FOIA Data Base - The Law Office of Jeffrey Downey

Serving clients in Washington D.C., Virginia and Maryland
If you have been injured in a nursing home or assisted living facility, call the law office of Jeffrey J. Downey for a free consultation.
Visit http:/www.jeffdowney.com

Phone: 703-564-7318; email: jdowney@jeffdowney.com

Kensington Healthcare Center
3000 McComas Avenue
Kensington, MD 20895

Facility Characteristics:

- Nursing Facility with 140 beds
- Managing Employees are Duramany Sesay and Charles Woodbury
- Operational and Managerial Control is done by Health Care Facility Management, LLC
- Website at http://www.communicarehealth.com/facility/kensington-healthcare-center/
- The For-profit corporation is owned by Kensington Nursing, LLC
- As of 2018 Kensington Healthcare Center was evaluated as a two-star facility (much below average) on Medicare.gov

Researching Nursing Homes

A note by attorney Jeffrey J. Downey:
Thank you for visiting my website. Anyone who is considering the admission of a loved one into a nursing home should undertake a review of surveys or other data that will provide a snapshot of some of the issues or problems that the facility is experiencing. Keep in mind that this information can be limited and may not reflect the actual condition of the facility when your loved one is admitted. You should consider personal visits of any facility you are evaluating.

The Maryland Department of Health inspects nursing homes including the Kensington Healthcare Center in Kensington, MD. Periodically they do inspections as complaint surveys which should be public record. You can write to the Office of Health Care Quality, Spring Grove Center, Bland Bryant Building, 55 Wade Avenue, Catonsville, MD 21228 or email maryland.molst@maryland.gov

Having already researched Kensington Healthcare Center and obtained FOIA responses, I am posting these statements of deficiencies here, in a searchable format. Keep in mind that these surveys have been altered during the conversion process and you should update your search results.

I am interested in any additional information you may have on this facility. Please call me with any question about this or any other facility you may be interested in searching or prosecuting civilly for patient neglect or abuse.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215043	A. BUILDING _____ B. WING _____	**02/16/2018**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KENSINGTON HEALTHCARE CENTER	**3000 MCCOMAS AVENUE KENSINGTON, MD 20895**

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 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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor review of the clinical records and interview of the facility staff and responsible party, it was determined that the facility staff failed to notify an individual and his/her responsible party when there was a change in condition. This finding was evident for 2 of 41 residents selected for review (resident #44 & 84) . The findings include: 1. On 02-14-18, review of the clinical record revealed that resident #44 was admitted to the facility in 2013 and had been receiving an oral diabetic medication, [MEDICATION NAME] 500 mg every AM, until the beginning of August 2017. Further review revealed that resident #44's hemoglobin A1C (HgA1c) level was elevated from 6.5% to 7.1% from April 2017 to August 2017. The resident's nurse practitioner set a new goal for the HgA1c to be less than 8%. Therefore, a new plan of care was addressed to discontinue [MEDICATION NAME] and only control the diabetes by diet. HgA1c is a blood test to determine an average level of blood sugar in the past 3 months. However, there was no evidence that the resident and the resident's legal guardian of person were notified about this new diabetic management plan until 12-17-17. A new diet order was written on 12-17-17 to provide a consistent low carbohydrate diet for resident #44. On 12-24-17, the resident was sent to a hospital due to a change in mental status. The resident's HgA1c was 11% when admitted to the hospital. On 02-16-18 at 3 PM, interview of the administrator revealed no additional information. 2. This finding was identified during the investigation of facility reported incident MD 672. The findings include: On 02-12-18, surveyor review of facility reported incident MD 672 revealed that resident #84 was identified as an alleged perpetrator in a case of abuse of another resident in the facility. The incident was reported to the facility staff on 02-06-18. At that time, resident #84 was identified as the perpetrator. Further review revealed that, on 02-06-18, the facility placed resident #84 on 1:1 staff monitoring, while the local police were notified. On 02-07-17, resident #84 was interviewed by the facility's social work director, who documented that the resident denied the allegations. However, there was no documented evidence that the facility had contacted resident #84's responsible party of the allegation of abuse or investigation of resident #84 as an alleged perpetrator. On 02-12-18 at 4:20PM, surveyor interview with resident #84's responsible party revealed that facility staff usually contacted them for any changes in the resident's medications and mental/behavior changes. However, there had been no recent contact by the facility staff of an allegation of abuse by resident #84. On 02-14-18 at 5PM, surveyor interview with the director of social work revealed that he/she was unaware that resident #84's responsible party had not been notified. On 02-14-18 at 5:20PM, surveyor interview with the facility administrator and corporate administrator revealed no additional information.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor review of the facility's investigation report, clinical record review and interview of residents and the facility staff, it was determined that the facility staff failed to thoroughly investigate an allegation of staff abuse. This finding was identified during an investigation of MD 814 for resident(#67). The findings include: On 02-13-18 at 11:44 AM, resident #67 reported to the surveyor that a nursing assistant grabbed his/her wrist and pushed him/her to the hallway a few weeks ago. On 02-16-18, review of the nursing progress note, dated 01-28-18, revealed that the resident reported that staff # 10 twisted his/her wrist and pushed him/her to room [ROOM NUMBER] on 01-27-18 when he/she wanted to take his/her pants back from staff #10. Further review of the facility's investigation report revealed that staff #10 denied the allegation of staff abuse. However, no other staff interviews or interview of resident #69, who resided in room [ROOM NUMBER], was done. On 02-02-18, the facility staff determined that the allegation of staff abuse was unsubstantiated. On 02-16-18 at 10 AM, interview of the director of nursing revealed the room number, which was documented in the progress note on 01-28-18, was a data entry error. Therefore, no interview was conducted with resident #69. It was unknown how the director of nursing could determine the data entry error without interview with the writer of the nursing progress note, who worked on 01-28-18. On 02-16-18 at 3 PM, interview of the administrator revealed no additional information.
F 0625 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor review of the clinical records and interview with the facility staff, it was determined that the facility staff failed to ensure that residents and/or responsible parties were informed in writing of the facility's bed hold policy at the time of hospital transfers. This finding was evident in 2 of 41 residents selected for review during the survey. (#40, #98) The findings include: 1. This finding was identified during the investigation of a facility reported incident MD 672. On 02-14-18, closed record review revealed that, on 02-07-18, resident #40 requested to be transferred to the hospital due to pain. Further review revealed that staff notified the attending physician, obtained an order for [REDACTED]. However, further review revealed no evidence that resident #40's responsible party was provided the bed hold policy in writing at the time of the hospital transfer. On 02-16-18 at 3:45PM, surveyor interview with the facility administrator revealed no additional information. 2. On 02-15-18, surveyor review of the clinical record revealed that, on 02-15-18 at 5PM, resident #98 had a change in condition. Further review revealed that the attending nurse practitioner ordered the resident to be transferred via 911 to the hospital for evaluation. Further review revealed the resident was listed as his/her own responsible party, with family listed as an emergency contact. On 02-15-18 at 5:40PM, surveyor interview with the evening supervisor revealed that a telephone report was called into the

