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

Cadia Healthcare – Hyattsville
4922 Lasalle Road
Hyattsville, MD 20782

Facility Characteristics:

- Skills Nursing Facility with 270 beds
- Operating Manager Mark Yost
- Website at www.cadiahealthcare.com/locations/maryland/hyattsville
- The For-profit corporation is owned by Wye Oak Healthcare of Hyattsville LLC
- As of 2018 Cadia Healthcare - Hyattsville 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-Hyattsville in Hyattsville, 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 in Hyattsville, MD 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
	215145	A. BUILDING _____ B. WING _____	**12/12/2017**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CADIA HEALTHCARE - HYATTSVILLE	**4922 LASALLE ROAD HYATTSVILLE, MD 20782**

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 0567 **Level of harm -** Potential for minimal harm **Residents Affected -** Some	**Honor the resident's right to manage his or her financial affairs.** Based on the review, on 12/12/17, of the residents' personal funds records, including individual resident's account summaries, closed account summaries, transaction reports, and on the interview of the facility's business office personnel, this facility failed to deposit a resident's personal funds in excess of $50.00 into an individual, interest bearing account. Findings include: 1. This facility closed the individual, interest bearing, personal fund accounts for residents 1A and 2A on 1/15/16, for residents 3A and 4A on 1/19/16, for Resident 5A on 6/17/15, for Resident 6A on 6/24/15, and for Resident 7A on 3/17/16. Each resident's closing balance was in excess of $50.00. The facility transferred each resident's personal funds to a non-interest bearing, pooled, petty cash checking account. Each resident's personal funds remained in the non-interest bearing account until 10/28/16. 2. This facility closed the individual, interest bearing, personal fund accounts for Resident 8A on 7/25/16, for Resident 9A on 10/7/16, for Resident 10A on 10/26/16, and for Resident 11A on 11/18/16. Each resident's closing balance was in excess of $50.00. The facility transferred each resident's personal funds to a non-interest bearing, pooled, petty cash checking account. Each resident's personal funds remained in the non-interest bearing account until 10/25/17.
F 0568 **Level of harm -** Potential for minimal harm **Residents Affected -** Some	**Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the review, on [DATE], of the residents' personal funds records, including individual resident's account statements, transaction reports, transaction receipts, and on the interview of the facility's business office personnel, this facility failed to maintain a system that ensures a full and complete accounting of the residents' personal monies entrusted to this facility. Findings include: 1. Resident 12A expired on [DATE]. This facility continued to receive and deposit additional resource checks for the months of ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], and ,[DATE]. This facility did not appropriately notify the resource agency until [DATE]. The monies were not returned to the appropriate resource agency until [DATE]. Additionally, this facility closed the resident's personal fund account on [DATE], without appropriate authorization. The resident's $9,045.32 closing balance was transferred by the facility to a non-interest bearing, pooled, petty cash checking account. The facility did not re-deposit the resident's personal funds back into an interest bearing account until [DATE]. 2. Resident 13A expired on [DATE]. This facility received and deposited an additional resource check on [DATE], for $758.30. On [DATE], the facility transferred $681.30 from the resident's personal fund account to a facility account, as a cost of care payment for ,[DATE]. The facility did not re-deposit the resident's funds back into their account until [DATE]. 3. As of [DATE], there was no evidence that statements of each resident's personal fund account had been appropriately furnished for the quarter ending [DATE].

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	215145	A. BUILDING _____ B. WING _____	**11/16/2017**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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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 medical record review it was determined that facility staff failed to revise the resident's care plan related to elopement risk when the resident attempted to elope from the facility. This was evident for 1 (Resident #5) of 8 sampled residents selected for review. The findings include: Resident #5 was admitted to the facility in June 2016. The resident has a [DIAGNOSES REDACTED]. The resident's medical record was reviewed on 10/31/17, 11/15/17 and 11/16/17. Medical record review revealed that the resident was hospitalized in the past due to his/her psychiatric diagnosis. Prior to hospitalization , the resident had been missing for 30 days and was found at a local shelter. Medical record review revealed that on 6/9/16 the facility initiated a care plan related to the resident's risk for elopement related to a history of elopement with the goal that the resident would not leave the facility without the physician's approval and would only leave the facility accompanied by staff or other authorized persons. Medical record review revealed that on 11/8/16 the Social Service Assistant documented that the resident was offered a wanderguard, but the resident refused despite education and encouragement. The Social Service Assistant documented that staff were made aware and would continue to monitor the resident for elopement risk. Medical record review revealed that on 6/6/17 the nurse documented that the restorative aid went to the resident's unit to escort the resident to the rehabilitation department. When the restorative aid approached the resident, the resident made the aid aware that he/she was waiting for the physician to take him/her outside. The physician arrived on the unit and asked the aid are you taking her outside? The restorative aid replied, I can if you like. The restorative aid proceeded to escort the resident off the unit and outside of the facility. As they were walking along the sidewalk, the resident suddenly took off running from the aid. Another staff member witnessed the incident and attempted to assist in redirecting the resident back into the facility. Staff were eventually able to redirect the resident back into the facility without injury. At that time, staff offered a wanderguard to the resident, but the resident resisted placement and stated that he/she did not want it and if placed he/she would remove it and throw it away. Medical record review revealed that on 8/5/17 the nurse documented that the resident got on the elevator and left the facility, went across the street to an unknown house and sat on the porch refusing to leave. Staff notified the resident's guardian who was unable to assist in getting the resident back into the facility. Staff called 911 to assist and after approximately 1 hour the resident was assisted back into the facility. Medical record review revealed that on 8/8/17 the resident was standing by the elevator pressing the keyboard. Once the elevator door opened the resident got on the elevator and left the unit despite staff encouragement. The nurse documented that interventions were put in place and outcome was improved. The resident again refused wanderguard placement at that time. Review of the resident's elopement risk care plan revealed that although the resident refused to wear a wanderguard, attempted to elope on 8/5/17 and 8/8/17, the facility staff failed to re-evaluate and revise the resident's care plan. In fact, on 8/30/17 the staff documented that the care plan goals had been met. Medical record review revealed that on 9/28/17 the nurse documented that the resident entered the elevator unaccompanied by staff. Staff followed the resident to the front desk/lobby. The resident stated that he/she wanted to go and get fresh air outside. After sitting outside for a few minutes, the resident stood up and started walking toward the bus stop. Staff followed the resident and the resident was eventually convinced to return to the unit. The resident's guardian was notified and asked to speak to the resident. The resident declined and requested staff to tell the guardian to come and take me to another place and walked away. Again, the facility staff failed to re-evaluate and revise the resident's care plan. Medical record review revealed that on 10/27/17 the nurse documented that the resident was seen on the unit at approximately 11:00 A.M. in his/her room with the door closed. At approximately 12:45 P.M. the resident was not in his/her room when the aid went to serve the resident's lunch meal. The unit was searched and the resident was not located. Senior administrative staff and the attending physician were notified. The facility and facility surroundings were searched and the resident was not located. The police were notified and responded to the facility. The resident's guardian was notified. Interview of the resident's guardian on 12/15/17 revealed that the resident has not been located. Refer to F 323.
F 0323 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 medical record review and interview of facility staff it was determined the facility failed to revise policies and procedures to prevent residents from eloping from a secured unit. This was evident for 2 (Resident #4 and Resident #5) of 8 sampled residents selected for review. The findings include: 1. Resident #4 was admitted to the facility in August 2016. The resident has a [DIAGNOSES REDACTED]. The resident's medical record was reviewed on 11/15/16 and 11/16/16. On 12/20/16 a care plan was initiated due to the resident's risk for elopement. Also, on 12/20/16 a physician's orders [REDACTED]. A wanderguard is a tracking device designed to prevent persons at risk from leaving a facility. The system tracks the person using a wrist or ankle band and automatically locks doors or alarms if the person moves outside of a defined area. Medical record review revealed that on 3/15/17 the physician documented the following entry in the progress notes: . has poor insight and continues to be adamant about leaving the facility despite the fact that (he/she) is (wheelchair) bound; (he/she) wants to go 'home'; (he/she) does not have a plan, (he/she) thinks (he/she) is able to walk and be independent . Medical record review revealed that on 3/16/17 the nurse documented in the progress note that facility staff received a telephone call from the resident's friend at 5:00 P.M. who informed staff that the resident had called him/her from a bus stop at a local hospital. Staff requested that he resident's friend call the resident and instruct him/her to stay where he/she was and facility staff would pick the resident up. At approximately 5:50 P.M. the resident called the facility and

