. The resident was awake watching TV. During an interview, Surveyor was informed that the resident did not request the bedrails and was not asked if they needed the bedrails, however the bedrails are helpful with bed mobility. A review of Resident #17’s electronic medical record on 7/17/2025 at 8:15AM failed to reveal documentation of a Bed Side Rail Tool assessment, the resident’s consent for use of bedrails, and a device assessment for the half bedrails. On 7/17/2025 at 9:20AM the Surveyors and the Director of Nursing (DON) confirmed that Resident #17 had half bedrails in place after going to the resident’s room. The DON stated that any resident with bedrails should have a Bed Side Rail Tool assessment, the resident’s or resident representative’s consent for use of bedrails, and a device assessment for the half bedrails documented in their electronic medical record. The Surveyor expressed the concern that the resident did not have these documents. The Surveyor requested the documents. On 7/17/2025 at 2:00PM, the DON stated that Resident #17 did not have a Bed Side Rail Tool assessment, the resident’s consent for use of bedrails, and a device assessment for the half bedrails. The nursing staff were working on completing all assessments. The DON provided the Surveyor with a copy of the Resident #17’s device assessment. On 7/18/2025 at approximately 1:00PM, the DON provided the Surveyor with a copy of the Bed Side Rail Tool assessment with the resident’s consent. 3. On 7/15/2025 at 9:25AM, during an interview with Resident #21, the Surveyor observed half size bedrails on each side of the resident’s bed. The head of the bed was raised to about 90 degrees and the right bedrail was raised. The Surveyor was informed that the resident did not need the bedrails, but they were already on the bed when he/she was admitted to that room. A review of Resident #21’s electronic health on 7/17/2025 at 8:10AM failed to reveal documentation of a Bed Side Rail Tool assessment, the resident’s consent for use of bedrails, and a device assessment for the half bedrails. On 7/17/2025 at 9:20AM, the Surveyor and the Director of Nursing (DON) confirmed that any resident with bedrails should have a Bed Side Rail Tool assessment, the resident’s or resident representative’s consent for use of bedrails, and a device assessment for the half bedrails documented in their electronic medical record. The Surveyor expressed the concern that the resident did not have these documents. The Surveyor requested the documents. On 7/17/2025 at 2:00PM, the DON stated that Resident #21 did not have a Bed Side Rail Tool assessment, the resident’s consent for use of bedrails, and a device assessment for the half bedrails. The nursing staff were working on completing all assessments. The DON provided the Surveyor with a copy of the Resident #21’s device assessment. On 7/18/2025 at approximately 1:00PM, the DON provided the Surveyor with a copy of the Bed Side Rail Tool assessment with the resident’s consent. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. On 7/22/2025 at 2:30PM, during an interview with a family member, the Surveyor observed Resident #68 in bed with the head of the bed raised about 30 degrees and half bedrails raised on each side of the bed. The resident appeared anxious and restless. The resident grabbed the right bedrail with his/her right arm and swung his/her feet to the right side of the bed attempting to get out of the bed. The family member was able to redirect the resident back to a laying position on the bed. On 7/23/2025 at 7:30AM, a review of Resident #68’s electronic medical record failed to reveal documentation of a Bed Side Rail Tool assessment.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview with staff, it was determined that the facility failed to maintain proper infection control procedures and failed to store and prepare food in a manner that maintains professional standards of food service safety. This practice was evident for 2 of 4 kitchens that prepare food for residents within the facility. The findings include:During a tour of the facility's 2nd floor kitchen conducted on 7/15/2025 at 8:00AM, the Surveyor observed [NAME] #28, Dietary Aide #29, and Dietary Aide #30 standing in the kitchen without hairnets while breakfast was being prepared. [NAME] #28 stated that they ran out of hairnets and the Dietary Manager #25 ordered some and they should be in today. The Surveyor observed a personal black handbag on the counter between the portable steam tray and sink, and a fabric covered book and two 16.9oz bottles of