FOIA Data Base - The Law Office of Jeffrey J. Downey
Serving clients in Washington D.C., Virginia, 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 or 703-564-7357;
email: jdowney@jeffdowney.com

Cherry Lane Nursing Center

9001 Cherry Lane

Laurel, MD 20708

Facility Characteristics:

- Skills Nursing Facility with 155 beds
- http://www.cherrylanenursing.com

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 Cherry Lane Nursing Center in Laurel, 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 Cherry Lane Nursing Center in Laurel, MD and obtained FOIA responses, I am posting these statements of deficiencies here, in a searchable format. Keep in mind that these surveys may 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
	215177	A. BUILDING B. WING	**09/28/2017**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CHERRY LANE NURSING AND REHABILITATION CENTER	**9001 CHERRY LANE LAUREL, MD 20708**

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 0156 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Give each resident a notice of rights, rules, services and charges. Tell each resident who can get Medicaid benefits about 1) which items and services Medicaid covers and which the resident must pay for.** Based on review of facility documents and verified by interview of social services staff, it was determined that facility staff failed to ensure that the residents or their representatives were given appropriate liability and appeal notices when Medicare coverage was terminated. This was evident for three (Residents #1, #5 and #208) of four residents reviewed for this requirement. The findings include: On 9/28/17, at 12:00 PM, the surveyor reviewed documentation for four residents to determine if the residents or their representatives were given notice that Medicare coverage was ending for the residents. These notices provide residents or their representatives information on appealing the termination of coverage. For residents 1, 5 and 208, the Social Worker Assistant documented that the residents or representatives were given verbal notice of termination of coverage, but there was no evidence that written notification was given. Interview of the Social Worker Assistant verified that written notice was not provided, as required.
F 0279 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop a complete care plan that meets all of a resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and medical record review, it was determined that the facility staff failed to initiate a care plan that included the appropriate goals and approaches for [MEDICAL CONDITION] for 1 (#61) of the 25 residents reviewed in the Stage 2 sample. The findings include: A care plan is a guide that addresses the unique needs of each resident. It is valuable in preventing avoidable declines in functioning or functional levels. It must reflect immediate steps for assuring outcomes which improve the resident's status and outcomes. A medical record review conducted on 09/27/2017 revealed that Resident #61 was admitted to the facility with a past medical history of [REDACTED]. During an interview conducted on 09/27/2017 at 2:00 PM the Psychiatric Nurse Practitioner stated that Resident #61 has a history of [MEDICAL CONDITION] and verbalized agreement that there should be a [MEDICAL CONDITION] care plan in place. At an interview conducted on 09/28/2017 at 11:15 AM, Resident #61's attending physician revealed that the resident has a past medical history of [REDACTED]. On 09/28/2017 at 12:30 PM this surveyor was provided a copy of a [MEDICAL CONDITION] care plan that was initiated on 09/27/2017. The facility staff must ensure that every resident has a comprehensive care plan in place.
F 0356 **Level of harm -** Potential for minimal harm **Residents Affected -** Some	**Post nurse staffing information/data on a daily basis.** Based on observation upon entrance to the facility, it was determined that the facility failed to have in place notification for public and visitor viewing of their staffing pattern. The findings include: On (MONTH) 25, (YEAR) the survey team entered the facility at 7:30 AM. While observing the lobby, it was noted that there was no posting of the facility's staffing pattern. The posting would allow anyone visiting the facility to get an overall picture of the availability of the nursing staff scheduled on any given shift.
F 0371 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Store, cook, and serve food in a safe and clean way** Based on observation while conducting kitchen tour and verified by the facility Dietary Manager, it was determined that facility staff failed to install plumbing in a manner that ensures that food contact equipment is not contaminated in case of a sewage blockage. The findings include: During an initial kitchen tour on (MONTH) 25, (YEAR) at 8:15 AM, the following observations were made: 1. One of the 3 compartment sinks drain tubes was below the sewage flood rim. The tub that is designated for sanitizing the dishes was installed with the drain tubing end-point below the flood plain of the sewage drain. There is a potential for sewage water to back up into the drain line and contaminate the sanitizing sink water if there is not an air gap between the sinks drain line and the receiving drain. Therefore, the sink's drain lines need to terminate with an air gap above the flood plain of the drain leading to the main sewage line.
F 0431 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	2. The dishwasher pressure gauge (the pressure gauge lets the facility staff know that the dishwasher is applying the proper amount of water pressure to the dishes during the washing and rinsing cycles) was reading zero during the washing and rinsing cycles. During the washing and rinsing cycle the water pressure should measure between 1 pounds per square inch to (PSI) 25 PSI. Too little or too much water pressure will not sanitize the dishes properly. Facility staff must be able to monitor the pressure gauge to ensure that dishes are sanitized adequately. The Kitchen Manager and Kitchen Supervisor were informed of the findings.
	Maintain drug records and properly mark/label drugs and other similar products according to accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