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	215145	A. BUILDING _____ B. WING _____	**11/16/2017**

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CADIA HEALTHCARE - HYATTSVILLE	**4922 LASALLE ROAD HYATTSVILLE, MD 20782**

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F 0323 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) informed facility staff of his/her location. Facility staff picked the resident up and the resident was returned safely to the facility. On 11/16/17 at 12:05 P.M. the Nursing Home Administrator provided the surveyor with the investigation of the elopement incident. Review of the facility's investigation revealed that the resident had left the unit without informing staff after participating in an activities program on the unit. The resident informed staff that he/she was assisted to the bus stop by young people he/she could not identify. Interview of the Nursing Home Administrator revealed that the facility failed to report the elopement incident to the Office of Health Care Quality. Interview of the Nursing Home Administrator on 11/16/17 at 2:30 P.M. revealed that staff were re-educated on the facility's elopement policy and procedure. However, the facility's policy and procedure related to the prevention of elopement was not updated or revised at that time, and no further action was taken to ensure that other residents at risk for elopement were prevented from leaving the secured unit and/or the facility without the knowledge of staff. 2. Resident #5 was admitted to the facility in June 2016. The resident has a [DIAGNOSES REDACTED]. The resident's medical record was reviewed on 10/31/16, 11/15/16 and 11/16/16. Medical record review revealed that the resident was hospitalized in the past due to his/her psychiatric diagnosis. Prior to hospitalization , the resident had been missing for 30 days and was found at a local shelter. Medical record review revealed that on 6/9/16 the facility initiated a care plan related to the resident's risk for elopement related to a history of elopement with the goal that the resident would not leave the facility without the physician's approval and would only leave the facility accompanied by staff or other authorized persons. Medical record review revealed that on 11/8/16 the Social Service Assistant documented that the resident was offered the wanderguard, but the resident refused despite education and encouragement. The Social Service Assistant documented that staff were made aware and would continue to monitor the resident for elopement risk. Medical record review revealed that on 6/6/17 the nurse documented that the restorative aid went to the resident's unit to escort the resident to the rehabilitation department. When the restorative aid approached the resident, the resident made the aid aware that he/she was waiting for the physician to take him/her outside. The physician arrived on the unit and asked the aid are you taking her outside? The restorative aid replied, I can if you like. The restorative aid proceeded to escort the resident off the unit and outside of the facility. As they were walking along the sidewalk, the resident suddenly took off running from the aid. Another staff member witnessed the incident and attempted to assist in redirecting the resident back into the facility. Staff were eventually able to redirect the resident back into the facility without injury. At that time, staff offered a wanderguard to the resident, but the resident resisted placement and stated that he/she did not want it and if placed he/she would remove it and throw it away. Medical record review revealed that on 8/5/17 the nurse documented that the resident got on the elevator and left the facility, went across the street to an unknown house and sat on the porch refusing to leave. Staff notified the resident's guardian who was unable to assist in getting the resident back into the facility. Staff called 911 to assist and after approximately 1 hour the resident was assisted back into the facility. Medical record review revealed that on 8/8/17 the resident was standing by the elevator pressing the keyboard. Once the elevator door opened the resident got on the elevator and left the unit despite staff encouragement. The nurse documented that interventions were put in place and outcome was improved. The resident again refused a wanderguard placement at that time. Medical record review revealed that on 9/28/17 the nurse documented that the resident entered the elevator unaccompanied by staff. Staff followed the resident to the front desk/lobby. The resident stated that he/she wanted to go and get fresh air outside. After sitting outside for a few minutes, the resident stood up and started walking toward the bus stop. Staff followed the resident and the resident was eventually convinced to return to the unit. The resident's guardian was notified and asked to speak to the resident. The resident declined and requested staff to tell the guardian to come and take me to another place and walked away. Medical record review revealed that on 10/27/17 the nurse documented that the resident was seen on the unit at approximately 11:00 A.M. in his/her room with the door closed. At approximately 12:45 P.M. the resident was not in his/her room when the aid went to serve the resident's lunch meal. The unit was searched and the resident was not located. Senior administrative staff and the attending physician were notified. The facility and facility surroundings were searched and the resident was not located. The police were notified and responded to the facility. The resident's guardian was notified. Interview of the resident's guardian on 12/15/17 revealed that the resident has not been located. As a result of this incident, on 10/30/17 the facility revised the policy and procedure for elopement prevention on the secured unit as follows: Policy: The nursing station shall have a staff member at all times to ensure that the elevators are monitored to ensure that the residents do not elope. In the event that staff need to leave the station unmanned due to an emergency response, staff will immediately call for assistance as soon as practicable and conduct a head count upon conclusion of the emergency response. Purpose: To ensure security on the secured floor at the facility. Procedure: 1. The nursing station shall be manned 24 hours per day, 7 days per week by at least one staff member. 2. In the event that all staff need to leave the station, staff shall call for assistance to man the station as soon as practicable. 3. Whenever the station is unmanned due to emergencies or other circumstances, as soon as the station is manned again, the staff shall immediately conduct a head count to ensure that all residents are accounted for in the unit. If any resident is missing, the elopement protocols and procedures shall be initiated. Based on review of the facility's investigation, medical record review and interview of facility staff revealed that F 323 resulted in past non-compliance on March 16, 2017 through October 29, 2017. On October 30, 2017 the facility implemented a plan of correction for F 323 compliance.

