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.

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CADIA Health Care
900 Van Buren Avenue
Annapolis, MD 21403

Facility Characteristics:

- Skills Nursing Facility with 97 beds that is embedded
- Operating Manager Mark Yost
- Website at www.cadiahealthcare.com
- The For-profit corporation is owned by Wye Oak Healthcare of Annapolis LLC serving the mid-Atlantic in the Annapolis, MD area

- As of 2018 Cadia Health Care was evaluated as a one-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 Cadia Healthcare facility in Annapolis, 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 CADIA Healthcare Annapolis and obtained FOIA responses, I ma 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
	215005	A. BUILDING _____ B. WING _____	12/20/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CADIA HEALTHCARE - ANNAPOLIS	900 VAN BUREN STREET ANNAPOLIS, MD 21403

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 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interviews with facility staff it was determined the facility failed to ensure that an accurate care planning process was followed to ensured care plans were based on 1) residents with behaviors that result in verbal and physical altercations with other residents, 2) resident's interdisciplinary care plan for nutrition, and 3) resident assessment, medical option assessment and are consistent with the resident care provided. This was evident for 3 of 12 residents (#5, #6 and #3) reviewed during the complaint survey. A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess and evaluate the effectiveness of the resident's care. The findings include: 1a) Review of a facility investigation revealed Resident #5 was involved in verbal and physical altercations with other residents on 10/14/17 or 10/15/17, 11/15/17, and 11/20/17. Review of Resident #5's care plan revealed the resident had behaviors resulting in multiple altercations with other residents. One of the care plan approaches was for staff to accompany the resident when safety was an issue. An interview was conducted with the Assistant Director of Nursing (ADN) on 12/13/17 at 1:45 PM and s/he stated that Resident #5 had agitation and aggressive behaviors that result in altercations with other residents. The ADN stated that the resident would be accompanied with staff when going out to the courtyard. Observations were made of the resident returning from the courtyard on 12/13/17 and 12/14/17 and the resident was not accompanied by staff. The ADN was made aware of this at the time of the observations. 1b). Review of Resident #5's nutrition care plan developed, 11/16/17, stated for the nurse aide to record meal intake. Review of the geriatric nursing flow sheet for October, November and through December 19th, 2017 revealed the following dates and meal times percentages not documented: October 2017 -Breakfast: 10/17, 10/18, 10/21, 10/23, 10/24, 10/25, 10/26, 10/31; -Lunch: 10/17, 10/18, 10/21, 10/23, 10/24, 10/25, 10/26, 10/31; -Dinner: 10/5, 10/7, 10/10, 10/11, 10/15, 10/22, 10/25, 10/30, 10/31; November 2017 -Breakfast 11/13, 11/14, 11/24; -Lunch 11/13, 11/14, 11/22, 11/24; -Dinner 11/4, 11/5, 11/16, 11/18, 11/21, 11/23, 11/24, 11/25; December 2017 -Breakfast 12/1, 12/3, 12/5, 12/10, 12/13, 12/14, 12/15, 12/16, 12/17, 12/18; -Lunch 12/1, 12/3, 12/5, 12/10, 12/13, 12/14, 12/15, 12/16, 12/17, 12/18; -Dinner 12/4, 12/7, 12/9, 12/11, 12/15, 12/17. 2. Review of Resident #6's nutrition care plan developed 7/12/17, stated for the nurse aide to record meal intake. Review of the geriatric nursing flow sheet for October, November and through December 19th, 2017 revealed the following dates and meal times percentages not documented: October 2017 -Breakfast 10/17, 10/18, 10/19, 10/21, 10/23, 10/24, 10/25, 10/26, 10/31; -Lunch 10/17, 10/18, 10/19, 10/21, 10/23, 10/24, 10/25, 10/26, 10/31; -Dinner 10/5, 10/7, 10/8, 10/10, 10/11, 10/15, 10/22, 10/27, 10/30, 10/31; November 2017 -Breakfast 11/13, 11/14, 11/24; -Lunch 11/13, 11/14, 11/22, 11/24; -Dinner 11/4, 11/16, 11/18, 11/21, 11/23, 11/24, 11/25; December 2017 -Breakfast 12/1, 12/3, 12/5, 12/10, 12/13, 12/14, 12/15, 12/16, 12/17, 12/18; -Lunch 12/1, 12/3, 12/5, 12/10, 12/13, 12/14, 12/15, 12/16, 12/17, 12/18; -Dinner 12/4, 12/7, 12/9, 12/11, 12/15; Interview with the Acting Administrator and Quality Assurance Manager on 12/20/17 at 1:45 PM confirmed the facility failed to follow the written care plan. 3) On 12/15/17 Resident #3's medical records and care plans were reviewed. This review revealed that the resident was admitted to the facility for long term care and with a [DIAGNOSES REDACTED]. Review of the psychiatric provider notes revealed that the resident scored poor on verbal recall, insight, and ability to follow commands. Further review revealed that the resident was significantly cognitively impaired such that he/she was not able to follow simple basic commands and that the resident appeared more responsive to non-verbal cues. Review of the Minimum Data Set (MDS) admission assessment dated [DATE] section B Hearing, Speech and Vision revealed that the resident had unclear speech and that the resident did not have the ability to understand others. The Minimum Data Set (MDS) is a multi-disciplinary tool that allows many facets of the resident's care (cognition, behavior, mobility, activities of daily living, accidents, activities, weight, pain and medications to name a few) to be addressed. Review of the Care Area Assessments (CAA) revealed that self-care deficit, cognitive loss and falls were triggered and care planned. Care Areas are triggered by MDS item responses that indicate the need for additional assessment. Review of the resident's care plans revealed the following problems to be care planned: -Self-care deficit related to confusion, intervention for the resident included teaching as indicated and reorient as able; -Potential for complications related to poor impulse control, interventions used included ask open ended questions, paraphrase resident words, allow adequate response time and encourage resident to speak; -Ask questions that can be answered with yes or no; -Impaired cognition related to intellectual disability interventions included redirect and reorient reside when needed. Give resident ample time to respond and allow to vent; -Potential for falls related to cognitive status, interventions encouraged compliance with safety measures encourage resident to call for assistance