Pepsi sitting on the silver island in the food prep area. The black handbag was moved into a tall brown cabinet with a sticky-like substance on the handles. Inside the cabinet, the Surveyor observed one open 25lb white bag of sugar and one open 25lb white bag of flour, neither in plastic containers or labeled. During a continued tour of the 2nd floor kitchen, the Surveyor observed the brown cabinets and drawers. The handles of the cabinets and drawers had sticky-like substance on them and the doors had dried cream colors stains. Inside the cabinets were random items like white towels with tan colored stains on them, clear plastic trash bags, and serving utensils. The fans were blowing with a thick gray dust like material stuck to tall black fan and thick brown and gray dust like material stuck to the white floor fan. Under the base of the black fan, there was an orange color stain with a circular pattern. The floor had tan and brown stains, especially in the corners.During a tour of the facility's 3rd floor kitchen conducted on 7/15/2025 at 8:24AM, the Surveyor observed the refrigerator. There was a container of watermelon pieces that was not fully covered with plastic wrap and sitting on the bottom shelf. There was a carton of Sysco Thickened cranberry cocktail with opened and labeled with a date of 6/30-7/19; the directions state to refrigerate after opening and discard after 7 days. On a continued tour of the 3rd floor kitchen, the Surveyor observed the brown cabinets and drawers. The handles of the cabinets and drawers had sticky-like substance on them and the doors had dried cream colors stains. Inside the cabinets were random items like white towels with tan colored stains on them, clear plastic trash bags, serving utensils, a clear plastic container with a silver and black coffee container, and dried food-like substance by the door. There was a paper cup of dried brown meat sitting in the cabinet next to the plastic container. The kitchen floor had tan and brown stains, especially in the corners. In the dry goods area, there was a clear cup with a white granule-like substance inside. On 7/15/2025 during an interview with Dietary Manager #25, the Surveyor reviewed the concerns of the 2nd and 3rd floor kitchens. The Surveyor reviewed the staff not wearing hairnets, the personal items in the food prep area, the cleanliness of the fans, floors, and cabinets, the opened and unlabeled bags of sugar and flour, the poorly covered container of watermelon on the bottom shelf of the refrigerator, and the expired carton of thickened cranberry cocktail. Dietary Manager #25 stated that there were hairnets available to the kitchen staff on the 3rd floor kitchen. Once the stock gets low, she places an order for more. The personal items were removed from the food prep area and tall cabinet, the sugar and the flour needed to be replaced, the watermelon and the expired thickened cranberry cocktail was discarded. The cup of dried brown meat and clear cup of white granule-like substance were discarded.On 7/18/2025 at 12:30PM, the Regional Dietary Manager #26 informed the Surveyor that the fans, floor, and cabinets were cleaned out on the 2nd and the 3rd floor kitchens.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Nursing and Rehab Center at Stadium Place	1010 East 33rd Street Baltimore, MD 21218

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on reviews of medical records, interviews with residents, and interviews with facility staff, it was determined that facility staff failed to maintain complete and accurate medical records in accordance with acceptable professional standards. This was evident for 1 of 2 residents (Resident #66) reviewed for pain management and 1 of out of 4 residents (Resident #68) reviewed for accidents during the survey. The findings include: 1. Resident #66 was diagnosed with displaced closed fracture of the left tibia and admitted to the facility on [DATE]. On [DATE] at 11:24 AM Resident #66 stated that right leg pain occurs regularly and there has been a delay in the staff responding to the call bell which means the resident is in pain for longer periods of time. The resident's spouse stated that he/she spoke to nursing staff regarding the delay in the delivery of pain medication and some improvements occurred, but the delays in the staff’s response to the call bells still occur routinely. On [DATE] at 9:10 AM Resident #66 's care plan and medication administration record (MAR) was reviewed by the surveyor via the electronic medical record. The review of the Resident # 66's MAR revealed that the