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	215145	A. BUILDING _____ B. WING _____	09/27/2017

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CADIA HEALTHCARE - HYATTSVILLE	4922 LASALLE ROAD HYATTSVILLE, MD 20782

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F 0309 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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 medical record review it was determined the facility staff failed to administer treatments and/or failed to clarify physician's orders for treatments to Resident #8's vascular wounds. This was evident for 1 of 10 sampled residents selected for review. The findings include: Resident #8 has a [DIAGNOSES REDACTED]. Medical record review revealed that the resident was evaluated by the wound physician on 8/30/17. The wound physician assessed the resident with a right anterior leg wound and a left anterior leg wound. The wound physician recommended cleansing the bilateral leg wounds with normal saline solution, applying [MEDICATION NAME] powder, an Unna boot, [MEDICATION NAME], kerlix and and an ace wrap to the bilateral leg wounds every week. Review of the treatment administration record (TAR) revealed that the facility staff failed to administer a treatment to the resident's left anterior leg wound 9/1/17 and 9/2/17. The facility failed to administer a treatment to the resident's right anterior leg wound 9/1/17 through 9/6/17. Additionally, the facility staff failed to document that kerlix was applied to the left and right leg wounds on 9/7/17. Medical record review revealed that on 9/9/17 the resident was sent to the hospital emergency department at the request of the responsible party. Review of the hospital discharge summary revealed that the resident was hospitalized , on 9/9/17 through 9/13/17, for bilateral lower extremity swelling with superficial oozing ulcers. At admission, the resident was febrile with redness, warmth and swelling in the lower extremities with multiple blisters. A wound culture revealed strep and staph growth which was positive for [MEDICAL CONDITION]-resistant Staphylococcus aureus (MRSA). The resident was treated in the hospital with intravenous antibiotics and readmitted to the facility on [DATE]. Medical record review revealed that the resident was evaluated by the wound physician on 9/13/17. The wound physician assessed the resident with a right anterior leg wound, a left anterior leg wound, a right lateral leg wound and a left posterior leg wound. The wound physician recommended cleansing the bilateral leg wounds with normal saline solution, applying silver alginate and covering the wounds with kerlix daily. Review of the TAR revealed that the facility staff documented that the resident's bilateral leg wounds were cleansed with normal saline solution and silver alginate was applied daily. The facility staff failed to document that the wounds were covered with kerlix 9/13/17 through 9/21/17 and their was no documented evidence that the facility staff clarified the order with the physician to cover the resident's bilateral leg wounds with kerlix.
F 0314 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review it was determined that the facility staff failed to initiate and implement interventions to offload pressure of bony prominence's to prevent the development of pressure ulcers. Resident #10 was affected by the deficient practice. The findings include: Resident #10 had resided at the facility since April of 2013. The resident's medical record was reviewed on 9/26/17. Review of the Minimum Data Set (MDS), an assessment tool, dated 5/17/17 revealed that the resident was dependent on staff for bed mobility. Review of the June 2017 treatment administration record (TAR) revealed that prior to 6/29/17, there was no documented evidence that the resident was on a turning and positioning program to relieve pressure to the resident's bony prominence's to prevent the development of pressure ulcers. Medical record review revealed that on 6/28/17 the nurse documented that the resident was assessed with [REDACTED]. The area measured 3.8 cm. x 3.8 cm. x UTD (unable to determine). The physician was notified and gave an order for [REDACTED].>Further review of the TAR revealed that it was not until 6/29/17, after the resident developed an open area to the sacrum, that the facility initiated and implemented an intervention to turn and position the resident every 2 hours and as needed.
F 0514 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Keep accurate, complete and organized clinical records on each resident that meet professional standards** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review it was determined that nursing staff failed to accurately document the medical condition of Resident #10. This was evident for 1 of 10 sampled residents selected for review. The findings include: Resident #10 was admitted to the facility on [DATE] after being hospitalized and treated for [REDACTED]. The resident's medical record was reviewed on [DATE], [DATE] and [DATE]. Medical record review revealed the physician visited the resident on [DATE] and documented that the resident's prognosis was guarded. Medical record review revealed that on [DATE] the physician documented the follow entry in the progress notes: MD Discharge Summary: [DATE]: The patient was seen today due to (he/she) developed some congestion over the weekend. As per the patient for the past day the patient has developed a repetitive cough. Examination showed that the patient had developed +2 [MEDICAL CONDITION] BLE (bilateral lower extremities) . After 3 minutes of walking out of the patient's room, the patient became unresponsive while she was getting ready for therapy. The patient was checked and did not have a pulse nor was (he/she) breathing. A code blue was called after making sure the patient is a full code . after 25 minutes of Cardiopulmonary Resuscitation (CPR), the patient regained a pulse. 911 arrived and placed the patient on an Automated External Defibrillator (AED) in order to affirm a pulse. The patient was eventually taken to the hospital for further evaluation and treatment. Medical record review revealed that the documentation in the nursing progress notes was not consistent with the physician's progress note of [DATE]. There was no documented evidence in the nursing progress note that the resident had been assessed

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F 0514 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) by nursing related to complaints of congestion and coughing nor was the resident assessed by nursing with bilateral lower extremity [MEDICAL CONDITION].