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F 0625 **Level of harm -** Potential for minimal harm **Residents Affected -** Some	(continued... from page 1) hospital of resident #98's pending transfer. Transfer papers arranged to be sent with the resident at the time of transfer included a face sheet, physician orders [REDACTED]. However, there was no evidence that resident #98 was provided with the facility's bed hold policy in writing at the time of the hospital transfer. On 02-16-18 at 3:45PM, surveyor interview with the facility administrator revealed no additional information.
F 0645 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**PASARR screening for Mental disorders or Intellectual Disabilities** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor review of the clinical records and interview of the facility staff and resident #8's legal guardian, it was determined that the facility staff failed to ensure that a Preadmission Screening and Resident Review (PASRR) level I ID screen for individual's with a mental disorder (MD), and individuals' with intellectual disability (ID) and level II evaluation, were done timely and accurately. This finding was evident in 2 of 41 residents selected for review (#8 & #67). The findings include: The purpose of PASRR level I screen is to identity individuals who have or may have a MD/ID or related condition, who would then require a PASRR Level II evaluation and determination prior to admission to the facility. Level II PASRR is a comprehensive evaluation conducted by the appropriate state-designated authority that determines whether an individual has MD, ID or a related condition, determines the appropriate setting for the individual, and recommends what, if any, specialized services and/or rehabilitative services the individual needs. 1. This finding was identified during the investigation of a facility reported incident MD 955. On 02-12-18 at 4 PM, telephone interview of resident #8's court appointed guardian revealed that resident #8 had mental illness and refused to take showers or change clothes when asked. On 02-13-18, review of a Pre-Admission Screening and Resident Review (PASRR) level I ID screen, completed in 2016, revealed that resident #8 was determined to have a serious mental illness, and required a level II evaluation. However, there was no evidence that a referral was made to the appropriate government agency for a level II evaluation based on the level I screen in 2016. On 02-16-18 at 1:20 PM, interview of the facility social worker revealed no additional information. 2. This finding was identified during the investigation of a facility reported incident MD 814. On 02-13-18, review of the clinical record revealed resident #67 was admitted to the facility in July 2017 following a hospitalization . The resident was recommended for comprehensive psychiatric and neurology treatment as an outpatient. Further review of the PASRR level I screen revealed that resident #67 was expected to stay in the facility less than 30 days. Therefore, no further evaluation was needed. Four days after admission, resident #67's family member reported to the facility's social worker that the resident might have a history of [MEDICAL CONDITION]. Due to mental illness and behavior issues, the resident was unable to care himself/herself and unable to live in the community. On 08-31-17, a psychiatric evaluation was done, which indicated that resident #67 had [MEDICAL CONDITION] disorder. On 09-01-17, the facility's social worker completed another PASRR level I screen, but documented that the resident did not have a major mental illness, functional impairment or significant disruption to normal living situation, which was inconsistent with resident #67's recent hospitalization , clinical [DIAGNOSES REDACTED]. In November 2017, resident #67 was sent to a hospital and readmitted to the facility. Based on the hospital discharge summary, [MEDICAL CONDITION] disorder was one of the resident's ongoing diagnoses. However, there was no PASRR level I screen done prior to re-admission in November 2017. On 02-16-18 at 4 PM, interview of the facility's social worker revealed no additional information.

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F 0155 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Let the resident refuse treatment or refuse to take part in an experiment and formulate advance directives.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor review of the clinical record and staff interview, it was determined that facility staff failed to insure the residents right to formulate his/her advance directive. This finding was evident in 1 of 43 residents in the stage 2 reviews. (#158) The finding includes: Review of the clinical record revealed resident #158 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On [DATE] a certification of incapacity to make medical decisions was documented by the attending physician. The facility medical director documented a second certification of incapacity on [DATE]. On [DATE] further review of the clinical record revealed a blank (NAME)land Medical Orders for Life-Sustaining Treatment (MOLST) 90 days after the residents admission to the facility. There was also a blank Health Care Decision Making Worksheet. There was a physicians order dated [DATE] for cardiopulmonary resuscitation (CPR) in the event of [MEDICAL CONDITION]. However, there is no evidence that the facility staff discussed with the resident's responsible party choices related to health care decision making in an effort to complete the MOLST in a timely manner or to ascertain the responsible party's wishes as they relate to advance directives.
F 0167 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Allow residents to easily view the results of the nursing home's most recent survey.** Based on surveyor observation and staff interview, it was determined that the facility failed to post in a place readily accessible to residents, family members and legal representatives of residents, the results of the most recent survey of the facility. This finding was evident during the initial tour of the facility. The findings include: On 2-14-17 at 12 PM, surveyor observation revealed a binder in the facility lobby that contains survey results from previous years. However, review of the surveys revealed that the results of the two most recent complaint surveys that were investigated on 7-18-16 and 8-18-16, were not in the binder. On 2-14-17 at 3 PM, surveyor interview with the administrator revealed that he wasn't aware that the results weren't in the binder. The survey results of the two surveys were later put into the binder by facility staff.
F 0172 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Give the resident the right to receive visitors.** Based on surveyor observation and staff and resident interviews, it was determined that the facility staff failed to ensure residents were able to have visitors at any time and that all visitors enjoy full and equal visitation privileges consistent with resident preferences. In addition, the facility failed to ensure that visitors and residents have easy access into the facility. This finding was evident in 3 of 43 residents selected in the stage 2 reviews. (#66, #78, #95) The findings include: On 02-14-17 at 8 AM, the survey team was at the front door of the facility but were unable to enter the building as the doors were locked. There was no signage as to how to gain entry into the facility if the doors were locked. A staff member getting out of the car observed the team standing out front and ran around the building to inform other staff. After approximately 10 minutes assistance was provided so the survey team could enter the building. 1. On 02-14-17 at 11:30 AM, interview with resident #66 revealed visitors are not allowed to visit after 8 PM. However, resident # 66 stated that he/she was aware of a family member of another resident that visits at various hours and doesn't feel it's fair that this one resident is allowed special privileges. 2. On 02-15-17 at 2 PM, interview with resident #78 revealed that visitors are not allowed in the facility after 8 PM. The doors are locked at 8 PM and no one can enter the facility. 3. On 02-15-17 at 1 PM, a telephone interview with resident #95's family member/responsible party revealed that the previous week she drove this resident to a doctor's appointment. They returned to the building after 8 PM and were unable to enter the facility through the front door. There was no buzzer or other information about how to gain entrance. The family member further stated that she called the cell phone number of the business office manager and informed her of the situation. The business manager called the facility twice before someone answered and informed them that resident #95 and their family member needed help to enter the building. Resident #95 and the family member were assisted in to the facility after approximately 20 minutes. On 02-17-17 at 2 PM, interview with the business manger revealed that the family member did call her and ask for assistance getting back into the building. On 02-17-17 at 2:30 PM, interview with the DON and administrator revealed no additional information. However, after surveyor intervention a sign was posted on the front door instructing visitors and residents how to contact facility staff if the front door was locked.
F 0176 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Determine if it is safe for the resident to self-administer drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation, review of the clinical record and staff and resident interviews, it was determined that the facility staff failed to ensure a resident that was capable and clinically appropriate was able to self administer medications. This finding was evident in 1 of 43 residents selected in the stage 2 reviews. (#54) The findings include: On 02-15-17 at 9:30 AM, observation and interview with resident #54, revealed that this resident had a tube of [MEDICATION NAME] ointment to apply to both shoulders when pain was experienced. The resident showed the tube to the surveyor which was tucked into the resident's sheets on the bed. In addition, the resident is in a private room and keeps the door closed to the hallway. The resident expressed that staff were frequently slow in responding to requests for the [MEDICATION NAME] ointment so he/she preferred to have it close by to use when needed. Review of the clinical record revealed an order dated 12-06-16 for [MEDICATION NAME] Ointment 5%, apply to both shoulders q (every) 12 hours PRN (as needed) for pain. [MEDICATION NAME] ointment is a topical anesthetic to relieve pain. Further review of the clinical record revealed no evidence of an interdisciplinary team assessment of resident #54's ability to use and self-administer this medication properly. Additionally, there was no evidence of an interdisciplinary team determining who is responsible for storage and documentation of the administration of drugs. On 02-17-17 at 2 PM, interview of the DON (Director of Nursing) revealed no additional information.

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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.