	Based on observations, it was determined that the facility staff failed to ensure: 1) that medications were stored within

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215177	A. BUILDING B. WING	**09/28/2017**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CHERRY LANE NURSING AND REHABILITATION CENTER	**9001 CHERRY LANE LAUREL, MD 20708**

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F 0431 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) the recommended temperatures of 36° F to 46°F and 2) that blood glucose (sugar) monitoring supplies were properly labeled after opening. This deficient practice was found in 1 of 1 medication storage refrigerators on 1 of 2 floors (2nd floor) and in 3 of 4 medication carts on the 2nd floor. This practice has the potential to affect any resident receiving medications from the 2nd floor refrigerator and any resident receiving blood glucose monitoring on the 2nd floor. The findings include: 1) Observations conducted on [DATE] at 8:45 AM revealed that the temperature in the medication storage room refrigerator on the 2nd floor registered at 50°. The refrigerator contained a variety of medications including insulin pens. This finding was verified by the 2nd floor Unit Manager (UM.) According to the product labels of insulin manufacturers, it is recommended that insulin (both vials and pens) be stored unopened in a refrigerator at approximately 36°F to 46°F to maintain potency until expiration date. 2) Observations conducted on [DATE] at 9:00 AM on the 2nd floor revealed that 3 out of 4 medication carts that had blood glucose monitoring supplies each contained 1 opened bottle of Quintet AC® blood glucose monitoring strips that were not labeled with the date opened. These findings were verified by the 2nd floor UM. On [DATE] at 9:25 AM the findings were brought to the attention of the Director of Nursing. According to the manufacturer of Quintet AC® blood glucose monitoring supplies, the date opened should be recorded on the bottle label and any remaining test strips should be discarded within 3 months after first opening or until the expiration date printed on the label (whichever comes first). It is important to follow the manufacturer's instructions regarding the labeling and discarding of blood glucose monitoring test strips. Test strips contain an enzyme that reacts with blood. Over time the enzymes breakdown and this can lead to an inaccurate test result if expired test strips are used. Inaccurate readings could potentially compromise the safety of a diabetic resident. Facility staff must ensure that medication refrigerators are kept within specified temperature parameters. Additionally, facility staff must ensure that all blood glucose monitoring supplies are labeled with the date opened.
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 observations and verified by staff interview, it was determined that the facility staff failed to handle clean linens in a manner consistent with current infection control practices. This deficient practice was observed on 1 of 2 floors (2nd floor) and has the potential to affect any resident using the linens. The findings include: An observation conducted 09/25/2017 on the 2nd floor at 8:45 AM revealed that between Units 2A and 2B there were 2 carts with uncovered folded linens sitting outside the clean linen closet. Staff #1 verified that the linens were clean and stated They put them on the cart and take them out to the floor. At 9:00 AM on Unit 2C outside room [ROOM NUMBER], there was 1 cart with uncovered folded linens. An observation conducted at 10:00 AM on Unit 2C revealed that the folded linens outside room [ROOM NUMBER] were covered with a sheet. Approximately 8 inches of the left-hand corner of the sheet was observed lying on the ground. The portion of the sheet covering the front of the cart was pulled up exposing folded linens and gowns on the bottom shelf of the cart. This finding was corroborated by staff #2 who then proceeded to pull the sheet up and in the process dragged the contaminated portion of the sheet over top of the clean linens. With surveyor intervention the linens were removed from the floor. An observation conducted on 09/27/2017 at 8:30 AM, on Unit 2A, revealed a cart with folded linens covered in a sheet that was partially on the ground. This finding was corroborated by staff #3. These findings were brought to the attention of the Director of Nursing. The facility staff must ensure that linens are handled properly in order to help prevent the spread of infections.