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F 0164 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Keep each resident's personal and medical records private and confidential.** Based on observation and interview, it was determined the facility staff failed to ensure that Resident #1 was provided with privacy in order to prevent exposure of body parts from public view. This was evident for 1 of 9 sampled residents selected for review. The findings include: An observation conducted on 09/06/2017 at 2:00 PM revealed that Resident #1 was sitting in his/her bed without any visible clothing or gown. The door to the room was wide open and a private body part was exposed to anyone walking in the hallway. The resident was heard speaking loudly in the room, potentially drawing additional attention. Staff #1 was observed for approximately 3 minutes working at the nursing cart directly across the hall from Resident #1. Two additional staff members were observed walking in front of the room in that time period. The surveyor alerted Staff #1 that the resident was exposed. Staff #1 went into the room, pulled back the blanket, and redressed the resident in a gown that had been pushed under the cover. Staff #1 did not close the door while in the room with the resident. In a subsequent interview, Staff #1 explained that it was a family member that had left the door open. Staff #1 then apologized and stated, I have to see she removed it. I missed that point because I was doing something and she's not supposed to be like that, she's supposed to be dressed. This finding was brought to the attention of the Nursing Home Administrator and the Director of Nursing. It is the responsibility of the facility staff to treat residents in a manner that maintains the privacy of their bodies.
F 0309 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**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 medical record review and interview of facility staff it was determined the facility staff failed to provide adequate care for the treatment of [REDACTED]. This was evident for 2 of 9 residents selected for review. Resident #6 and Resident #8 were affected by the deficient practice. The findings include: Resident #6 was readmitted to the facility on [DATE] after being hospitalized and treated for [REDACTED]. It may occur as a complication of a penetrating wound to the eye, [MEDICAL CONDITION], [DIAGNOSES REDACTED], or corneal ulcer). Review of the hospital medical record revealed the hospital discharge instructions were for the resident to be continued on [MEDICATION NAME] drops 4 times per day in both eyes, preservative free artificial tears every 2 - 3 hours, lacrilube every 6 hours and follow up with an Opththalmologist 8/28/17. Medical record review revealed that the resident's readmission orders [REDACTED]. On 8/27/17 the physician gave an order for [REDACTED]. Review of the Medication Administration Record [REDACTED]. On 8/28/17 the order for lubricant eye ointment was discontinued. The facility staff did not start artificial tears until 8/30/17. Between the resident's readmission to the facility on [DATE] through 8/29/17, the facility staff failed to provide any lubrication to the resident's eyes. The facility staff failed to administer fortified [MEDICATION NAME] eye drops as ordered by the physician 8/29/17 through 8/31/17. Medical record review revealed that the resident was seen and examined by the infectious disease physician on 8/30/17. The infectious disease physician documented: continue [MEDICATION NAME] eye drops as indicated per hospital records until ophthalmology appointment. On 9/1/17 the resident's attending physician gave an order to administer fortified [MEDICATION NAME] eye drops every day at 9:00 P.M., instead of 4 times per day as recommended in the hospital discharge summary, and recommended by the infectious disease physician. The attending physician failed to document a rationale for changing the order to 1 time per day. The facility staff administered fortified [MEDICATION NAME] eye drops every day at 9:00 P.M. 9/1/17 through 9/5/17. Medical record review and interview of ophthalmology office staff on 9/8/17 revealed that the facility staff did not contact the ophthamologist's office until 9/7/17 to make a follow up appointment. On 9/8/17 the resident was seen as a walk in at the hospital for an ophthalmology consult. Review of the Ophthalmoligist's consult notes revealed that the resident was diagnosed with [REDACTED]. The Ophthalmologist recommended aggressive lubrication: lacrilube QID (4 times per day) alternate with [MEDICATION NAME] ointment QID and to follow up in 1 week for cornea check. Resident #8 was readmitted to the facility on [DATE] after a hospitalization . While in the hospital, the resident was diagnosed with [REDACTED]. Medical record review revealed that the resident's readmission physician's orders [REDACTED]. Review of the Medication Administration Record [REDACTED]. The order was discontinued on 9/9/17. The resident had received only 3 of the 5 doses of [MEDICATION NAME] eye ointment that was ordered by the physician.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215145	A. BUILDING _____ B. WING _____	07/24/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CADIA HEALTHCARE - HYATTSVILLE	4922 LASALLE ROAD HYATTSVILLE, MD 20782