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F 0176 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1)
F 0241 **Level of harm -** Potential for minimal harm **Residents Affected -** Some	**Provide care for residents in a way that keeps or builds each resident's dignity and respect of individuality.** Based on surveyor observation and staff and resident interview, it was determined that the facility staff failed to provide an environment that promotes the residents quality of life and dignity. This finding was evident in 1 of 43 residents selected in the stage 2 reviews. (#54) The findings include: On 02-15-17 at 9:30 AM, resident # 54 stated to the surveyor that the bottom bed sheet on the bed had not been changed for several months, possibly since October 2016. Observation of the bottom sheet revealed it was yellowed and very dirty. Resident #54 revealed that he/she would ask for a clean top sheet every few days and would place it over and tuck the clean sheets under the feet to prevent them from touching the bottom sheet. The resident did have several piles of belongings at the bottom of the bed and said that he/she wanted to clean that area up prior to having the sheets changed. Observation again on 02-16 and 02-17-17, revealed the same bottom sheet on resident #54's bed. In addition, resident #54 stated that no one had changed the linens. On 02-17-17 at 2 PM observation with the DON, and corporate staff revealed the same condition of the sheet. The staff were unaware of the condition of the bed sheets and initiated a plan to ensure the sheets were changed.
F 0246 **Level of harm -** Potential for minimal harm **Residents Affected -** Many	**Reasonably accommodate the needs and preferences of each resident.** Based on surveyor interviews with residents and staff, it was determined that the facility staff failed to provide reasonable accommodation of resident needs. This finding was evident in 4 of 43 residents selected in the stage 2 reviews (#17, #43, #171, #54). The findings include: 1. On 2-2-16-17 at 1 PM, surveyor interview with resident #17 revealed that she/he had used her/his own underpads for a long time, and in the past year, the facility staff refused to use the pads anymore because they aren't compatible with her/his type of bed. Furthermore, resident #17 stated that she/he had made repeated requests to use the underpads because when they aren't used her sheets get wet and all of the bed linens need to be changed. Underpads are rectangular, absorbent pads designed to protect the bed. They are often used with people who are incontinent of urine or stool. 2. On 2-14-17 at 2 PM, interview with residents #43 revealed that this resident has requested that staff provide the previously used washable underpads, but the facility staff has taken them away and they can't be used anymore. 3. On 2-14-17 at 2:15 PM, interview with resident #171 revealed that this resident has requested the previously used washable underpads, but the facility has taken them away and they can't be used anymore. These residents stated that despite the risk of skin breakdown, they want to use the underpads because the current disposable briefs leak urine on to the sheets causing discomfort. On 2-17-17 at 3 PM, surveyor interview with the Director of Nursing and the Corporate Nurses revealed that the company now uses a more effective disposable brief. Furthermore, the underpad used with the briefs increases the risk of skin breakdown and the corporate policy is not to use the underpads anymore. 4. On 02-15-17 at 9:30 AM, interview with resident #54 revealed he/she was scheduled to have a bath on Tuesdays and Fridays on the 3-11 shift. He/she also revealed that the preferred time for bathing would be during the 7-3 shift. When the surveyor questioned if the preference had been shared with the facility staff, he/she revealed yes but was told that baths are given according to room number and the staff said they could not change the time. On 02-16-17 at 2 PM, interview with the DON revealed he was unaware of the request and would make the necessary changes.
F 0247 **Level of harm -** Potential for minimal harm **Residents Affected -** Some	**Give notice to the resident before a room or roommate change.** Based on surveyor review of the clinical record and interview of facility staff, it was determined that the facility staff failed to provide a written or verbal notice when a change of roommate was made within the facility. This finding was evident in 1 of 43 residents selected in the stage 2 review (#159). The findings include: On 02-21-17, review of the clinical record revealed resident #159 moved into a semi-private room at the beginning of January 2017. About 9 days later, resident #162 moved into the same room with resident #159. However, there was no evidence that resident #159, or his/her responsible party received a written or verbal notice before resident #162 moved into the same room. On 02-21-17 at 2:30 PM, interview of the director of nursing revealed the facility social worker would follow up. On 02-22-17 at 2:50 PM, telephone interview of the facility social worker revealed no additional information.

F 0248 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide activities to meet the interests and needs of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation and staff and family interviews, it was determine that facility staff failed to implement appropriate activities to meet the needs of a resident. This finding was evident in 1 of 43 residents selected in the stage 2 reviews. (#29). The findings include: On 02-14-17 at 8:30 AM, surveyor observed resident #29 in his/her room standing in the doorway, behind a secured gate that prevented the resident from leaving the room. The resident has a [DIAGNOSES REDACTED]. [MEDICAL CONDITION] is defined as injury to the brain due to a lack of oxygen. The resident was also observed by the surveyor standing in the doorway looking out at other residents and staff passing by on 02-14-17 at 11:00 AM, 12:50 AM, 2:10 PM, and 3:30 PM. There was no observation of the facility staff interacting with the resident during these times. On 02-14-17 at 3:45 PM, interview with the Severn unit manager revealed resident #29 was in his/her room to prevent him/her from wandering in the hallway. The unit manager stated resident #29 is fully ambulatory and could get into other residents rooms as he/she was incapable of understanding due to brain damage. The unit manager also stated the residents responsible party visited frequently and took the resident out of the facility on leave of absence. On 02-15-17 at 9:20 AM, further observation of resident #29 revealed this resident to be pacing back and forth in room and to doorway to look out. The resident was additionally observed standing in the doorway at 12:10 PM, 2:45 PM, and 4:15 PM. The surveyor did not observe staff interacting with the resident during these times. On 02-16-17 at 1:00 PM, interview with the facility administrator revealed resident #29 had previously had an individual caregiver (1:1) to maintain the safety of other residents due to poor impulse control and wandering related to the [MEDICAL CONDITION]. The 1:1 was discontinued when a gate was provided by the responsible party to prevent resident #29 from independently exiting the room and potentially impacting the safety of the other residents. Review of the clinical record revealed no physicians order for the gate, and no written plan of care as it related to resident #29 although an active plan of care directed staff to avoid isolation. There was documentation in the clinical record on 12-12-16 that activity staff attempt to visit and provide 1:1 visit, however resident grabbs at staff and attempts to bite or touch them. Review of the clinical notes revealed no further evidence of resident #29 being physically aggressive. The clinical record also reflected contradictory interventions in the plan of care, which instructed the facility staff to turn on TV, music in room to provide sensory stimulation, while another intervention stated to reduce any distractions-turn off TV, radio, close door etc. Additionally the plan of care directed the interdisciplinary staff to give one-to-one attention for a few minutes several times each day, however, there was no evidence during numerous surveyor observations that this occurred. On 02-21-17 at 9:00 AM, interview with the facility activity director revealed there was no documentation to reflect the type of activities, frequency or participation of resident #29 to include the one to one attention daily. On 02-21-17 at 9:30 AM, interview with resident #29's responsible party revealed that he/she had to come in frequently to get the resident out of the room. The responsible party also voiced concern to the surveyor about the resident being in a