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	215177	A. BUILDING B. WING	**04/20/2017**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CHERRY LANE NURSING AND REHABILITATION CENTER	**9001 CHERRY LANE LAUREL, MD 20708**

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F 0279 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop a complete care plan that meets all of a resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review it was determined the facility failed to develop a discharge plan of care that included participation of the multidisciplinary team and the resident/resident's family member to ensure that the resident's continuing care needs would be met when the resident was discharged to the community. This was evident for 1 of 10 sampled residents selected for review. Resident #9 was affected by the deficient practice. The findings include: Resident #9 was admitted to the facility for rehabilitation on 7/22/16 after being hospitalized and treated for [REDACTED]. The resident's medical record was reviewed on 4/19/17 and 4/20/17. On 11/4/16 the Office of Health Care Quality received a complaint from the resident's family member alleging that the facility failed to adequately plan for the resident's discharge to the community. The resident's family member further alleged that he/she was advised at a care planning meeting on 10/26/16 that the resident was to be discharged on [DATE] because he/she (the resident) had reached his/her 100 days (meaning that Medicare would no longer pay for the resident's stay in the facility). Medical record review revealed that on 7/25/16 the Social Worker initiated a care plan for discharge planning related to the need for supportive services with the goal that the resident and/or family would agree upon a discharge plan within 90 days and resident would be discharged within 90 days. Approaches included resident and/or family will be invited to care plan conference; consult with multi-disciplinary team on resident's status, discharge needs and discharge potential, consult with resident and/or family about discharge planning, explore available and appropriate community resources with resident and/or family and educate on Medicaid Waiver Services. There is no evidence in the discharge plan of care that the facility identified the resident's post-discharge needs, developed a post-discharge plan of care with the participation of the interdisciplinary team and the resident's family member or provided pre-discharge preparation and education to the resident/resident's family member. Review of the evaluation of the discharge planning care plan revealed that on 7/25/16 the Social Worker documented that the resident was at the facility for short term care. On 10/26/16 the Social Worker documented that the resident was at the facility for short term care and would be discharged on [DATE]. Review of the Discharge Instructions provided to the resident/resident's family member at the time of discharge revealed that the reason for the resident's discharge was that the resident had exhausted the Medicare benefit. There was documentation that equipment and supplies had been ordered, but failure to identify the equipment and supplies ordered. For discharge treatments the facility documented med management. There were no instructions for follow-up with the resident's physician post-discharge, instructions on medication administration, pressure ulcer prevention, level of assistance required for activities of daily living, assistive devices required, dietary instructions, etc.
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 failed to follow physician's orders and the drug manufacturer's recommendation related to the application of a [MEDICATION NAME]. This was evident for 1 of 10 sampled residents selected for review. Resident #9 was affected by the deficient practice. The findings include: Resident #9 was admitted to the facility for rehabilitation on 7/22/16 after being hospitalized and treated for [REDACTED]. The resident's medical record was reviewed on 4/19/17 and 4/20/17. Medical record review revealed that on 9/17/16 the resident had a physician's order for an [MEDICATION NAME] Patch to be applied every 24 hours. The physician further ordered that the [MEDICATION NAME] Patch was not to be applied to the same area more than once every 14 days. Review of the manufacture's directions for application of the [MEDICATION NAME] Patch confirmed that when applying the [MEDICATION NAME] Patch, avoid using the exact same spot until at least 14 days have passed. Review of the (MONTH) (YEAR) Treatment Administration Record revealed that the facility staff failed to ensure that the [MEDICATION NAME] Patch was not applied to the same area more than once every 14 days.

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	215177	A. BUILDING B. WING	07/13/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CHERRY LANE NURSING AND REHABILITATION CENTER	9001 CHERRY LANE LAUREL, MD 20708