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 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**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 observation, staff interviews, interviews of residents and visitors, interview of the Ombudsman and interview of Emergency Medical Services (EMS) personnel it was determined the facility failed to take appropriate action to ensure clinical interventions were initiated and implemented to monitor residents for heat related illness and failed to promptly initiate clinical interventions to prevent dehydration of residents when the facility's air conditioning unit that supplies cool air to residents' rooms failed during predicted extreme outdoor temperatures. Resident #4 was affected by the deficient practice. The following room numbers exceeded temperatures of 81 degrees Fahrenheit during observation on 7/21/17 between 6:30 p.m. through 9:15 p.m.: 223, 258, 259, 321, 322, 323, 332, 333, 334, 335, 344, 346, 348, 350, 351, 352, 354, 357, 358, 404, 412, 415, 417, 418, 440, 446, 448, 449, 454, 452, 454, 453, 452, 522, 523, 545, 558 exceeded temperatures of 85 degrees Fahrenheit. On 7/24/17 at 4:00 P.M. the nursing home administrator was advised that it was determined a condition of immediate jeopardy existed beginning 7/20/17 at 10:00 A.M. placing residents at risk for heat related illness, dehydration and death due to the facility's failure to take prompt and appropriate action when the potential existed for extreme room temperatures when the air conditioning unit to residents' rooms failed. The Office of Health Care Quality remained onsite until immediate jeopardy was abated on 7/24/17 at 8:30 P.M. The findings include: Interview of the Ombudsman on 7/22/17 at 1:00 P.M. revealed that on Thursday morning (7/20/17) at 3:00 A.M. a resident of the facility left a message that the building was hot as hell. The Ombudsman visited the building at approximately 11:30 A.M. through 4:00 P.M. The Ombudsman confirmed that the building was hot during that time. Residents and visitors complained to the Ombudsman in regard to the hot temperatures in the building. Interview of the Assistant Administrator on 7/24/17 at 1:45 P.M. revealed that he became aware that there was a problem with the air conditioning in residents' rooms at approximately 10:00 A.M. on 7/20/17. He stated the Director of Nursing was made aware and he started contacting air conditioning service vendors. During a tour of the facility on 7/21/17 between 11:45 A.M. and 12:00 P.M. multiple patients' rooms were noted to be warm. Residents and visitors complained to the surveyors that rooms were warm. Multiple residents on the 4th floor were noted to be without water pitchers at the bedside. Observation and medical record review of 4 tube fed residents on the 3rd floor (Resident #8, Resident #9, Resident #10 and Resident #11) that are dependent on facility staff for nutrition and hydration, did not have physician's orders [REDACTED]. At that time, the surveyors determined that there had been no plan initiated to monitor residents for heat related complications, including monitoring residents' vital signs, and there was not a process to ensure that residents were given additional fluids to prevent dehydration. At that time, the surveyors met with the nursing home administrator and the director of nursing and requested the facility's plan going forward to ensure that residents were monitored for heat related problems, as well as, interventions that would be put into place to ensure residents' hydration would be increased. Review of the facility's temperature logs revealed that on 7/20/17 at 10:00 A.M. through 7/21/17 at 5:00 P.M. the temperatures were recorded at or below 83 degrees Fahrenheit. On 7/21/17 at 6:15 P.M. the surveyor obtained the facility's digital thermometer and calibrated the thermometer to ensure accuracy. The surveyor toured the facility at 6:30 P.M. and checked temperatures of 11 rooms on the 3rd floor (room numbers: 323, 333, 334, 335, 344, 344, 346, 348, 350, 351, 352, 354) and 4 rooms on the 4th floor (room numbers: 440, 448, 454, 542). The room temperatures ranged from 86F to 95F. The Nursing Home Administrator was notified of the findings. Interview of the Director of Nursing on 7/21/17, after the 6:15 P.M. tour of the facility, revealed interventions had been initiated to monitor residents' vital signs every 4 hours starting at 6:00 P.M. On 7/21/17 at 7:30 P.M. the surveyor toured the facility and checked temperatures of 5 rooms on the 3rd floor (room numbers: 321, 322, 332, 357, 358), 6 rooms on the 4th floor (room numbers: 446, 448, 449, 452, 453, 454); and, 4 rooms on the 5th floor (room numbers 522, 523, 545, 558). The room temperatures ranged from 85F degrees to 91F. On 7/21/17 at 8:45 P.M., the surveyor observed delivery of portable cooling units to the facility. (The Nursing Home Administrator had contacted the vendor on 7/21/17 at 3:13 P.M. to make arrangements to obtain the portable cooling units). On 7/21/17 at 9:15 P.M. the Chief Executive Officer (CEO) questioned the accuracy of the room temperatures the surveyor had obtained at 6:30 P.M. and 7:30 P.M. The CEO accompanied the surveyor to 5 rooms on the 4th floor (room numbers: 404, 412, 415, 417, 418). The temperatures ranged from 83 degrees in 1 room to 93 degrees in 2 rooms. Although the facility was aware that the air conditioning unit that provides cool air to residents' rooms was not operational as early as 7/20/17 at 10:00 A.M., it was not until more than 24 hours later, and after the intervention of the Office of Health Care Quality and Emergency Medical Services (EMS) personnel, that action was taken to obtain portable cooling units, monitor residents' vital signs to alert staff of any heat related complications and increase hydration to prevent dehydration. The failure to initiate and implement clinical interventions related to prolonged exposure to high temperatures can lead to heatstroke which occurs when the body overheats. Heatstroke requires emergency treatment and if left untreated, can lead to damage to the brain, heart, kidneys and muscles. The longer treatment is delayed can increase the risk of serious complications, including death. Symptoms to look for in heatstroke include a high body temperature, altered mental status, alteration in sweating, nausea and vomiting, flushed skin, rapid and shallow breathing, elevated heart rate and headache. Additional findings include: Resident #4 has [DIAGNOSES REDACTED]. The resident's medical record was reviewed on 7/21/17 and 7/24/17. The hospital medical record was provided by the admitting hospital on [DATE]. Medical record review revealed that on 7/21/17 the resident was transferred to the hospital after the physician assessed the resident with oral foaming, decreased responsiveness, fever and rigidity. Review of the hospital medical record revealed that Resident #4 arrived at the hospital on [DATE] at 1:01 P.M. The resident was admitted with [MEDICAL CONDITION], high fever and [MEDICAL CONDITION] for which cardioversion was done. The resident's tympanic temperature was elevated at 41.1 degrees Celsius (105.98 degrees Fahrenheit). The resident's respiratory rate was elevated at 26 breaths per minutes, oxygen saturation was low at 77%, heart rate was elevated at 161 beats per minute and blood pressure was low at 73/39. The resident was intubated in the emergency department to assist with breathing. Resident #4 was subsequently admitted to the hospital intensive care unit with [DIAGNOSES REDACTED]. The facility developed a plan sufficient to remove immediacy which was reviewed and accepted on 7/24/17 at 8:30 P.M. while surveyors remained onsite. The plan included: - The Air Conditioning unit was repaired and functional on 7-21-17. Resident rooms were all checked and were in compliance

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215145	A. BUILDING _____ B. WING _____	07/24/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CADIA HEALTHCARE - HYATTSVILLE	4922 LASALLE ROAD HYATTSVILLE, MD 20782

