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.

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

Clinton Healthcare Center
9211 Stuart Lane
Clinton, MD 20735

Facility Characteristics:

- Skills Nursing Facility with 267 beds
- Operating Manager Keith Davis
- Website at www.communicarehealth.com
- The For-profit corporation is owned by Clinton Nursing, LLC
- As of 2018 Clinton 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 Clinton Healthcare Center in Clinton, 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 Clinton Healthcare Center in Clinton, 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
	215231	A. BUILDING _____ B. WING _____	**01/04/2018**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CLINTON HEALTHCARE CENTER	**9211 STUART LANE CLINTON, MD 20735**

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 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.** Based on medical record review and verified by staff interview, it was determined the facility staff failed to ensure that a medication order was discontinued and that staff did not continue to document administration of the medication. This was evident for 1 resident (#1) of the three reviewed during a complaint investigation. The findings include: A medical record review conducted on 01/05/2017 revealed that Resident #1 had an order initiated on 12/05/2017 for a medicated wound care powder. New wound care orders were initiated on 12/13/2017. From 12/13/2017 to 12/27/2017 facility staff were still documenting daily the medicated powder was being used. An interview conducted with the Nursing Home Administrator (NHA) and the wound care nurse familiar with Resident #1's care, corroborated the order written on 12/05/2017 for medicated wound care powder should have been discontinued on 12/13/2017 and that the facility staff should not have been documenting the continued use of the powder. The facility staff have the responsibility to ensure that medication orders are accurate.

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215231	A. BUILDING _____ B. WING _____	**11/01/2017**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CLINTON HEALTHCARE CENTER	**9211 STUART LANE CLINTON, MD 20735**

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F 0253 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide housekeeping and maintenance services.** Based on observation while conducting the initial tour of resident areas and verified while conducting environmental rounds, it was determined that facility staff failed to ensure that repairs in resident areas were completed in a timely manner. The findings include: The surveyor conducted environmental rounds accompanied by the Maintenance Director and Operations Manager on October 26,2017, beginning at 10:00 AM. The following observations were made: 1) In Room 312 the privacy curtain was damaged and the floor under the sink was excessively soiled. The raised toilet seat for this room was rusty and not able to be cleaned. 2 The call cord box was loose in Room 344. 3) In Room 322, a brown stain was observed on the ceiling. 4) In Room 337, the bathroom walls and floor were unclean. 5) In Room 345, drawer fronts were missing on one dresser and one end table. 6) In Room 216, a hole was observed in the wall by the sink. 7) In Room 229, the raised toilet seat was rusty and not cleanable. 8) In Room 245, the wall by the sink was damaged. 9) In Room 248, dresser drawer fronts were missing. 10) In Room 107, the heating unit was rusty. In the Shower Rooms, the following observations were made: 1) In the 3 west shower room 1 the sink was inadequately attached to the wall. 2) In the 3 west shower room, a soiled towel was observed on a wheelchair. The floor was unclean, especially at the wall floor juncture. 3) In the 3 east shower # 1, wall damage was observed by the sink. Standing water was observed at the entrance to a shower stall in shower # 2. 4) In the 2 west shower room, a soiled washcloth was observed on the grab bar for the toilet. In the 2 west shower # 2, bathroom tissue was stored on the holder.

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	215231	A. BUILDING _____ B. WING _____	**08/15/2017**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CLINTON HEALTHCARE CENTER	**9211 STUART LANE CLINTON, MD 20735**