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F 0279 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop a complete care plan that meets all of a resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview it was determined that the facility staff failed to develop and implement a care plan (Resident #206). This was evident for 1 of 33 residents selected for review in the stage 2 survey sample. A comprehensive care plan is used to identify care area concerns that are specific to the resident and are used to improve and maintain a resident's status. A care plan includes a measurable objective and a time frame to evaluate its effectiveness. The findings include: Resident #206 was admitted on [DATE] with moderately impaired vision-limited vision; not able to see newspaper headlines but can identify objects according to the MDS assessments of 3/31/16 and 5/11/16. The Minimum Data Set (MDS) is part of the U.S. federally mandated process for clinical assessment of all residents. This process provides a comprehensive assessment of each resident's functional capabilities and helps nursing home staff identify health problems. Categories of MDS (Minimum Data Set) are: cognitive patterns, communication and hearing patterns, vision patterns, physical functioning and structural problems which includes the assessment of range of motion, continence, psychosocial well-being, mood and behavior patterns, activity pursuit patterns, disease diagnosis, other health conditions, oral/nutritional status, oral/dental status, skin condition, medication use and treatments and procedures. At the end of the MDS assessment the interdisciplinary team develops the plan of care for the resident to obtain the optimal care for the resident. On the physician admission history and physical of 3/25/16 it was noted Resident #206 had poor vision and use to wear glasses. The nursing admission assessment did not assess Resident #206's vision. Interview with the Assistant Director of Nursing on 7/12/16 at 10:50 AM and the Unit Manager on 7/12/16 at 9:00 AM confirmed the facility staff failed to initiate a care plan to address impaired vision for a resident.
F 0313 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	Refer to F313. **Make sure that residents receive proper treatment and assistive devices to maintain their vision and hearing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, the facility failed to provide services to maintain adequate vision (Resident # 206). This is evident for 1 out of 33 residents selected for review during Stage 2 of the survey process. The findings include: During interview with Resident # 206 on 7/7/16 at 11:30 AM, the resident stated he/she did not receive needed eye glasses after an appointment with the Ophthalmologist. review of the resident's medical record revealed [REDACTED]. Review of Resident # 206's 3/31/16 and 5/11/16 MDS assessments revealed the facility staff coded the resident in Section B 1000 Vision as impaired and Section B 1200 Corrective Lens (contacts, glasses or magnifying glass used) as no. The Minimum Data Set (MDS) is part of the U.S. federally mandated process for clinical assessment of all residents. This process provides a comprehensive assessment of each resident's functional capabilities and helps nursing home staff identify health problems.
F 0329 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	Interview the Unit Manager on 7/7/16 at 9:00 AM and the Assistant Director of Nursing on 7/7/2016 at 10:50 AM confirmed the facility staff failed to obtain corrective lenses for Resident #206 as ordered by the Ophthalmologist. Refer to F279. **1) Make sure that each resident's drug regimen is free from unnecessary drugs; 2) Each resident's entire drug/medication is managed and monitored to achieve highest well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, it was determined the facility staff failed to identify and monitor targeted behaviors to justify continued use of a psychoactive medication (Resident # 130). This was evident for 1 of 33 residents selected for review in the stage 2 survey sample. The findings include: Resident #130 was ordered [MEDICATION NAME] (an antipsychotic medication) by their physician for dementia with behavioral disturbances. The facility listed anxiety as the targeted behavior to monitor to justify continued use of the antipsychotic medication. On 5/10/16 Resident #130 became agitated and attempted to elope from the facility twice. The agitated behavior with elopement attempts had occurred twice before on 2/28/16 and 2/29/16. On the behavioral monitoring tool on 5/10/16 the facility staff noted no anxiety behaviors exhibited. The facility failed to identify individual specific behaviors related to Resident #130 to justify continued use of the antipsychotic medication. This finding was confirmed by the Unit Manager on 7/8/16 at 1:00 PM. The Assistant Director of Nursing confirmed the finding on 7/12/16 at 10:50 AM.
F 0356 **Level of harm -** Potential for minimal harm **Residents Affected -** Many	**Post nurse staffing information/data on a daily basis.** Based on observation during the initial tour and interview, it was determined the facility failed to post the required daily nursing staffing data in a clear and readable format in a prominent place readily accessible to residents and visitors. The findings include: On 7/7/2016 at 8:30 AM , during the initial facility tour, all units had their staffing posted, however the daily staffing sheet was not in a clear and readable format in a prominent place visible to residents or visitors.

	On 7/12/2016 at 10:00 AM the Director of Nursing confirmed the daily staffing sheets on all the nursing units were not

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	215177	A. BUILDING B. WING	**07/13/2016**

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F 0356 **Level of harm -** Potential for minimal harm **Residents Affected -** Many	(continued... from page 1) visible to residents and visitors. Failure to display the nursing information in a clear and readable format did not allow residents or visitors easy access to names of daily caregivers.