PRN Tylenol Extra Strength Oral table 500mg (2 tablets) by mouth every 8 hours as needed (ordered on [DATE]) was not documented as given on 07/19 and [DATE] the evening shifts (3PM-11:00PM). Both the Resident #66's and the Resident # 66's spouse stated the Tylenol for pain was received 30 to 60 minutes after requested on these two dates. On [DATE] at 1:39 PM Resident #66's hard copy MAR was reviewed by the surveyor. Specific instructions regarding the order of and use of a Pain Assessment using a 0-10 scale or non-verbal scoring tool every shift had an order date of [DATE] on the resident’s medication administration record. On [DATE] at 12:48 PM the surveyor interviewed the resident # 66's spouse and the resident. Resident #66 stated that she/he wanted to leave the facility. Stated that over the weekend there were terrible problems to the evening staff answering the call bells in a timely manner. The resident's spouse stated that he/she had to return to the facility on Saturday, [DATE]th, because Resident #66 was upset because his/her pain medication and bedtime medications were not delivered in a timely manner. On [DATE] at 3:02 PM the surveyor received a copy of the Resident #66's MAR that reflected the LPN #13 assigned to administer medications did not sign off that the PRN pain medication was given on evening of [DATE]th or the evening of [DATE]. On [DATE] at 3:10 PM the DON stated that she had spoken with Resident #66 and the Resident's spouse. The DON stated that she informed the couple that the medication administration time for the 1st floor was 8:00 PM and that the physician would need to be contacted to change the administration of Resident #66's evening shift pain medication and bedtime (HS) medication in order for them to be given at the same time as requested by the resident. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The potential deficit practice was discussed with the administrator and DON prior to and during the exit conference on [DATE]. 2. On [DATE] at 7:40AM, during a review of Resident #68’s electronic medical record, the Surveyor discovered that the resident was admitted to the facility on [DATE] with diagnoses of but not limited to hemiplegia and hemiparesis after a stroke affecting the left dominant side, seizures, high blood pressure, diabetes, difficulty walking, and adult failure to thrive. Additional review revealed Resident #68 was taking medications for high blood pressure, diabetes, seizures, and insomnia. On [DATE] at 8:00AM, the Surveyor discovered that Resident #68 had an un-witnessed fall on [DATE] at 7:30AM. At the time, the resident was alert to self and confused. A Fall Risk Scoring Tool assessment was completed on [DATE] at 9:05AM. The resident scored a 10, equaling moderate risk. Scores less than 9 are low risk, 10-11 moderate risk, and 12 and above high risk. A review of the Fall Risk Scoring Tool assessment failed to reveal Resident #68’s predisposing diagnoses of a cerebrovascular accident (CVA or stroke) and seizures or the use of antiseizure medication for seizures. The Fall Risk Scoring Tool assessment did not include the current fall history. On [DATE] at 9:00AM, the Surveyor expressed the concern that the resident had an inaccurate Fall Risk Scoring Tool assessment completed after the fall on [DATE]. The DON stated she would review the assessment. On [DATE] at 9:51AM, the DON provided the Surveyor with an updated Fall Risk Scoring Tool. Resident #68 scored 16 and was considered a high fall risk. 3. Do Not Resuscitate (DNR) is an order placed in a person’s medical record by a doctor informs the medical staff that CPR should not be attempted. Do Not Intubate (DNI) is an order placed in a person’s medical record by a doctor informs the medical staff that chest compressions and cardiac drugs may be used, but no breathing tube will be placed. Maryland Medical Orders for Life-Sustaining Treatment (MOLST) is a form which includes medical orders for emergency medical services or other medical personnel regarding CPR (cardiopulmonary resuscitation) and other life-sustaining treatment options. On [DATE] at 7:40AM, during a review of Resident #68’s electronic medical record, the Surveyor discovered a physician’s Medical Visit note created on [DATE] which identified the resident’s code status as DNR/DNI with all other interventions under the Advance care planning section. Further review revealed a MOLST form, signed and dated [DATE] by the physician, which stated that Resident #68’s code status of “No CPR”, DNR/DNI. A full code provides full support, including CPR, and allows all interventions needed to restore breathing and/or heart functioning. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 7:51AM, during a review of Resident #68’s active physician’s orders, the Surveyor noted an order for Full Code created on [DATE]. On [DATE] at 8:44AM, during an interview conducted with the Director of Nursing (DON), the Surveyor expressed the concern that Resident #68 had a active physician’s order stating that the resident was a Full Code and a MOLST stating that the resident’s current code status was DNR/DNI as of [DATE]. The DON confirmed the Surveyors’ findings and stated that the resident’s orders would be reviewed and revised to reflect the resident’s current code status of DNR/DNI.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, record review, and interview with staff, it was determined that the facility failed to ensure staff donned appropriate personal protective equipment for enhanced barrier precautions and failed to ensure a resident's order for enhanced barrier precautions was maintained and followed. This was evident for 2 (Resident #21 and #32) out of 14 residents reviewed for enhanced barrier precautions during the survey. The findings include:Enhanced Barrier Precautions (EBP) are an infection control strategy that uses gloves and gowns during high-contact resident care to reduce the spread of multidrug-resistant organisms (MDROs). EBP's are used in nursing homes for residents who are infected with an MDRO, or those at risk for acquiring one, such as residents with wounds or indwelling devices.Personal protective equipment (PPE) refers to protective items or garments worn to protect the body or clothing from hazards that can cause injury and to protect residents from cross-transmission. PPE can include gloves, masks, safety goggles, and gowns. 1. On 7/16/2025 at 1:40PM, the Surveyor observed an Enhanced Barrier Precautions sign on the resident's door and a PPE cart at the doorway upon entering the room. During an interview with Resident #21, the Surveyor was informed that the resident had his/her left great toe amputated. The Surveyor observed a white, gauze-like dressing covering the area of the wound stump.On 7/16/2025 at 1:58PM, the Surveyor observed Licensed Practical Nurse (LPN) #23 enter Resident #21's room and inform the resident that they were there to provide wound care and change the resident's dressing. The Surveyor observed LPN #23 set up the materials necessary to change the resident's dressing, put on gloves, and proceed to change the resident's wound dressing and provide wound care to the left great toe stump. LPN #23 failed to put on a gown during wound care and the dressing change.On 7/16/2025 at 2:10PM, the Surveyor conducted an interview with LPN #23 regarding their understanding of PPE needed to be worn for a resident on enhanced barrier precautions. The Surveyor confirmed LPN #23 wore gloves during the dressing change and the LPN acknowledge they did not wear a gown during the dressing change. The Surveyor and LPN #23 reviewed an EBP sign, Wear a gown and gloves when entering room to provide the following high-contact resident care activities: dressings, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy, and wound care: any skin opening requiring a dressing. LPN #23 reported to the Surveyor that he did not have to wear a gown because he was not coming in contact with any body fluids and because he changes the dressing in a way that it will not come in contact with his clothing or have the resident's body touch him in any way. The Surveyor expressed the concern that a gown was not worn during wound care and dressing change for Resident #21.On 7/16/2025 at 2:25PM the Surveyor conducted an interview with the Assistant Director of Nursing (ADON) and Infection Preventionist (IP)#3. The Surveyor informed the ADON/IP #3 of their findings regarding LPN #23 performing wound care and a dressing change for Resident #21 without wearing a gown. The Surveyor confirmed that the facility's expectation is for personal protective equipment to be utilized for enhanced barrier precautions as stated on the signs on resident's rooms. Staff are required to wear a gown and gloves when providing wound care and dressing changes. ADON/IP #3 stated that LPN #23 will be reeducated regarding EBP and proper PPE to wear during wound care and dressing changes. 