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F 0157 **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 the resident of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview of the resident's guardian of property, interview of facility staff, review of the resident's medical record and review of the resident's admission agreement, it was determined the facility staff failed to notify the resident's guardian of property when the resident expired. The facility's failure to notify the guardian of property, resulted in the resident's remains being sent to the Anatomy Board, rather than the funeral home where pre-planning arrangements had been made by the guardian of property. This was evident for 1 of 15 sampled residents selected for review. Resident #1 was affected by the deficient practice. The findings include: Resident #1 had resided at the facility since 2011. The resident's medical record was reviewed on [DATE], [DATE], [DATE] and [DATE]. On [DATE] the Office of Health Care Quality received a complaint from the resident's guardian of property alleging that the facility failed to notify her when the resident expired on [DATE]. Interview of the guardian of property on [DATE] at 4:25 P.M. revealed that the guardian had made pre-need funeral arrangements for the resident, and the contact information for the funeral home was documented in the resident's admission agreement. Review of the resident's admission agreement, which was signed by the guardian of property on [DATE], the guardian designated that she be contacted, as well as, the funeral home where the remains were to go, and prepaid funeral arrangements had been made. Telephone numbers were provided in the admission agreement. Medical record review revealed that on [DATE] at 10:27 P.M. the nurse documented that the resident was unresponsive (the resident had expired). The nurse documented that he/she attempted to notify the resident's family member without success. However, there is no documented evidence that the nurse notified the resident's guardian of property. On [DATE] the nurse documented that the Anatomy Board was notified at 1:30 A.M. The resident's remains were subsequently picked up by the Anatomy Board. Further review of the medical record revealed that there is no documented evidence that the facility followed up with the resident's guardian of property regarding the resident's death, or notified the guardian of property that the resident's remains had been picked up by the Anatomy Board. Interview of the Nursing Home Administrator and review of an email that the Nursing Home Administrator provided to the surveyor on [DATE] revealed that on [DATE] the Business Office Manager contacted the guardian of property to inquire as to the reason the guardian was still sending payments to the facility to pay for the resident's care. According to the guardian of property, it was at that time that she was informed by the facility that the resident had expired on [DATE]. On [DATE] the guardian of property sent an email to the funeral home where prepaid funeral arrangements had been made (copy provided to the surveyor on [DATE]) to inquire if the facility had contacted them when the resident expired. The funeral home informed the guardian that the funeral home had not been contacted by the facility. Interview of the Anatomy Board staff member on [DATE] revealed that the resident was cremated on [DATE].
F 0253 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide housekeeping and maintenance services.** Based on observation and verified by staff, it was determined that facility staff failed to ensure that resident areas were kept in good repair. The findings include: On July 28, 2017, an environmental tour of the facility was conducted. The following observations were made: 1) In Rroom 327, the floor in the toilet room was soiled, particularly at the wall floor juncture. 2) In the 3 East Shower Room, the paint on the door was peeling and the door vents were dusty. 3) In the 3 East Shower Room # 2, standing water was observed on the floor at the entrance to two showers. The floor drain was above the level of the standing water. 4) In Rroom 332, the floor was visibly soiled. 5) In Rroom 334, the floor at the entrance to the room was visibly soiled. 6) In the 3 West Shower Room, a very soiled bathtub was installed. Interview of the Maintenance Director indicated that the tub had been out of use for some time. The floor in this shower room was soiled with a black substance , particularly at the wall floor juncture. 7) Ceiling damage was observed in the 2 West # 2 Shower Room. 8) Unused dispenser holders for body wash were observed attached to the walls. Interview of the Maintenance Director indicated that the holders are no longer in use. 9) In the 2 West #1 Shower Room, the floor was excessively soiled. The ceiling in this room was damaged. 10) In the 2 East Shower Room #1, the grout and caulk were damaged and soiled. The ceiling was damaged and repaired with cardboard. 11) The shower curtain in the 2 East Shower Room had a large tear. 12) Shower heads throughout the facility lacked backflow preventers. 13) In Room 110, wall damage was observed behind the bed. The floor was excessively soiled. 14) Slide locks were observed on the exterior of both doors to the toilet room for Rooms 109 and 110. On surveyor intervention, the locks were removed. Interview of the Maintenance Director revealed that the locks had been installed in the past and were no longer in use.
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 that the facility nursing staff failed to assess the resident after the resident experienced a change in medical condition. This was evident for 1 of 15 sampled residents selected for review. Resident #5 was affected by the deficient practice. The findings include: Resident #5 had resided at the facility since 2012. The resident's medical record was reviewed on [DATE] and [DATE]. Medical record review revealed that the resident had [DIAGNOSES REDACTED]. Medical record review revealed that on [DATE] the physician signed orders for life sustaining treatments which included

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215231	A. BUILDING _____ B. WING _____	08/15/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CLINTON HEALTHCARE CENTER	9211 STUART LANE CLINTON, MD 20735