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Facility ID: 215177

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	215177	A. BUILDING B. WING	**05/09/2016**

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F 0166 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Try to resolve each resident's complaints quickly.** Based on resident and family interviews and review of resident council minutes, it was determined the facility failed to adequately respond to ongoing concerns voiced by Residents #2, #13, #14, and #15 of staff 's failure to respond to call lights in a timely manner. This was evident for 5 of 15 residents reviewed during this complaint survey.The findings include:Surveyor review of complaint MD 559 on 5/5/15, 5/6/16 and 5/9/16 revealed concerns about the lack of timely responses to resident call lights.On 5/5/16 at 11:38 AM Resident #2 reported that on 5/4/16 on the 3-11 shift, he/she waited for someone to respond to his/her call light for greater than 30 minutes before wheeling himself/herself into the hall to get staff 's attention.On 5/6/16 at 11:50 AM Resident #14 reported staff were consistently slow to respond to call lights. The resident reported waiting as long as 45 minutes to an hour. He/she further stated this issue had been discussed repeatedly in the resident council meetings. He/She indicated that they were not going to bother attending the resident council meetings anymore because the their concerns were not adequately addressed.On 5/6/16 at 12:05 PM Resident #15 stated sometimes it takes 30 minutes for a staff member to respond to his/her call light. This resident also reported this issue was raised in resident council meetings.On 5/5/16 at 12:20 PM Resident #8 reported there were times when the call light was not answered at all or sometimes staff canceled the light without responding to the resident's needs.On 5/6/16 at approximately 11:45 AM, Resident #13 indicated delayed call light response continued to be a problem on the 3-11 shift. Review of the resident council minutes on 5/6/16 revealed complaints about delayed call light response in the meetings that were held on 11/30/15, 1/18/16, 2/22/16 and 3/21/16. Facility staff noted the actions that were taken to address the concerns included providing in-service to staff and reminding staff to answer call lights in a timely manner.During an interview with the Assistant Director of Nursing on 5/6/16 at 1:45 PM he/she stated supervisory staff make rounds all shifts and if a problem is identified with a specific staff member, the individual is disciplined. Further review of the resident council minutes failed to reveal alternatives to in-service and reminders to address this concern. Interviews with residents and the Director of Nursing failed to reveal the implementation of a plan for the ongoing monitoring of this issue to ensure staff 's compliance with answering call lights in a timely manner.
F 0323 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** Based on medical record review and staff interview, it was determined the facility staff failed to: 1) maintain adequate supervision for a functionally impaired resident (Resident #3) with an assessed fall risk; and 2) ensure the resident's chair alarm was in the on position when the resident was left unattended, resulting in the resident suffering a fall while attempting to ambulate independently. This was evident in 1 of 15 residents reviewed during this complaint survey.The findings include:Review of Resident #3's medical record revealed Fall Risk Assessments completed on 3/4/16, 3/11/16 and 3/18/16 that yielded a score of 14 (a score of 10 or above represents high risk).An MDS assessment completed on 4/29/16 that revealed the facility entered a BIMS score of 11 out of 15 in Section C Cognitive Patterns. Brief Interview for Mental Status (BIMS) is an assessment that assists staff in determining a resident's cognitive understanding. A score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment. A nursing assessment note dated 5/5/16 at 8:31 AM reported the resident demonstrated some confusion which was noted to be usual behavior for this resident.Facility staff coded the resident in Section G Functional Status D Walk in the Corridor and F Locomotion off the Unit as a 3/2 (extensive assistance of 1 staff). A care plan that addressed a history of falls included the interventions to assist with transfers and encourage the resident not to ambulate without assistance and use of bed/chair alarms. A physician's progress note dated 3/30/16 reported the resident is receiving rehabilitation services to address his/her abnormal gait.On 5/5/16 at approximately 3:35 PM the surveyor observed Resident #3 sitting at the end of the hall on the second floor near the rehabilitation center. The resident was sitting in a wheelchair with a walker in front of him/her and had a chair alarm attached to the chair, unattended by facility staff at this time. At approximately 3:43 PM the surveyor heard a thud, and looked into the hallway and observed the resident on the floor with the walker on top of him/her. A chair alarm was attached to the wheelchair but was not sounding.During an interview with the surveyor on 5/6/16 at 10:05 AM the resident stated he/she was going to the place where he/she gets therapy, when the fall occurred and then stated, I'm okay, it's mostly my head that hurts. During an interview with the surveyor on 5/6/16 at 12:55 PM the Rehabilitation Director reported PT #1 finished therapy with Resident #3 and assisted him/her to the wheelchair which was in the hallway. PT #1 went to the rehabilitation center to get a pulse oximeter (a device used to measure the oxygen level of the blood). Prior to leaving the resident he/she failed to turn the chair alarm to the on position, thus staff were not alerted when the resident rose from his/her wheelchair and attempted to ambulate independently.