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F 0248 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) dark room with the windows closed and no music or tv on several occasions when he/she had visited. Upon surveyor intervention, the facility staff were noted to subsequently remove resident from the room to ambulate (walk) him/her in the corridor and talking to resident #29 during ambulation.
F 0250 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide medically-related social services to help each resident achieve the highest possible quality of life.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor review of the clinical records and interview of residents and facility staff, it was determined that the facility social worker failed to assist a resident with discharge planning and failed to provide medically-related social services to residents to maintain the highest practicable physical, mental and psychosocial well-being. This finding was evident in 3 of 43 resident selected in the stage 2 review (#87, #126 and # 112). The findings include: 1. On 02-16-17 at 10 AM, interview of resident #87 revealed that this resident is alert and oriented. The resident complained that the facility social worker did not offer assistance in discharge planning. The resident had an independent case manager to assist him/her in house hunting and community support. However, the facility social worker did not coordinate with the independent case manager in discharge planning. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that resident #87 wanted to talk to someone about the possibility of leaving the facility and returning to live and receive services in the community. The MDS is an assessment tool to determine an individuals physical, mental and functional status. Further review of the clinical record revealed resident #87 informed the facility social worker in December 2016 that he/she would like to be discharged in the future. On 02-21-17 at 1 PM, interview of the Severn unit manager revealed resident #87 expressed to everyone in the unit that he/she wanted to be discharged to the community. However, there was no evidence a follow up was made by the facility social worker with resident #87 after December 2016. In addition, no care plan was developed related to a community discharge for this resident. On 02-21-17 at 2:30 PM, interview of the director of nursing revealed that the facility social worker would follow up. On 02-21-17 at 2:40 PM, interview of the facility social worker revealed she was aware of resident #87's independent case manager, but had not arranged a meeting among the resident, the independent case manager and the facility social worker in developing a plan for discharge. 2. On 2-16-17 at 10 AM, surveyor review of resident #126's clinical record revealed that he/she was admitted to the facility on [DATE], after a hospitalization . Further review of the clinical record revealed that, on admission, resident #126 was assessed to make his/her own decisions. Review of the admission contract revealed that, on 2-16-16, he/she had designated his/her fiance as Power of Attorney. However, the facility was unable to provide documentation, signed by the resident, designating this authority to the fiance. On 2-21-17 at 2 PM, surveyor interview with the nurse practitioner revealed that she recalled the fiance who was involved with resident # 126 in the beginning (of the nursing home stay) but had stopped coming to the facility. Furthermore, the NP didn't consider resident #126 able to make his/her own medical decisions at this point. On admission, the Minimum Data Set (MDS), section C (cognitive patterns), the BIMS (Brief Interview for Mental Status) score was 13, which indicated that the resident was cognitively intact. However, on 11-21-17, the MDS, section C was coded as 5, which indicated that the resident had a severe impairment in cognitive function. There is no evidence that the social worker addressed the decline in cognitive function or the absence of the Power of Attorney with resident #126's family. 3 Resident #112 was admitted to the facility on [DATE] with a 90 day order for temporary guardianship of person. On 02-15-17 at 1:00 PM, interview with the facility social worker revealed there was no evidence in the clinical record that permanent guardianship had been obtained and no evidence to support efforts to reflect permanent guardianship. The social worker stated that he/she would contact the guardian to determine if permanent guardianship had ever been established. On 02-15-17 at 4:00 PM the social worker stated she had contacted the guardian who stated he/she could not locate a permanent guardianship letter for resident #112, and would have to obtain a copy from the court, and fax it to the facility. On 02-16-17 at 10:00 AM, interview with the attending physician revealed resident #112's guardian had been appointed specifically to have the resident admitted to the facility after a hospitalization related to alcohol dependence. The physician stated upon interview that the resident has been alert and oriented. On 02-16-17 at 2:00 PM, the social worker stated the facility had not received documents related to permanent guardianship for resident #112. Review of the clinical records revealed this resident scored 15 out of 15 on the admission Minimum Data Set (MDS). A brief interview for Mental Status (BIMS) and most recent MDS BIMS dated 01-04-17 also reflected a score of 15 out of 15. There was no evidence in the clinical record that social services had attempted to have the resident's physician determine his/her decision making capacity as related to medical decisions based on the BIMS reflecting no cognitive impairment for resident #112 at the time of the two assessments. On 02-21-17 at 7:45 AM, after surveyor intervention a copy of a letter of permanent guardianship was received from the guardian for resident #112 and placed in the clinical record. On 02-21-17 at 2:21 PM interview with the court appointed guardian confirmed the temporary guardianship documents the facility had maintained in the clinical record had been issued in 2015 to facilitate resident #112's discharge from the hospital to a nursing facility.
F 0272 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Conduct initial and periodic assessments of each resident's functional capacity.** Based on surveyor review of the clinical records and interview of facility staff, it was determined that the facility staff failed to conduct accurate and timely resident assessments. This finding was evident in 2 of 43 residents selected in the stage 2 review (#11, #123). The findings include: 1. On 02-17-17, review of the closed clinical record revealed resident #11 was admitted to the facility in October 2016 following a hospitalization . Upon admission, an order was written to measure resident #11's abdominal girth due to ascites (accumulation of fluid in abdominal cavity). Abdominal girth is the measurement of the distance around the abdomen at a specific point. Measurement is most often made at the level of the belly button. Further review of the Treatment Administration Record (TAR) revealed the nursing staff documented that resident #11's abdominal girth was 45 cm (17 inches) between 10-05-16 and 10-13-16. Although the nursing staff signed off that resident # 11's abdominal girth measurement was done daily between 10-14-16 and 10-31-16, no actual measurement was recorded. In November 2016, resident #11's abdominal girth varied between 17 inches and 53 inches. Before resident #11 was sent to a hospital in December 2016, the abdominal girth varied between 18 inches and 147 inches. However, there was no evidence of further assessments to verify the technique and accuracy of the measurement or to follow up with the attending physician related to the significant difference in abdominal girth measurements within a month. On 02-17-17 at 12 PM, interview of the director of nursing (DON) revealed it was questionable about the resident's abdominal girth to be 17 inches at the beginning of October 2016. However, there was no additional information provided to determine resident #11's actual abdominal girth upon admission or during the stay in the facility. 2. On 02-16-17, review of the closed clinical record revealed resident #123 was admitted to the facility with a stage 2 pressure ulcer on the sacrum. A treatment was initiated upon admission. Further review revealed the nursing staff signed off that the sacral ulcer was cleaned with normal saline solution, pat dry and applied a hydrolloid dressing every 3 days between 09-18-16 and 10-07-16. However, there was no evidence of any skin assessments related to the sacral ulcer. On 10-07-16, resident #123 was discharged home with home health services. On 02-16-17 at 4 PM, interview of the director of nursing revealed no additional information.
F 0279 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop a complete care plan that meets all of a resident's needs, with timetables and actions that can be measured.**

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F 0279 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor review of the clinical records and interview of staff, it was determined that the facility staff failed to develop a comprehensive care plan to meet a resident's medical and psychosocial well-being. This finding was evident in 1 of 43 residents selected in the stage 2 reviews (#146). The findings include: On 2-16-17 surveyor review of resident #146's clinical record revealed that on admission he/she was assessed by the nurse as being always incontinent of urine. At this time, on 8-12-16, no care plan was developed for the urinary incontinence. The urinary incontinence was first addressed in the care plan on 11-29-16. Further review of the clinical record revealed that on admission resident #146 was assessed as being frequently incontinent of bowel. The Minimum Data Set (MDS), dated [DATE], was coded always incontinent (no episodes of continent bowel movements). However, there is no evidence that a care plan was ever developed to address the bowel incontinence. On 2-21-17 at 3 PM, surveyor interview with the Director of Nursing (DON) revealed no further information.
F 0280 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Allow the resident the right to participate in the planning or revision of the resident's care plan.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor review of the clinical records and interview of staff and residents, it was determined that the facility staff failed to revise a care plan to reflect a resident's current medical condition, failed to conduct a timely care plan meeting for a new admission and failed to have quarterly care plan meetings for residents. This finding was evident in 4 of 43 resident selected in the stage 2 reviews (#95, #54, #66 and #132). The findings include: 1. On 02-15-17 at 1 PM, a phone interview was conducted with resident #95's responsible party. The responsible party stated that no care plan meeting had been conducted since the resident's admission on 12-06-2016. Review of the clinical record revealed no evidence a care plan meeting had been conducted since the residents admission. On 02-16-17 at 9 AM, interview with the social worker revealed no additional information. 2. On 02-15-17 at 9:30 AM, interview with resident #54 revealed that it had been some time since a care plan meeting had been held. Resident #54 is not mobile and the care plan meetings are held in resident #54's private room, according to the resident. Further review of the clinical record revealed no evidence of a care plan meeting with resident #54 since 03-02-16. On 02-16-17 at 9 AM, interview with the social worker revealed no additional information. 3. On 02-14-17 at 11:30AM, resident # 66 was interviewed. The resident stated that it had been a while since a care plan meeting had been conducted. The resident also revealed that a plan for discharge to a group home was being discussed. Further review of the clinical record revealed the last care plan meeting was held on 03-09-16 with resident #66. The last social service progress note was written 06-15-16 and was referring to a form the social worker had assisted resident #66 to complete. On 02-16-17 at 9 AM, interview with the social worker revealed no additional information. 4. On 02-16-17 at 11:00 AM, surveyor review of the clinical record revealed a physician order [REDACTED]. Further review of the clinical record revealed a care plan that did not reflect the sacral pressure area on resident #132 sacrum. The care plan that was initiated on 12-05-16 read resident has a potential for pressure ulcer development related to decrease mobility. The facility staff failed to revise the care plan to accurately reflect the condition of resident #132's skin condition. On 02-16-17 at 11:40 AM, surveyor interview with the Director of Nursing (DON) revealed no new information.
F 0281 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Make sure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation, review of the clinical records and staff interviews, it was determined that the facility staff failed to ensure that services provided by the facility met professional standards of quality. This finding was evident in 8 of 43 residents selected in the stage 2 reviews (#123, #11, #166, #10, #66, #78, #54 and #52). The findings include: 1. On 02-16-17, review of the closed clinical record revealed a verbal order was written for resident #123 on 09-22-16 to add 300 ml water every shift for 7 days due to an elevated blood urea nitrogen (BUN - a clinical indicator of kidney function) and to continue water restriction as ordered. This physician's order was unclear because no specific amount of water restriction was listed. In addition, interview of the dietitian on 02-16-17 at 4:30 PM revealed the physician's verbal order on 09-22-16 was contradictory and questionable because additional water should not be offered to an individual who was on a water restriction. However, there was no evidence a clarification order was made to determine the appropriate hydration program for resident #123. As standard of nursing practice COMAR.10.27.09.02 B(2)(a) Analysis & Nursing Criteria, a registered nurse shall analyze the data, consider the options, including technology, and make a determination as to whether the selected options are appropriate for the needs of the client. On 10-06-16 at 8 PM, the nursing staff documented that a 12 lb weight gain was noted a week after 09-22-16. The attending physician was paged, but did not call back. There was no evidence that the nursing staff attempted to contact the attending physician. As standard of nursing practice COMAR.10.27.09.02 E (2)(f) Evaluation, a response to interventions shall be documented and communicated to the client and other members of the health care team. On 02-17-17 at 10 AM, interview of the director of nursing revealed no additional information. 2. On 02-17-17, review of the closed clinical record revealed resident #11 was admitted to the facility in October 2016 following a hospitalization . One of the diagnoses was ascetics (accumulation of fluid in the abdominal cavity). Upon admission, a diuretic, [MEDICATION NAME] 10 mg, and a Potassium supplement, Potassium Chloride ER 20 meq, were ordered daily for the resident. On 10-10-16, resident # 11 was sent to a hospital for a blood transfusion. According to the hospital discharge summary dated 10-11-16, the discharge medications included, but were not limited to, [MEDICATION NAME] 40 mg daily and Potassium Chloride 20 meq daily. Further review of the clinical note dated 10-11-16 and the re-admission order, revealed the attending physician ordered [MEDICATION NAME] 40 mg daily and Potassium Chloride 20 meq daily for resident #11. In addition, the nursing staff were instructed to resume all the previous medications, which also included [MEDICATION NAME] 10 mg daily and Potassium Chloride 20 meq daily. On 02-17-17, review of the Medication Administration Record [REDACTED]. Then, [MEDICATION NAME] 40 mg and Potassium Chloride 20 meq were given daily at 9 AM. Therefore, according to the documentation resident #11 received a total of 50 mg [MEDICATION NAME] and a total of 40 meq Potassium Chloride daily between 10-12-16 and 11-23-16. However, there was no evidence that staff clarified these orders with the attending physician to determine the appropriate dosage of [MEDICATION NAME] and Potassium Chloride for resident #11 upon re-admission on 10-11-16. As standard of nursing practice COMAR.10.27.09.02 B(2)(a) Analysis & Nursing Criteria, a registered nurse shall analyze the data, consider the options, including technology, and make a determination as to whether the selected options are appropriate for the needs of the client. 3. On 02-16-17, review of the clinical record revealed resident #166 was admitted to the facility in January 2017 following a hospitalization . Upon admission, a [MEDICAL CONDITION] medication, [MEDICATION NAME] 100 mg three times a day, was