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

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 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) During an interview with the Assistant Director of Nursing (ADON) on 12/19/17 the surveyor asked if she knew the resident and the ADON verbalized she did. The surveyor asked if the resident was able to understand what was being said and if she/he was able to communicate with staff. The ADON revealed she did not think so. Although a plan was generated in the facility on 7/17/17, it did not reflect the needs of the resident, nor was it consistent with services staff members were providing to the resident, and was never updated during the resident's entire length of stay. The resident's severe cognitive impairment was documented throughout the resident's medical records.
F 0745 **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 medical records review and interview with the facility staff, the facility failed to assure that sufficient and appropriate social services were provided to meet the resident's needs as evidence by failure to pursue or ensure the resident had an appropriate guardian a timely manner. This was evident for 1 out of the 8 residents (#3) in the complaint survey. The findings include: On 12/19/17 at 9:00 AM Resident #3's medical records were reviewed. This review revealed the resident was admitted to the facility in July 2017 from an acute care hospital for long term care and with [DIAGNOSES REDACTED]. Further review of the hospital transfer note revealed that the resident had a guardian that resided in a different state Review of the social service admission note dated 7/20/17 documented the resident's medical diagnosis, Brief Interview of Mental Status (BIMS) score and depression score but failed to reveal any documentation about the resident's guardian. Further review of the social service note revealed an admission BIMS dated 7/17/17 with a total score of 00. The BIMS is a test given by medical professionals that helps determine a resident's attention, orientation and ability to register and recall new information. A BIMS score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment. Further review of the medical records revealed that on 7/20/17 and 7/24/17 two physicians signed certification related to substitute decision making, medical condition and treatment limitations. The two-physicians certified that the resident was unable to understand and sign admission documents, unable to effectively communicate a decision and unable to make rational evaluation of the burden risk and benefits of the treatment. Further review of the certification revealed that the resident was incapable of making an informed decision regarding all medical decisions. Review of the discharge planner note dated 7/28/17 revealed that she was informed that the resident had a guardian, and that the discharge planner was trying to get supportive documentation. Review of the social service note dated 9/8/17 revealed that 56 days after admission to the facility social service spoke with the resident's guardian. Further review of social service note revealed that the guardian stated she did not see the need for her to be involved since there was nothing that the guardian could do. Review of the social service note revealed that a care plan meeting was held on 9/21/17 and the note documented the following: Resident currently has no RP (responsible party) or guardian. Resident is pending guardianship requested by the facility. Review of the social service note dated 11/22/17 revealed that the following: SW and IDT (inter-disciplinary team) members have attempted to contact residents RP to participate or update on care of resident and to discuss care plans. Resident continues to have no guardian or RP. SW has forward the information to legal time (team) to start the process of guardianship. SW will continue to f/u (follow-up) with legal team on the process and guardianship. Review of the guardianship documentation revealed that they were signed by two physicians on 12/7/17 and 12/11/17. The 12/12/17 social services note documented the following: SW provided guardianship paperwork for physicians to complete to start the process