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F 0309 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) cardiopulmonary resuscitation (CPR) if cardiac or [MEDICAL CONDITION] arrest were to occur, artificial ventilation, blood transfusion, hospital transfer, medical workup, antibiotics, artificially administered fluid and nutrition and [MEDICAL TREATMENT]. Medical record review revealed that the resident had been hospitalized [DATE] through [DATE] for flash [MEDICAL CONDITIONS]. The resident recovered and was readmitted to the facility. Medical record review revealed that the nurse documented that on [DATE] at 2:34 P.M., the physician was notified at 1:00 P.M. on that day that the resident had a change in condition. Review of the physician's progress note revealed that the physician assessed the resident with shortness of breath vs. volume overload. The physician documented that she tried to transfer the resident to the hospital and tried to arrange for an extra [MEDICAL TREATMENT] treatment, but the resident refused at that time. The physician further documented that a nebulizer treatment was administered and a chest x-ray ordered. The physician documented that the resident agreed to go to the hospital if the chest x-ray revealed pneumonia. Medical record review revealed that there is no further documentation of a comprehensive assessment of the resident by nursing, specifically, a thorough respiratory assessment, after the progress note that was written on [DATE] at 2:34 P.M. A thorough respiratory assessment should include general appearance, speech, respiratory noises, chest auscultation, respiratory rate, respiratory effort, pulse rate, skin color, consciousness, pulse oximetry (oxygen saturation). Medical record review revealed that on [DATE] at 10:57 P.M. the nurse documented that a nebulizer treatment was administered and was effective. However, the nurse failed to document a respiratory assessment of the resident. At 11:14 P.M. the nurse documented that a telephone call was made to the x-ray facility, but that the result was not yet available. There was no further follow up with the x-ray facility after [DATE] at 11:14 P.M. Medical record review revealed that on [DATE] at 10:56 A.M. the final results of the resident's chest x-ray were faxed to the facility. The Radiologist documented that the findings were worse than previous examination with extensive infiltrate throughout the right lung field. The Radiologist further documented that the findings were consistent with pneumonia. There is no documented evidence that the physician was notified of the chest x-ray result at that time. Medical record review revealed that on [DATE] at 2:59 P.M. the nurse documented the following entry in the progress notes: Resident was noted cool and clammy during ADLs (activities of daily living). Assessment done. FS (finger stick for blood glucose) 103. Resp (respirations) labored. Vitals obtained. O2 (oxygen) via N/C (nasal canula) in use but changed to non-rebreather mask per nursing judgment and O2 increased. During assessment resp (respirations) ceased and CPR (cardiopulmonary resuscitation) was initiated at 1250 (12:50 P.M.). 911 was called. Emergency Medical Technicians (EMTs) arrived and continues with CPR. Resident was pronounced expired per EMTs at 1330 (1:30 P.M.). Medical record review revealed that on [DATE] at 6:18 P.M. the physician documented the following entry in the progress note: Discharge Diagnosis: [REDACTED]. Was called by NH (nursing home) staff for CXR (chest x-ray) report. It showed increased infiltrates b/l (bilaterally), mainly on the right side. I ordered pt (patient) to be sent to (hospital) by 911 for PNA (pneumonia) and respiratory distress. Pt was coded when 911 arrived. (He/She) was pronounced at 1:30 P.M. In summary, nursing failed to document a thorough respiratory assessment of the resident after [DATE] at 2:34 P.M. when the resident had a change in medical condition. Additionally, although the final report of the chest x-ray result was available on [DATE] at 10:56 A.M., there was no evidence that nursing had followed up on the chest x-ray result after [DATE] at 11:14 P.M., or had notified the physician when the final results of the chest x-ray were available.
F 0386 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that doctors see a resident's plan of care at every visit and make notes about progress and orders in writing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review it was determined the physician failed to taper a resident off of a steroid medication used to treat an exacerbation of [MEDICAL CONDITION]. This was evident for 1 of 15 sampled residents selected for review. Resident #14 was affected by the deficient practice. The findings include: Resident #14 has a [DIAGNOSES REDACTED]. The resident's medical record was reviewed on 7/27/17 and 7/28/17. Medical record review revealed that the resident was hospitalized [DATE] through 6/26/17 with a [DIAGNOSES REDACTED]. While hospitalized , the resident received [MEDICATION NAME] 20 mg. 3 tablets daily. Review of the hospital discharge summary revealed that the discharge plan was for the resident's [MEDICATION NAME] to be tapered. Review of the hospital discharge instructions provided to the surveyor on 8/24/17 revealed that the resident was to begin taking [MEDICATION NAME] 10 mg. tablets, dose pack. A [MEDICATION NAME] 10 mg. tablet dose pack provides 42 10 mg. tablets which are tapered over a 12 day period. On day 1 the patient begins with 6 tablets per day which is gradually decreased to 1 tablet per day on the 11th and 12th day. The resident was readmitted to the facility on [DATE]. The physician's admission orders [REDACTED]. There was no plan to taper the steroid medication. [MEDICATION NAME] is a steroid similar to [MEDICATION NAME], a hormone produced by the adrenal glands. If [MEDICATION NAME] is taken for a prolonged period of time, the adrenal glands decrease the production of [MEDICATION NAME]. [MEDICATION NAME] helps to regulate the body's salt and water balance and reduces inflammation. It is used to treat a variety of diseases including certain lung conditions. When [MEDICATION NAME] is prescribed, the goal is to control the illness with the lowest effective dose for the shortest period of time. When [MEDICATION NAME] is discontinued, it should be tapered by gradually reducing the dosage to allow the adrenal glands to resume normal function. When [MEDICATION NAME] is taken more than one month, abruptly stopping it can cause an acute withdrawal reaction that can lead to a crisis situation. Medical record review revealed that the resident had a physician's order to administer [MEDICATION NAME] 20 mg. 3 tablets 1 time per day 6/26/17 through 8/4/17. Medical record review revealed that on 8/1/17 the resident was seen by the Nurse Practitioner. The Nurse Practitioner documented that the resident was seen per her request due to complaints of weight gain secondary to receiving [MEDICATION NAME] daily. The Nurse Practitioner's plan was to continue daily [MEDICATION NAME] and to schedule the resident for a pulmonolgy consult, as soon as possible. Medical record review revealed that on 8/4/17 the resident's attending physician abruptly discontinued [MEDICATION NAME]. The physician failed to provide documentation of rationale for the abrupt discontinuation of [MEDICATION NAME]. The physician failed to gradually reduce the dose of [MEDICATION NAME] over a prescribed period of time placing the resident at risk for symptoms of [MEDICATION NAME] withdrawal.
F 0441 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Have a program that investigates, controls and keeps infection from spreading.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation while conducting the facility environmental tour and verified by staff interview, it was determined that facility staff failed to ensure that personal care items were stored in a sanitary manner that reduces the risk of infection. The findings include: On July 28, 2017, the surveyor, accompanied by the Maintenance Director, made the following observations: 1) In the toilet room that serves room [ROOM NUMBER], shaving cream was observed on the bathroom tissue holder. An empty urine specimen bottle was observed in a plastic bag on the floor near the toilet. A portable urinal was stored on the grab bar near the toilet. This is a shared toilet room. 2) In the 3 East Shower Room # 2, a soiled washcloth was observed on the grab bar and a hospital type gown was observed on the floor. 3) In the 2 West Shower Room # 2, four bottles of body wash and an can of shaving cream were left unattended. 4) In the toilet room for rooms [ROOM NUMBERS], a portable urinal was stored on the grab bar.