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F 0281 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) ordered for this resident. On 01-06-17, a new order was written to increase [MEDICATION NAME] to 125 mg three times a day. On 01-09-17, another order was written to check resident #166's [MEDICATION NAME] level on 01-16-17 for monitoring purpose. On 01-16-17, a laboratory report indicated that resident #166's [MEDICATION NAME] level was as high as 33.9 mcg/mL. The reference range is between 10-20 mcg/ml. The on-call physician was notified by phone, but no new order was given. However, there was no evidence the facility staff questioned the on-call physician whether to continue to administer [MEDICATION NAME] 125 mg three times a day. On 01-16-17 at 4 PM, interview of the director of nursing revealed the on-call physician heard that the resident's [MEDICATION NAME] level on 01-16-17 was 13 mcg/mL instead of 33.9 mcg/mL. Otherwise, further intervention would have been given on 01-16-17. As standard of nursing practice COMAR.10.27.09.02 B(2)(a) Analysis & Nursing Criteria, a registered nurse shall analyze the data, consider the options, including technology, and make a determination as to whether the selected options are appropriate for the needs of the client. 4. On 02-17-17, review of the closed clinical record revealed resident #10 was readmitted to the facility following a hospitalization on [DATE]. Upon re-admission, a skin tear was noted on the resident's left buttock. The nursing staff documented that the current treatment for [REDACTED]. In addition, a surgical wound was noted on the resident's abdomen. The nursing staff documented that the current treatment was to clean with normal saline, pat dry, apply [MEDICATION NAME] ointment and cover with 4x4 and tape daily. However, review of the TAR revealed that the nursing staff documented that the treatment to the skin tear on the resident's left buttock was to clean with normal saline, pat dry, apply Hydrogel, cover with 4x4, secure with tape every shift. The surgical wound on the resident's abdomen was to clean with normal saline, pat dry, apply Hydrogel, cover with 4x4 and tape daily. There was no evidence that staff clarified the appropriate ointment to use for the resident's left buttock wound or abdominal surgical wound. On 12-26-16, the resident was sent to a hospital because of a change in condition. On 02-17-17 at 4:30 PM, interview of the director of nursing revealed no additional information. 5. On 02-14-17, during an interview with resident #66, it was revealed that he/she had a [MEDICAL CONDITION] machine for sleep apnea. Sleep apnea is a condition that occurs when a person's breathing is interrupted during sleep. They may stop breathing repeatedly during the night. [MEDICAL CONDITION] is continuous positive airway pressure provided by a machine that increases air pressure in the throat so that the airway doesn't collapse when breathing. The machine assists a person who has obstructive sleep apnea breathe more easily during the night. Resident # 66 state that after a room change, the [MEDICAL CONDITION] machine had been placed in the closet and then a staff member removed it from the closet. He/she has not been using a [MEDICAL CONDITION] machine for a while. Further review of the clinical record revealed resident #66 does have sleep apnea. However, review of the physician and nurse practitioner notes revealed no [DIAGNOSES REDACTED]. Review of the care plans revealed no plan for the use of a [MEDICAL CONDITION] due to [DIAGNOSES REDACTED].#66 to maintain an adequate airway during hours of sleep. On 02-17-17 at 2 PM, interview of the DON revealed no additional information. It is a standard of nursing practice to implement the interventions identified in the plan of care. 6. On 02-17-17, review of the clinical record revealed resident #78 had a skin graft performed on the top of the left foot for a venous ulcer and returned to the facility following surgery on 12-12-16. Upon admission the initial nursing assessment dated [DATE], revealed skin issues requiring treatment on the front of the left thigh (skin removed from there for graft) and the top of the left foot. There were no measurements or assessments documented at this time. Further review revealed no continued documentation of assessments or measurements of these areas until a skin grid non-pressure assessment was completed on 02-09-17. The measurement of the left thigh wound was 15.8 cm. x 22.5 cm. x 0.5 cm. with full thickness with adjacent tissue destruction. There were no further assessments of the left thigh wound until it healed. Interview of resident #78 on 02-21-17 at 1 PM revealed the thigh area was healed. Interview with the DON on 02-21-17 revealed he thought the wound nurse was keeping a record of the skin areas and provided the weekly wound tracking worksheet for resident #78. This form is used by the wound nurse to keep track of all wounds in the facility and is not part of the resident's clinical record and is not always available to other staff members. Review of the wound nurse's worksheet revealed a lapse of assessment from 12-12-16, the readmitted , until 12-28-16. Additionally, there was no assessment of this area the week of February 1, 2017. It is a standard of nursing practice to collect resident health data using appropriate assessment techniques. In addition, the data collection process shall be comprehensive, systematic and ongoing. Relevant health data shall be documented in an authorized record which is accessible and in a retrievable form. 7. On 02-14-17 at 09:50 AM interview of resident #54 revealed the he/she had no teeth and had been asking to see the dentist so he/she could obtain dentures. Further review of the clinical record revealed an order for [REDACTED]. On 02-16-17 at 0:15 AM, surveyor interview with the DON revealed no additional information. It is a standard of nursing practice to only document actual treatments rendered. 8. On 02-16-17, surveyor review of the clinical record revealed that resident #52 was admitted to the facility and receives all nutrition and medications through an enteral feeding tube ([DEVICE]). On 02-16-17 at 12:20 PM, surveyor observation of the medication administration to resident #52 revealed that LPN #1 failed to check the G- tube placement and feeding residual as indicated in the facility enteral protocol order sheet. In addition, there was no physician order to check the placement of the [DEVICE] prior to medication administration and feeding. As a standard of nursing practice a licensed nurse is required to clarify any unclear orders with the physician as indicated in section 10.27.09.01 of the Nurse practice act under collaboration of care. On 02-16-17 at 1:00 PM, surveyor interview with the Director of Nursing and the Administrator revealed no further information.
F 0309 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide necessary care and services to maintain the highest well being of each resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor review of the clinical records and interview of facility staff, it was determined that the facility staff failed to follow physician orders [REDACTED]. This was evident in 4 of 43 residents selected in the stage 2 reviews (#132, #157, #126, #86). The findings include: 1. On 02-15-17 at 10:55 AM surveyor review of the clinical record revealed that resident #132 was admitted with multiple [DIAGNOSES REDACTED]. Further record review for resident #132 revealed a physician order [REDACTED]. Additional record review revealed an occupational therapy (OT) initial assessment on 01-31-17, 46 days after the initial physician order. On 02-15-17 at 11:20 AM, surveyor interview with OT revealed that the occupational therapy department did not receive the physician order [REDACTED].#132 right hand on 02-02-17, 48 days after the physician order. On 02-15-17 at 11:20 AM, surveyor interview with the Director of Nursing (DON) revealed no new information. 2. On 02-17-17 at 12:22 PM, surveyor review of the clinical record revealed that resident #157 was admitted on [DATE] with a physician order [REDACTED]. Further record review revealed that the facility dietitian met and evaluated resident #157 and changed the diet from mechanical soft to a regular diet. In addition, the dietitian recommended a speech therapy evaluation. The speech therapist evaluated resident #157 on 12-07-16 and recommended a mechanical soft diet as previously ordered and discontinued the regular diet. However, as at 02-17-17 resident #157 has a regular diet on the physician order [REDACTED]. On 02-17-17 at 1:15 PM, surveyor interview with the dietitian and DON revealed no new information. 3. On 2-16-17 at 10 AM, surveyor review of resident #126's clinical record revealed that he/she was admitted to the facility on [DATE], after a hospitalization . The hospital discharge summary included a recommendation that resident #126 follow up with a primary care physician for an Infectious Disease consultation related [MEDICAL CONDITION].The consultation was ordered by the nurse practitioner (NP) on