of guardianship. SW informed legal (team) about the documentation and certificates that need to be signed. SW also informed the legal (team) that once they are signed that they will be sent over to (name of staff member), the legal team. SW obtained the documents and were sent over to legal (team). SW will f/u on the process of the guardianship and update IDT members about the process. SW will continue to provide support and f/u as necessary. Further review of the medical records revealed that the resident was discharged on [DATE]. During an interview with social services on 12/20/17 the surveyor asked if she knew that the resident had a guardian upon admission, and she reported she did because it was part of the hospital discharge information. The surveyor asked her prior to the September (9/8/17), did she attempt to contact the guardian. The Social Services staff replied, no she did not. The surveyor also asked the Social Services staff to explain the conversation she had with the guardian when she informed her that she didn't see the need to be involved, and if she asked her if it was for the care plan or for the resident. The Social Services staff replied it was about the resident; that the guardian felt that she could not care for the resident. The Social Services staff was asked to clarify the note that was written on 9/21/17 about pending guardianship, and she reported she was going to discuss with the facility about obtaining guardianship. When asked if she did discuss this with the facility at that time, she stated that she did not. Documentation indicating that guardianship was started in September, October or November was requested from the Social Services staff, and she indicated she did not have any. The surveyor asked what documentation she did have to show the facility was starting the process of guardianship, and she indicated the only documentation she had was the one that was dated for December. When the Social Services staff was asked to provide an explanation for the following: knowing since 9/8/17 that the guardian did not want to remain the guardian for the resident, documenting on 9/21/17 that the resident was pending guardianship by the facility, however not being able to provide documentation for October or November indicating this; and why it took so long to initiate and complete the guardianship process, she failed to respond to the questions.
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 medical record review and interview with facility staff it was determined that the staff failed to maintain complete documentation as evidenced by the failure to consistently document the resident's food intake. This was found to be evident for 1 out of 12 residents (Resident #3) reviewed for the complaint survey. The findings include: On 12/15/17 Resident #3's medical records were reviewed. This review revealed that the resident was admitted to the facility in July 2017 for long term care. Review of the dietary assessment dated [DATE] revealed that the resident's BMI per dietary was 14.93 and he/she was underweight. Further review of the dietary notes revealed that the resident had a significant weight loss and that the resident required complete assistance with all meals to ensure adequate intake. Dietary also indicated that they would monitor the resident for dietary intake. Review of the geriatric nursing assistant (GNA) documentation of meal intake for July and August 2017 revealed missing documentation for breakfast and lunch occurred on 7/27/17, and 8/2/17, 8/4/17, 8/7/17 8/8/17, 8/9/17, 8/12/17, 8/15/17, 8/17/17 8/22/17, 8/23/17, and 8/25/17. Missing documentation for dinner occurred on 7/18/17, 7/23/17, 7/28/17, 7/29/17, 7/30/17, and 8/3/17 and 8/19/17. There was no meal intake documented or the following dates: 7/20/17, 7/24/17, 8/13/17, 8/20/17, 8/21/17, 8/24/17, 8/26/17, and 8/27/17. Review of meal intake documentation for October and November 2017 revealed similar lack of documentation from the GNA staff. On 12/12/17 at 9:58 PM, the GNA documented that the resident ate 100% of his/her meal. However, review of the nurse's notes revealed that the resident was transferred to the hospital at approximately 3:30 PM due to not being able to swallow.