2. On 7/21/2025 at 8:05AM, a review of Resident #32's electronic medical record, the Surveyor discovered an active physician's order for Enhanced Barrier Precautions.On 7/21/2025 at 12:00PM, the Surveyor conducted a tour of the 2nd floor nursing unit. During the tour, the Surveyor noted that Resident #32 did not have an Enhance Barrier Precautions sign on the door nor did the resident have a PPE cart outside their room.On 7/21/2025 at 12:45PM, during an interview with ADON/IP #3 and the Director of Nursing (DON), the Surveyor was informed that any resident with an order for Enhanced Barrier Precautions should have an Enhanced Barrier Precautions sign on their door and a PPE cart outside their door for staff to utilize. Resident #32 was on EBP for a healing sacral wound with a dressing and was being seen by a wound care physician. The Surveyor confirmed that the resident should have an Enhanced Barrier Precautions sign on their door and a PPE cart outside the room.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observations, record review, and interviews with residents and staff, it was determined that the facility failed to ensure a system was in place to timely respond to the needs of a resident (Resident #21) reviewed for accommodation of needs during the survey.The findings include: On 07/15/2025 at 9:25AM, the Surveyor conducted an interview with Resident #21. The resident stated that he/she had to wait for 2 hours to get cleaned up over the weekend. The resident stated that he/she would not use the call bell because the staff does not respond and they do not carry the pagers they are supposed to carry to alert them to the resident's call. Instead, the resident has to yell out into the hallway for assistance. The resident pressed the call bell at that time.On 7/15/2025 at 9:45AM, the Surveyor walked into the hallway and observed staff passing out breakfast trays and preparing PPE carts. The Surveyor did not hear any beeping sounds. The Surveyor stopped Geriatric Nursing Assistant (GNA) #24 in the hallway. The Surveyor asked the GNA how she would know when a resident needs assistance. The GNA informed the Surveyor that the facility uses pagers. When the resident presses the call bell, a message is sent to the pagers. The Surveyor requested to see the pager to see how the alert message would appear. GNA #24 did not have a pager. Resident #21's call bell was still on in his/her room.On 7/15/2025 at 10:15AM, during an interview with the Nursing Home Administrator (NHA), the Surveyor was informed that the facility uses a pager system for call bells. The nursing staff and the NHA carry pagers which alert them when a resident needs assistance. The Surveyor expressed the concern that Resident #21 stated that they have to yell out in order to get assistance because the nursing staff do not carry or use their pagers. The NHA stated that all nursing staff should be carrying pagers.On 7/16/2025 at 1:00PM, the Surveyor requested to see Registered Nurse (RN) #9's pager. RN#9 stated the pager was not currently on her, it was in the nurse's office. The Surveyor requested to see GNA #15's pager. The GNA stated she did not have one.On 7/17/2025 at 9:12PM An interview with the DON was conducted. The Surveyor expressed the concern that nursing staff do not have pagers to alert them when a resident needs assistance. The DON stated that GNA's and nurses should have pagers. There are 2 nurses, one on first and second floors and one on third and fourth floors, the DON, the Assistant Director of Nursing (ADON), and NHA have all floor pagers. The GNA's have floor specific pagers. The resident would press the call bell in their room or bathroom, the message would go to the pagers with the room number and the location of the resident (room or bathroom). Reasonably, staff should answer within 15-20 mins. If they check on the resident and they are in the middle of care with another, they should let them know what they are doing and give a time they will come back. When the staff answers the call bell and presses the lit button in the room, the pager will show cancelled. Some staff do not have pagers. People have taken them home and haven't brought them back or they are just lost. If nursing staff do not have a pager, they should be making frequent rounding on their residents, every 1-2 hours every shift especially for those residents who usually need more assistance. The DON advised the facility had to order more pagers and there will be 8 new pagers used for all floors and 8 floor specific pagers for total of 16 new pagers. The new pagers should be in 7/18/2025 at 10:30AM.On 7/19/2025 at 8:00AM during a tour of the facility, the Surveyor observed nursing staff with pagers and the Surveyor could hear the beeping alert when a resident used the call bell.