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F 0309 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 5) 2-16-16, but there is no evidence that the appointment was ever scheduled by facility staff. On 6-29-16, the NP once again ordered an Infectious Diseases consultation. The NP's progress note revealed: Spoke with patient regarding weight loss and how it is probably linked to [MEDICAL CONDITION] how important it is to go to Infectious Disease. Patient agreed to go to Infectious Disease appointment. There is no evidence that this appointment was made by the facility staff. On 7-8-16 the NP wrote: Infectious Disease consult pending. On 12-14-16, resident #126's physician once again ordered an Infectious Disease appointment. Eventually, resident #126 received the Infectious Disease consultation on 1-10-17. On 2-16-17 at 9:50 AM, surveyor interview with the social worker and the unit manager revealed that neither knew why there was a delay in obtaining the infectious disease consultation for resident # 126. On 2-21-17 at 2 PM, surveyor interview with resident #126's nurse practitioner revealed that despite the recommendation, he/she once refused to go to the Infectious Disease consultation (the NP couldn't recall the date of the refusal). However, there is no evidence that the facility collaborated with resident #126, his/her family and the medical team to get the Infectious Disease consultation done, or if the resident continued to refuse, to develop a plan of care. On 2-21-17 at 2 PM, surveyor interview with the Director of Nursing revealed no further information. 4. On 02-14-17 review of the clinical record for resident #86 revealed an order for [REDACTED]. On 02-14-17 at 4:00 PM additional observation of resident revealed the absence of the bilateral knee braces for resident #86. On 02-15-17 at 9:20 AM during resident interview and observation, it was noted that the bilateral knee braces were not present. Resident #86 stated that he/she had not worn the braces for over one year, and, in fact there was only one brace remaining which facility staff did not attempt to put on. Resident #86 informed the surveyor that the brace could be found in the second dresser drawer. Upon consent of the resident, surveyor observed one black knee brace in the location stated by the resident, and no other braces were located in the room. On 02-15-17 at 4:15 PM, a second observation revealed the absence of resident #82's bilateral knee braces as ordered by the physician. Review of the treatment administration record (TAR) revealed the bilateral knee braces had been signed off as applied on both 02-14-17 and 02-15-17. The Severn nursing unit manager was notified of the observation on 02-15-17 at 4:30 PM. On 02-16-17 further review of the clinical record revealed a physician's orders [REDACTED].
F 0312 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Assist those residents who need total help with eating/drinking, grooming and personal and oral hygiene.** Based on surveyor observation, review of the clinical records and interviews of residents and staff, it was determined that the facility staff failed to ensure that residents' who are unable to carry out activities of daily living receives the necessary services to maintain good personal hygiene. This finding was evident in 3 of 41 residents selected in the stage 2 review (#33, #132, # 120). The findings include: 1. On 02-14-17 at 08:30 AM surveyor observation revealed resident #33's was in bed and had a full beard. Interview of resident # 33 on 2-14-17 at 8:40AM revealed that the resident does not wish to keep the beard and stated that I am not able to shave myself because of muscle weakness. The facility staff help me to shave every morning but no-one has helped me in about 5 days. On 02-14-17 at 10:15 AM surveyor review of resident # 33's quarterly MDS (Minimum Data Set) with an ARD (assessment Reference Date) of 12-16-16, revealed that this resident requires extensive assistance with one person for personal hygiene which includes shaving. The MDS (Minimum Data Set) is a mandated process for clinical assessment of all residents in Medicare or Medicaid certified nursing homes. This process provides a comprehensive and accurate assessment of each resident's functional capacity and health status to assist nursing home staff in identifying health problems. MDS assessments are required for residents on admission to the nursing facility and then periodically, within specific guidelines and time frames. However, the facility staff failed to shave resident #33 as indicated in the MDS. On 02-14-17 at 11:20 AM, surveyor interview with the Director of Nursing (DON) revealed no new information. Following surveyor intervention on 02-14-17 resident #33 was showered and shaved. 2. On 02-15-17 at 09:10 AM, this surveyor observed resident #132 in a recliner chair with long finger nails measuring about 15 cm (centimeters) curved into both palms. Further observation revealed a brownish substance embedded in all the nails. On 02-15-17, surveyor review of the quarterly MDS assessment for resident # 132, with an ARD (assessment Reference Date) of 12-05-16, revealed that this resident is totally dependent on staff for all ADL's (activities of daily living) with one person for personal assist. However, facility staff failed to clean resident #132 finger nails. On 02-15-17 at 11:20 AM, surveyor interview with the Director of Nursing (DON) revealed no new information. Following surveyor intervention on 02-14-17 resident #132 fingernails were cleaned and trimmed. 3. On 2-15-17 at 10 AM, surveyor observation of resident #120 revealed long fingernails. When the surveyor asked the resident about the length of the fingernails, he/she stated that he/she would prefer that the fingernails be cut shorter but the staff won't do it. Furthermore, this resident stated that showers are not provided twice a week as scheduled. Review of resident #120's clinical record revealed that he/she is completely dependent on staff for assistance with activities of daily living and is scheduled to receive care with all ADL's including showers twice weekly (on Mondays and Thursdays). Review of the Activities of Daily Living Record revealed documentation that in January 2017, resident #120 received a shower only once, and on the remaining shower days, he/she had received bed baths. There is no evidence that resident #120 had refused the showers on these days. On 2-15-17 at at 2 PM, interview with the Unit Manger revealed no further information.
F 0323 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor review of the clinical record, review of administrative documents and interview of resident, the resident's responsible party and facility staff, it was determined that the facility staff failed to obtain the appropriate size lift sling to use when transferring resident # 162. This finding was evident in 1 of 43 residents selected in the stage 2 reviews. The finding include: Review of the clinical record revealed that resident # 162 was admitted to the facility on [DATE] for rehabilitation services. Additional review of the clinical record also revealed on 02-15-17 that resident #162 left the facility in the late afternoon to go on a leave of absence with his/her responsible party. Review of administrative documents revealed that on 02-15-17 at approximately 9:00 AM, while preparing to transfer resident #162 from the bed into the wheelchair, the geriatric nursing assistant (GNA staff #2) used an oversize (too large for residents actual size/weight) Hoyer (mechanical lift) sling, which resulted in the resident sliding from the bed onto the floor with the GNA (staff #2) attempting to break the fall by lowering the resident to the floor. The resident was assessed by the nurse, with no complaints of pain or discomfort with range of motion after the fall. On 02-16-17 at 9:45 AM, the attending physician documented resident #162 was sent to hospital because (he/she) fell during (his/her) transfer from bed to wheelchair when GNA was helping (him/her). (He/she) injured (his/her) right foot. In the hospital, x-ray shows closed displaced fracture of right talus (ankle bone) of right foot. On 02-16-17 at 10:00 AM, interview with resident #162 revealed that he/she was being transferred from the bed to the wheelchair by the GNA (staff#2) who dropped him/her during the transfer and fell on top of me. The resident's statement as provided was inconsistent with the facility documents related to the incident. On 02-16-17 at 10:20 AM, interview with the responsible party revealed he/she accompanied resident #162 out of the facility at approximately 5:00-6:00 PM on 02-15-17 to purchase shoes (transferring the resident from his/her car to the store and