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) on 7-22-17. - All residents have the potential to be impacted. Air Conditioning has been repaired and restored. This was completed on 7/22/17. - Administrative Leadership (Administrator, Assistant Admin, Director of Nursing, Assistant Director of Nursing and all department managers) and Maintenance staff have been educated on the facility's policy and procedure during a heat event (Heat Stroke Prevention Plan) by the facility Administrator on July 24, 2017. - The facility will do daily temperature monitoring checks of at least 3 rooms on each resident floor for a period of three months. This monitoring will be done by the Administrator or his designee. Any temperatures outside of the regulatory range of 71 to 81 degrees will be corrected immediately. - Results of these audits will be reported to the QA (Quality Assurance) Committee for a period of 3 months the QA Committee will determine what, if any additional interventions are required at the end of the three-month period. - Additionally, the entire facility staff will be in-serviced on the Heat Stroke Prevention Plan by July 26, 2017. Staff will check temperature of 3 rooms per floor per shift until facility wide in-service has been completed to ensure compliance and building is within regulations. Responsible Person for Implementation: Maintenance Director Responsible Person for Monitoring: Administrator Date of Compliance: 7/24/2017
F 0327 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Give each resident enough fluids to keep them healthy and prevent dehydration.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review and interview of facility staff it was determined the facility staff failed to ensure that intravenous fluids were promptly initiated for a resident at risk for dehydration. Resident #1 was affected by the deficient practice. This was evident for 1 of 6 sampled residents selected for review. The findings include: Resident #1 has multiple [DIAGNOSES REDACTED]. The resident's medical record was reviewed on 7/21/17, 7/22/17 and 7/24/17. Medical record review revealed that on 7/19/17 the resident had laboratory blood work. The laboratory blood work revealed that the resident's white blood count was 17.9 (normal range is 4.00 - 11.00); sodium 147 (normal range is 136 - 145); BUN (blood urea nitrogen) 50 (normal range is 7 - 25); creatinine 1.46 (normal range is 0.60 - 1.30; and BUN/creatinine ratio 34.2 (normal range is 8.0 - 25.0). An elevated sodium, BUN, creatinine and BUN/creatinine ratio indicates a decline in kidney function likely due to volume depletion which can lead to dehydration. On 7/20/17, the Office of Health Care Quality received a complaint that the facility did not have adequate air conditioning to cool the building. On 7/21/17, the surveyors made an onsite visit and determined that one of the facility's air conditioning units that supplies air to the residents' rooms was not functioning. The outdoor temperature on 7/20/17 and 7/21/17 was extremely hot and in the 90's. Refer to F 309. Medical record review revealed that the resident was seen and examined by the physician on 7/21/17 for follow up of leukocytosis (elevated white blood count). The physician documented that he discussed the resident's care with the infectious disease consultant. Based on his discussion with the infectious disease consultant, the physician ordered 1 liter of intravenous fluids. Observation of the resident on 7/21/17 at 1:33 P.M. revealed that the resident was receiving intravenous fluids as ordered by the physician. Medical record review revealed that on 7/22/17 the resident's white blood count was further elevated. The resident's physician was notified and ordered an intravenous antibiotic medication, Ertapenem 1 gram intravenously every day for 7 days for leukocytosis. No further intravenous fluids were ordered and no changes were made to the resident's plan of care to ensure that the resident was receiving adequate fluids to prevent dehydration. Medical record review revealed that on 7/24/17 the resident's laboratory blood work revealed that the resident's sodium was 150, which was critically elevated; BUN 78; creatinine 1.84; and BUN/creatinine ratio 42.4. The resident's kidney function had further declined since 7/21/17. Medical record review revealed that the physician was notified of the resident's critically elevated sodium level and gave an order to administer 3 liters of normal saline solution at 100 cc per hour on 7/24/17 at 12:00 P.M. Observation of the resident on 7/24/17 at 4:50 P.M. revealed that the resident was not receiving intravenous fluids as ordered by the physician. Interview of the Unit Manager, Staff #1, on 7/24/17 at 4:51 P.M. revealed that on 7/24/17 Resident #1's physician gave an order to administer normal saline solution, 3 liters intravenously at 100 cc per hour. When Staff #1 was questioned regarding why the physician's orders [REDACTED].#1 stated that when recommendations are made by the physician, the expectation is that the recommendation is carried out by the end of the shift and no later than the beginning of the next shift. Staff #1 further stated that the resident needed a new IV (intravenous access) and that she was not competent to start an IV and needed to have the Assistant Director of Nursing (ADON) start the IV. Medical record review revealed that on 7/24/17 the nurse, Staff #1, documented the following entry in the medical record at 5:31 P.M.: CRITICAL LAB RESULT DATE: 07/24/2017 TIME CRITICAL LAB CALLED TO FACILITY: 12:00PM NAME OF LAB TEST: CBC, CMP RESULT (ENTER VALUE): Sodium 150, Hemoglobin 7.0, Hematocrit 22.5 MD/NP NOTIFIED: Dr. (name of physician) DATE/TIME MD/NP NOTIFIED: Date: 07/24/2017 Time: 12:00PM ORDER/S RECEIVED: administer 3L NSS (normal saline solution) @ 100 c/hr for hydration, KCL 20 (mEq) x 1 dose, repeat CBC, CMP on 7/25 RP NOTIFIED: (name of responsible party) DATE/TIME RP NOTIFIED: Date: 07/24/2017 Time: 05:31PM. The entry was signed by Staff #1. Medical record review revealed that on 7/24/17 the nurse, Staff #1, documented the following entry in the medical record at 5:47 P.M.: COMMENTS: Writer followed up on orders written by MD secondary to elevated sodium level 150. New order obtained for 3L 0.9% normal saline @ 100 cc/hr for hydration. Writer attempted to insert peripheral IV line, however after several attempts was unsuccessful. PO (by mouth) hydration given in the interim. MD and ADON made aware, ADON was able to administer peripheral line in left hand. IV hydration to begin at this time. The entry was signed by Staff #1. Although the facility staff was aware that the resident had a critical sodium level, elevated BUN, creatinine and BUN creatinine ratio on 7/24/17 at 12:00 P.M., the facility staff failed to ensure that intravenous fluids were promptly initiated as ordered by the physician. It was more than 5 hours before the facility staff started the resident's intravenous fluids.
F 0328 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Properly care for residents needing special services, including: injections, colostomy, ureostomy, ileostomy, tracheostomy care, tracheal suctioning, respiratory care, foot care, and prostheses** Based on observation, interviews of facility staff and medical record reviews it was determined the facility staff failed to document: the time peripheral intravenous lines were inserted, the time intravenous fluids were initiated, the amount of intravenous fluids that residents received each shift; and, failed to monitor the administration of intravenous fluids to ensure that the resident received the correct rate per hour of intravenous fluid. This was evident for 3 of 3 sampled residents selected for review. Resident #1, Resident #2 and Resident #3 were affected by the deficient practice. The findings include: Review of Resident #1's medical record revealed that on 9/28/17 at 7:20 P.M. the physician gave an order to administer 0.9% sodium chloride solution x 2 liters at 100 ml/hour intravenously via the resident's right arm midline (intravenous access line). Medical record review revealed that the nurse failed to document the time that the first or second liter of 0.9% sodium chloride solution was hung and the amount of 0.9% sodium chloride solution the resident received on each shift. Review of Resident #2's medical record revealed that on 9/28/17 at 11:02 P.M. the Nurse Practitioner gave an order to administer 0.9% sodium chloride solution x 3 liters at 100 ml/hour via peripheral line. The facility staff failed to document the time that the peripheral intravenous line was inserted and the time that the first liter of 0.9% sodium