F 0467 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Have enough outside ventilation via a window or mechanical ventilation, or both.**

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	215231	A. BUILDING _____ B. WING _____	**08/15/2017**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CLINTON HEALTHCARE CENTER	**9211 STUART LANE CLINTON, MD 20735**

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F 0467 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) Based on observation while conducting the facility tour, it was determined that ventilation was inoperable in the resident central shower rooms. This was evident for eight of eight showers observed on the second and third floors. The findings include: During environmental tour, the surveyor, accompanied by the Maintenance Director, found that working ventilation was absent in all shower rooms on the second and third floor of the building, east and west wings. Upon entering the shower rooms, the air was stagnant and humid. The Maintenance Director was unable to locate operating outside ventilation fans for shower rooms. Adequate ventilation is required in shower rooms to prevent odors and excess humidity.

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	215231	A. BUILDING _____ B. WING _____	**05/19/2017**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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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, staff and resident interviews and observation it was determined the facility failed to ensure that an ambu bag was kept at the bedside of Resident #7. This was evident for 1 of 14 residents reviewed during this survey. The findings include: On 5/16/17 at 10:55 AM during an interview with Resident #7, the resident stated an ambu bag used to be kept at bedside but was no longer there. The surveyor observed that the resident had a [MEDICAL CONDITION] (trach) connected to an oxygen concentrator but did not observe an ambu bag at bedside. The Unit Manager of that floor and wing confirmed the finding. On 5/16/17 15 at 11:30 AM during a medical record review it was noted, the resident had an order to keep an ambu bag at bedside and for staff to check it every shift. An ambu bag is a self-refilling bag attached to a mask to be used to provide artificial respirations through [MEDICAL CONDITION] there is a respiratory arrest. It is also a minimum standard of nursing practice to keep an ambu bag at the bedside of residents that have a trach. The facility is responsible to ensure that the medical equipment needed to treat respiratory arrest is present, as required.

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