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F 0323 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 6) back to the car). The responsible party stated he/she was informed by resident #162 that he/she had been dropped by a GNA (staff #2) earlier in the day, however he/she also stated resident #162 did not complain of any pain either prior to or during the leave of absence from the facility to the shoe store. The responsible party stated upon removing resident #162's right shoe at the shoe store, he/she noticed swelling of the right ankle and transported the resident to a hospital where the resident was diagnosed with [REDACTED]. Review of the interview with the GNA conducted by the charge RN dated 2-16-2017 regarding the incident with resident # 162 that occurred on 2/15/2017, revealed that the GNA stated he/she was going to transfer resident # 162 from the bed to chair using the Hoyer Lift. After bringing the hoyer lift close to the room and while waiting for the co-worker to assist in the transfer the GNA went on and put the hoyer pad underneath the resident. The resident slipped off the bed when the GNA tried to pull off the pad on the otherside of the resident. The resident grabbed on to the bed and GNA eased her to the floor. Review of the facility summary of investigation into this incident received on 02-22-16, revealed the facility determined that there was no conclusive evidence that the incident involving the GNA caused the fracture of the right talus based on resident #162's assessment and behavior which was unchanged from baseline, along with the fact that the resident went on a leave of absence later that day with the responsible party who transferred her. In addition, during the post fall investigation, it was determined that the GNA used an oversized sling and should have used a smaller sling for this resident.
F 0328 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Properly care for residents needing special services, including: injections, colostomy, ureostomy, ileostomy, tracheostomy care, tracheal suctioning, respiratory care, foot care, and prostheses** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation, review of the clinical record and staff and resident interviews, it was determined that the facility staff failed to ensure that proper care and monitoring was performed for resident # 171's PICC line. This finding was evident in 1 of 43 resident selected in the stage 2 reviews. The findings include: On 02-17-17, review of the clinical record revealed resident #171 was receiving TPN (total [MEDICATION NAME] nutrition) through a PICC line. TPN was ordered after resident #171 had a small bowel obstruction to allow the colon to rest TPN is a solution that supplies all daily nutritional requirements. Since TPN solutions are concentrated and can cause [MEDICAL CONDITION] of peripheral veins, a central venous catheter is usually required. A PICC is a peripherally inserted central catheter to provide access that can be used for a prolonged period of time for TPN. A PICC requires routine care and maintenance to ensure it is working properly and to prevent infection. Maintenance includes observing the insertion site for any changes or signs of infection. In addition, measurements are taken to ensure the arm circumference have not changed or increased in size and that the external length of the catheter has not changed. The dressing around the area is to be changed weekly and as needed. Further review of the TAR for February 2017 revealed an order for [REDACTED]. Review of the nursing notes on those 2 days revealed no evidence of any measurement of the external catheter length or the arm circumference. There is no evidence of the required monitoring to ensure the safety and patency of the PICC line. On 02-17-17 at 2:30PM, interview with the DON revealed no additional information.
F 0329 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**1) Make sure that each resident's drug regimen is free from unnecessary drugs; 2) Each resident's entire drug/medication is managed and monitored to achieve highest well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor review of the clinical record and interview with the assistant medical director, it was determined that facility staff failed to attempt gradual dosage reductions of antipsychotic medication. This finding was evident in 1 of 43 residents selected in the stage 2 reviews. (#86) The findings include: On 02-21-17 review of the clinical record revealed resident #86 had [DIAGNOSES REDACTED]. Resident #86 received [MEDICATION NAME] 300mg twice daily to treat his/her impulse control disorder. A care plan addressing the [MEDICAL CONDITION] drug utilization related to the impulse control disorder stated a gradual dose reduction would occur per the facility protocol. On 05-17-16 a pharmacy recommendation directed facility staff to obtain a psychiatric consultation for resident #86 related to the use of the antipsychotic drug [MEDICATION NAME]. On 06-19-16 the pharmacist documented a repeat recommendation related to the antipsychotic drug [MEDICATION NAME] for resident #86. On 07-26-16 the pharmacist made a third recommendation related to the antipsychotic drug [MEDICATION NAME] for a psychiatric consult for resident #86. Further review of the clinical record revealed a physician's orders [REDACTED]. (same dosage and frequency as previously) The facility staff was unable to produce any psychiatric consultation for resident #86 between the pharmacist's first recommendation 05-17-16 and 11-10-16; (almost 6 months after the initial recommendation). The clinical record revealed psychiatric consultations dated 11-10-16; 12-21-16; and 02-08-17. None of the consultations addressed the gradual dosage reduction as stated in resident #86's written plan of care. Further review of the clinical record revealed there were no attempts to gradually reduce the antipsychotic medication and no specific documentation to support why a dosage reduction would be clinically contraindicated in resident #86. On 02-17-16 at 10:00 AM, interview with the assistant medical director revealed concurrence that the documentation in the clinical record did not reflect that a gradual dose reduction of the antipsychotic [MEDICATION NAME] had been attempted, and did not provide an explanation as to why a gradual dose reduction was contraindicated for resident #86 which was not consistent with facility protocol.
F 0333 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that residents are safe from serious medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor review of the clinical records and interview of facility staff, it was determined that the facility staff failed to prevent a significant medication error. This finding was evident in 1 of 43 residents selected in the stage 2 review (#166), The findings include: On 02-16-17, review of the clinical record revealed resident #166 was admitted to the facility in January 2017 following a hospitalization . Upon admission, a [MEDICAL CONDITION] medication, [MEDICATION NAME] 100 mg three times a day, was ordered for [MEDICAL CONDITION] disorder. On 01-06-17, a physician's orders [REDACTED]. The reference range of [MEDICATION NAME] is between 10 and 20 mcg/mL. On 01-20-17, the attending physician decreased [MEDICATION NAME] to 100 mg three times a day because the resident's [MEDICATION NAME] level was high- 33.9 mcg/mL. However, review of the Medication Administration Record [REDACTED]. Instead, the nursing staff administered both, [MEDICATION NAME] 100 mg and [MEDICATION NAME] 125 mg, three times a day between 01-21-17 and 01-23-17. On 01-23-17, another laboratory report indicated that resident #166's free [MEDICATION NAME] level was critically high at 4.4 mcg/mL. The reference range of free [MEDICATION NAME] was between 1-2 mcg/mL. The nurse practitioner was informed and discontinued all [MEDICATION NAME] on the same day. On 02-16-17 at 4 PM, interview of the director of nursing revealed no additional information. .
F 0364 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Prepare food that is nutritional, appetizing, tasty, attractive, well-cooked, and at the right temperature.** **Prepare food that is nutritional, appetizing, tasty, attractive, well-cooked, and at the right temperature.**