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	215145	A. BUILDING _____ B. WING _____	07/24/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CADIA HEALTHCARE - HYATTSVILLE	4922 LASALLE ROAD HYATTSVILLE, MD 20782

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F 0328 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) chloride solution was hung. Review of the Medication Administration Record [REDACTED].M. - 7:00 A.M. shift. Observation of the resident on 9/29/17 at 2:30 P.M. revealed that Staff #1 had documented on the bag of intravenous fluid that Bag #3 of intravenous fluid was hung at 10:30 A.M. There was approximately 200 ml of fluid remaining out of 1000 ml, or 1 liter. Therefore, the resident had received 2 times the prescribed rate of intravenous fluid that had been ordered by the physician. Interview of the nurse that hung the bag of intravenous fluid, Staff #1, revealed that he had made a mistake and that the second bag of IV fluid, and not the third bag, was hung at 10:30 A.M. Additionally, the facility staff failed to document the amount of fluid that the resident received on the 11-7 shift on 9/29/17. Review of Resident #3's medical record revealed that on 9/26/17 at 11:00 P.M. the Nurse Practitioner gave an order to administer 0.9% sodium chloride solution x 2 liters at 100 ml/hour. The facility staff failed to document the time that the peripheral intravenous line was inserted and the time that the first or second liter of 0.9% sodium chloride was hung, and failed to document the amount of 0.9% sodium chloride solution that the resident received on each shift, and the time that 0.9% sodium chloride solution was discontinued. Medical record review revealed that on 9/27/17 at 8:00 P.M. the physician gave an order to administer 0.45% sodium chloride solution x 2 liters at 100 ml/hour via peripheral line. The facility staff failed to document the time that the first or second liter of 0.45% sodium chloride solution was hung, the amount of intravenous fluid that the resident received on each shift, and the time that 0.45% sodium chloride solution was discontinued.
F 0353 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Have enough nurses to care for every resident in a way that maximizes the resident's well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and observation of resident care it was determined the facility failed to ensure that nursing staff have the appropriate competencies and skills to ensure that resident's received appropriate care and services. This was evident for 1 of 6 sampled residents selected for review. Resident #1 was affected by the deficient practice. The findings include: On 7/20/17 at 10:00 A.M. it was determined that facility staff was aware that one of the facility's air conditioning units that supplies cool air to residents' rooms was not functional. On 7/21/17 at 11:30 A.M. the surveyors entered the facility. The surveyors toured all units of the building and determined that several locations in the building were uncomfortably warm, particularly, residents' rooms. Resident #1 has [DIAGNOSES REDACTED]. The resident's medical record was reviewed on 7/21/17, 7/22/17 and 7/24/17. Observation of Resident #1 on 7/22/17 at 1:37 P.M. and 3:40 P.M. revealed that the resident's breathing pattern appeared rapid and shallow. On 7/22/17 at 5:26 P.M. the surveyor requested vital signs on the resident from the nurse assigned to care for the resident, Staff #2. The Geriatric Nursing Assistant (GNA) was at the bedside when Staff #2 obtained the resident's vital signs. When the nurse had obtained the resident's temperature, pulse and blood pressure, the nurse asked the GNA if she had checked the resident's respirations. The GNA stated that the resident's respirations were 16 breaths per minute. The surveyor then asked the nurse, Staff #2, to recheck the resident's respirations. The nurse assessed the resident's respirations for 1 minute and determined that the resident's respiratory rate was 27 breaths per minute. Normal respirations are 12 - 20 breaths per minute. Medical record review and interview of the Unit Manager, Staff #1, on 7/24/17 at 4:50 P.M. revealed that on 7/24/17 Resident #1's physician gave an order to administer normal saline solution, 3 liters intravenously at 100 cc per hour. When Staff #1 was questioned regarding why the physician's orders [REDACTED].#1 stated that when recommendations are made by the physician, the expectation is that the recommendation is entered as an order by the end of the shift and no later than the beginning of the next shift. Staff #1 further stated that the resident needed a new IV (intravenous access) and that she was not competent to start an IV and needed to have the Assistant Director of Nursing (ADON) start the IV. Medical record review revealed that on 7/24/17 the nurse, Staff #1, documented the following entry in the medical record at 5:31 P.M.: CRITICAL LAB RESULT DATE: 07/24/2017 TIME CRITICAL LAB CALLED TO FACILITY: 12:00PM NAME OF LAB TEST: CBC, CMP RESULT (ENTER VALUE): Sodium 150, Hemoglobin 7.0, Hematocrit 22.5 MD/NP NOTIFIED: Dr. (name of physician) DATE/TIME MD/NP NOTIFIED: Date: 07/24/2017 Time: 12:00PM ORDER/S RECEIVED: administer 3L NSS (normal saline solution) @ 100 c/hr for hydration, KCL 20 mEq x 1 dose, repeat CBC, CMP on 7/25 RP NOTIFIED: (name of responsible party) DATE/TIME RP NOTIFIED: Date: 07/24/2017 Time: 05:31PM. The entry was signed by Staff #1. Medical record review revealed that on 7/24/17 the nurse, Staff #1, documented the following entry in the medical record at 5:47 P.M.: COMMENTS: Writer followed up on orders written by MD secondary to elevated sodium level 150. New order obtained for 3L 0.9% normal saline @ 100 cc/hr for hydration. Writer attempted to insert peripheral IV line, however after several attempts was unsuccessful. PO hydration given in the interim. MD and ADON made aware, ADON was able to administer peripheral line in left hand. IV hydration to begin at this time. The entry was signed by Staff #1. Although Staff #1 stated to the surveyor that she was not competent to start an IV, Staff #1 documented that she attempted to start an IV on the resident several times. Although the facility was aware that the resident had a critical laboratory value at 12:00 P.M., the nurses failed to ensure that intravenous fluids were promptly initiated as ordered by the physician at that time. It was not until after the surveyor intervened that Resident #1's intravenous fluids were started.