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F 0364 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 7) Based on surveyor observation of meal preparation and service, it was determined that the facility staff failed to provide foods served at the proper temperature. This finding was evident in the kitchen during the stage 1 kitchen observation. The finding include: On 02-14-16 at 11:45 AM, surveyor observation of the lunch trayline revealed no documented evidence that temperatures were checked prior to tray line. Upon surveyor intervention, prior to the food being distributed to the residents, random temperatures on the trayline were checked and the ground ham on the trayline was 132 degrees farenheit instead of the required 135 degrees farenheit. Additionally a sample plate on a cart prepared for delivery to the nursing unit revealed that the ground ham was 122 degrees farenheit, and the sweet potatoes were 110 degrees farenheit prior to leaving the kitchen. (instead of the 135 degree hot food holding requirement) The kitchen staff failed to insure the potentially hazardous hot foods were held at 135F or above in the steam table and on the serving cart until served to the residents.
F 0371 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Store, cook, and serve food in a safe and clean way** Based on surveyor observation of meal preparation and service, it was determined that facility staff failed to maintain sanitary conditions within the kitchen. This finding was evident during the stage 1 kitchen observation. The finding include: On 02-14-17 at 8:30 AM, a tour of the kitchen revealed a reach in refrigerator with an internal temperature of 60 degrees. All items in the refrigerator were removed, (The refrigerator contained no potentially hazardous items,) and the unit was taken out of service pending repair. On 02-14-17 at 8:35 ice condensation was noted on the inside of the walk-in freezer unit. Frozen hamburger patties were noted in a bag sitting inside an opened box with the bag open and the hamburger patties exposed. No date was noted on the bag or the box. Additionally a container of vanilla ice cream had been opened and not sealed properly. There was no date noted on the ice cream container. On 02-14-17 at 11:30 AM, the dry food storage room was noted to have a heavy accumulation of mouse droppings around the perimeter of the floor.
F 0412 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide or obtain dental services for each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation, clinical record review and interview of a resident and facility staff, it was determined that the facility staff failed to arrange dental services for resident #87 as ordered. This finding was evident in 1 of 43 residents selected in the stage 2 review (#87). The findings include: On 02-16-17 at 10 AM, interview of resident #87 revealed no dental services for over a year. The resident further stated that a dentist recommended him/her to have a tooth extraction in a hospital more than a year ago, but no further follow up has been done. In the past few months, an abscess was noted in his/her teeth and required antibiotic therapy. During the interview, a few teeth were noted to the resident's upper jaw. Review of the clinical record revealed a dental consult was done in February 2016. At that time, the dentist recommended to have a full mouth extraction under general anesthesia in a hospital. On 12-13-16, a physician's orders [REDACTED]. On 12-22-16, the facility staff scheduled a dental appointment for resident #87 on 01-05-17 at 9:15 AM. On 12-30-16, another 7 day course of antibiotic therapy was ordered due to an abscess. Again, a nurse practitioner ordered a dental consult. However, there was no evidence that resident #87 went for the dental consult on 01-05-17 as ordered on 12-13-16 and 12-30-16. On 01-16-17, the nurse practitioner ordered a dental consult for possible tooth extraction for resident #87. On 02-21-17 at 12:30 PM, interview of resident #87 in the presence of the Severn unit manager revealed he/she was not aware of the dental appointment on 01-05-17 at 9 AM. On 02-21-17 at 1 PM, interview of the Severn unit manager revealed no dentist would accept resident #87 for tooth extraction in a dental office due to obesity. However, there was no evidence that the Severn unit manager explored other options and arranged transportation for the resident to go to a hospital for the tooth extraction as recommended in February 2016. On 02-21-17 at 2:30 PM, interview of the director of nursing revealed no additional information.
F 0441 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Have a program that investigates, controls and keeps infection from spreading.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation, review of the clinical records, and interview of facility staff, it was determined that the facility staff failed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection. This was evident in 1 of 43 residents identified in the stage 2 review. (#132). The findings include: On 02-14-17 at 08:40 AM during tour of resident # 132's room, observation revealed a suction machine also called an aspirator (a medical device used to extract mucus and other fluid from individuals) set up on the resident's bedside table. Further observation revealed the tubing for the mask was on the floor and the [MEDICATION NAME] (an oral suctioning tool designed to allow effective suction without damaging surrounding tissues) was left on the bare table top. Additional observation revealed a suction canister (a disposable hard plastic container used for collecting and retaining aspirated materials) and tubing connected to the suction machine had no date and the canister was filled with about 200 ml of fluid. Surveyor review of the clinical record for resident #132 revealed a physician order [REDACTED]. On 02-14-17 at 09:12 AM surveyor interview with the Director of Nursing (DON) revealed that the suction tubing and the [MEDICATION NAME] were to be stored in a plastic bag when not in use. Following surveyor intervention On 02-14-16 at 09:12 AM, the unit manager removed and discarded the suction canister, tubing and the [MEDICATION NAME]. 2. On 2-14-17 at 8:40 AM, surveyor observation of the 2nd floor shower revealed two shower chairs that had feces on the seats and another shower chair that was covered with grime and dirt. The Unit Manager was informed and the room was immediately cleaned by housekeeping staff.
F 0469 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.** Based on surveyor observation and staff interviews, it was determined that the facility staff failed to maintain an effective pest control program so that the facility is free of pests and rodents This finding was evident in the facility's kitchen and the 2nd floor shower room during the stage 1 initial tour. The findings include: 1. On 2-14-17 at 9 AM, surveyor observation revealed several fruit flies in the 2nd floor shower room. The surveyor informed the unit manager. On 2-17-17 the administrator informed the survey team that the area of concern was treated by the contracted pest control company on 2-15-17. 2. On 02-14-17 at 11:30 AM, the dry food storage room was noted to have a heavy accumulation of mouse droppings around the perimeter of the floor.
F 0514 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Keep accurate, complete and organized clinical records on each resident that meet professional standards**

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F 0514 **Level of harm -** Potential for minimal harm **Residents Affected -** Some	(continued... from page 8) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor review of the clinical records and interview of facility staff, it was determined that the facility staff failed to maintain complete and accurate clinical records. This finding was evident in 2 of 43 residents selected in the stage 2 review (#123 and # 112). The findings include: 1. On [DATE], review of the closed clinical record revealed resident #123 was discharged home on [DATE] with home heath services. On the day of discharge, no discharge paper including discharge instructions and resources could be given to the resident because the copier was broken. The resident agreed that the nursing staff could mail the discharge paper later to him/her. However, there was no evidence the discharge paper was mailed to the resident. On [DATE] at 4 PM, interview of the director of nursing (DON) revealed he would follow up. On [DATE] at 10 AM, interview of the DON revealed the MDS (Minimum Data Set) coordinator printed out the discharge paper on an unknown date and asked the front desk staff to mail it out to the resident. Since the front desk staff is no longer employed at the facility, the DON could not validate if the discharge paper was sent to resident #123 or not. In addition, resident #123 was admitted with a pressure ulcer on the left lateral ankle. A wound specialist evaluated the resident's pressure ulcer weekly. However, there was no skin assessment done after [DATE]. On [DATE] at 4 PM, interview of the DON revealed he would follow up with the wound specialist. On [DATE] at 3 PM, the DON stated the wound specialist evaluated resident #123 on [DATE], but no clinical note was found in the clinical record. Since the wound specialist's office was closed on [DATE], the resident's skin assessment, which was done on [DATE], would be faxed to the facility on [DATE] instead. A clinical record should include pertinent resident information including all skin assessments and discharge instructions after a resident is discharged . 2. Resident #112 was admitted to the facility on [DATE] with a 90 day order for temporary guardianship of person. On [DATE] at 1:00 PM, interview with the facility social worker revealed there was no evidence in the clinical record that permanent guardianship had been obtained and no evidence to support efforts to reflect permanent guardianship. The social worker stated that he/she would contact the guardian to determine if permanent guardianship had been established. On [DATE] at 4:00 PM the social worker stated she had contacted the guardian who stated he/she could not locate a permanent guardianship letter for resident #112, and would have to obtain a copy from the court, and fax it to facility. The guardian had been notified of changes in the resident's medical condition consistently based on a document in the clinical record which expired in 2015. On [DATE] at 7:45 AM, after surveyor intervention a copy of a letter of permanent guardianship was received from the guardian for resident #112 and placed in the clinical record. On [DATE] at 2:21 PM interview with the court appointed guardian confirmed the temporary guardianship documents the facility had maintained in the clinical record had been issued in 2015 to facilitate resident #112's discharge from the hospital to a nursing facility.