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	215145	A. BUILDING _____ B. WING _____	06/07/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CADIA HEALTHCARE - HYATTSVILLE	**4922 LASALLE ROAD HYATTSVILLE, MD 20782**

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0309 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**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 medical record review and interview of facility staff it was determined the facility staff: 1) failed to reconcile the hospital record with the physician's orders [REDACTED].#13 had a physician's orders [REDACTED].#8 when unable to obtain pain medication in a timely manner. This was evident for 2 of 15 residents reviewed during the survey. The findings include: 1. The facility staff failed to reconcile the hospital record with the physician's orders [REDACTED].#13 had a physician's orders [REDACTED]. Resident #13 has a [DIAGNOSES REDACTED]. Medical record review on 6/6/17 and 6/7/17 revealed that Resident #13 was hospitalized prior to being admitted to the facility for treatment of [REDACTED]. [MEDICAL CONDITION] stands for bilevel positive airway pressure. It is a form of therapy for patients that suffer from obstructive sleep apnea. [MEDICAL CONDITION] delivers pressurized air through a mask to the patient's airways allowing a patient to breath more easily and regularly throughout the night. Obstructive sleep apnea is a potentially serious sleep disorder which causes breathing to repeatedly start and stop. Medical record review revealed that Resident #13 was admitted to the facility on [DATE] at 5:00 P.M. At 8:00 P.M. the nurse documented in the progress notes that the resident's oxygen saturation was 97% on 2 liters of oxygen per nasal canula. At 11:50 P.M. the nurse documented that the attending physician was made aware of the resident's admission. Further review of the nursing progress notes revealed that there was no documented evidence that the nurse obtained a physician's orders [REDACTED]. Medical record review revealed that on 4/19/17 the physician gave orders to check the resident's lung sounds every shift and to check the resident's oxygen saturation to keep oxygen saturation greater than or equal to 92%. The physician failed to give orders for oxygen and/or [MEDICAL CONDITION] therapy. Medical record review revealed that on 4/20/17 at 12:00 A.M. the nurse documented that the resident's oxygen saturation was 96% on room air. At 7:30 A.M. the nurse documented that the resident was on 2 liters of oxygen per nasal canula. Although it was clearly stated in the hospital discharge summary, as well as, consults and progress notes provided by the hospital, that the resident required [MEDICAL CONDITION] therapy, the facility staff failed to ensure that the resident was evaluated by the respiratory therapist and received [MEDICAL CONDITION] therapy. Medical record review revealed that on 4/20/17 the resident had a change in condition at 9:00 A.M. The nurse documented that the reason for the change in condition was respiratory distress. The nurse further documented: During the morning rounds, resident was noted to be less responsive to verbal (stimuli). Upon assessment, resident stated that (he/she) was tired and (he/she) wants to sleep. O2 sat was 97% on 3L (liters of oxygen) via NC (nasal canula) . no SOB (shortness of breath), MD made aware, new order to place (him/her) on [MEDICAL CONDITION] machine. RT (respiratory therapist) made aware and [MEDICAL CONDITION] applied . O2 sat checked 30 minutes after it was 99% . The nurse further documented in the same entry: At around 1PM, during routing rounds, resident was noted with difficulty breathing using accessory muscles. O2 sat (saturation) checked noted to be 60%, vital signs were BP (blood pressure) 164/53, P (pulse) 133, T (temperature) 101.1, RR (respiratory rate) 16, BS (blood sugar) 164. RT came and started bagging 25L via facial mask, O2 sat increased to 98%, Pulse remained 124. MD made aware, and assessed resident at bedside and ordered resident to be sent out via 911. 911 called at 1:24PM, arrived at the facility at around 1:28PM and took over resident care . Review of the hospital record revealed that when the resident arrived at the emergency department, the resident was unresponsive and required intubation for respiratory distress. The resident was assessed with [REDACTED]. 2. The facility staff failed to contact a physician requesting a substitute pain medication for Resident #8 when unable to obtain pain medication in a timely manner. This was evident for 1 of 15 residents reviewed during the survey. The findings include: Resident #8 was admitted to the facility with [DIAGNOSES REDACTED]. Per a family member who came in on the morning of 4/24/17 at 5:35 AM, she found the resident sitting and shivering at the foot of the bed. She felt the resident was in pain. On 6/1/17 at 11:40 AM the medical record for Resident #8 was reviewed. On 4/18/17 the resident had an order for [REDACTED]. On 4/21/17 a new order was also given for [MEDICATION NAME] HCL 2mg to be given routinely at bedtime for moderate to severe pain. On 4/22/17 this order was discontinued and a new order was received to give the resident [MEDICATION NAME] HCL 2 mg every 4 hours (routinely rather than as needed) for moderate to severe pain. A review of the Medication Administration Record [REDACTED]. On 6/1/17 at 5:20 PM the Director of Nursing (DON) was interviewed. She explained the first dose was missed because the resident was in [MEDICAL TREATMENT] when the physician changed the order. Then she stated there were issues obtaining the medication quickly from the pharmacy because the order was a controlled substance and the pharmacy was closed at the time the order was given. The nurses were able to obtain 3 doses from the Advanced Pharmacy (AP) PassPort machine. (The AP PassPort is a fully automated, remotely monitored medication dispensing center located in the facility.) The DON went on to explain that nurses are limited in obtaining controlled substances such as [MEDICATION NAME] HCL from the PassPort until a form for the new prescription is processed by the pharmacy. According to documentation in nurses' notes, the nurse tried several times to reach the attending when the [MEDICATION NAME] HCL could no longer be obtained. This resulted in the resident missing some doses. When asked what the staff member should have done when the attending couldn't be reached, the DON stated staff should have contacted the Medical Director to ask for a substitute pain medication until the [MEDICATION NAME] HCL could be obtained. The facility is responsible to ensure that residents receive ordered medication in a timely manner or contact a physician for orders to administer an appropriate substitute.

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.