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TITLE

(X6) DATE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215177	A. BUILDING B. WING	**10/22/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CHERRY LANE NURSING AND REHABILITATION CENTER	**9001 CHERRY LANE LAUREL, MD 20708**

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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 0250 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide medically-related social services to help each resident achieve the highest possible quality of life.** Based on medical record review and staff interview it was determined facility social services failed to ensure resident and family participation in the discharge planning process for a resident (Resident #3) whose family expressed an interest in moving the resident to a facility closer to a family member. This was evident for 1 of 5 residents reviewed during this complaint survey. The findings include: On 10/21/15 review of a complaint revealed the family member of Resident #3 contacted the facility in (MONTH) (YEAR) to advise staff of the intent to relocate the resident to a facility closer to family. The family member alleged he/she had not received assistance with this endeavor. The BIMS score entered in the MDS on 4/15/15 was 10 out of 15. The quarterly MDS assessment completed on 7/8/15 revealed the facility entered a BIMS score of 9 out of 15 in Section C Cognitive Patterns.The Minimum Data Set (MDS) is a comprehensive assessment of the resident completed by the facility staff that allows many facets of the resident's care (cognition, behavior, mobility, activities of daily living, accidents, activities, weight, pain and medications to name a few) to be addressed. Brief Interview for Mental Status (BIMS) is an assessment that assists staff in determining a resident's cognitive understanding. A score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment. During an interview with the Administrator on 10/21/15 at 9:32 AM, indicated that he did advise the family member that it would be best not to transfer the resident to due to his/her fragile condition. The Administrator further stated that although the resident had a slow decline in the last 8 months he/she is his/her own responsible party. He stated the resident had not voiced the desire to leave the facility. In interview on 10/21/15 at 1:52 PM the family member stated the Administrator did advise her/him not to move the resident due to the resident's fragile condition. Medical record review revealed this family member was appointed the resident's health care agent effective immediately after the health care decision making document was signed (9/6/12). During an interview with the Social Services Director on 10/21/15 at 12:43 PM, he/she stated when families request a resident be relocated staff always defer to the doctor regarding the resident's ability to travel to a new location and the rehabilitation department would also be involved in the decision making. There was no evidence that this occurred when the resident's family member initially made the request for a transfer from the facility.Medical record review failed to reveal a reassessment of the resident's capacity to make decisions or an evaluation from a physician advising against travel for this resident.In interview with the resident on 10/22/15 at 8:55 AM he/she neither confirmed nor denied interest in relocating to a facility closer to family. The resident appeared drowsy during the interview and trailed off several times requiring redirection.
F 0278 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Make sure each resident receives an accurate assessment by a qualified health professional.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review it was determined that the facility staff failed to ensure the information used to complete the Minimum Data Set (MDS) comprehensive assessment for Resident #4's Functional Status was accurate and the assessment for Functional Status, Transfers was accurate for Resident #1. This was evident for 2 of 5 residents reviewed during this complaint survey. The findings include: 1) Review of Resident #4's medical record on 10/22/15 revealed that on 9/10/15 the resident was noted with left sided weakness and a change in mental status. The resident was transported to the hospital and determined to have had a [MEDICAL CONDITION] (stroke) with left sided weakness.An Interdisciplinary Rehabilitation Evaluation dated 9/15/15 indicated the resident was referred for services due to nursing staff's report that the resident's ability to feed herself/himself had declined. It was also noted that the resident had decreased active range of motion in the left upper extremity secondary to a history of a [MEDICAL CONDITION] (stroke).The MDS assessment completed on 9/28/15 revealed the facility staff coded the resident in Section G Functional Status G0400 Functional Limitation in Range of Motion A Upper Extremity as a 0 (no impairment). 2) The facility failed to accurately assess Resident #1's transfer status when completing the MDS assessment. Review of Resident #1's medical record on 10/22/15 revealed the resident was admitted to the facility on [DATE] for rehabilitation following repair of a right [MEDICAL CONDITION]. Review of a facility reported incident that occurred on 9/16/15 revealed the resident was upset when facility staff did not use the mechanical lift to transfer him/her back to bed.The MDS assessment completed on 9/17/15 revealed the facility staff coded the resident in Section G Functional Status G0110 B Transfers and Toilet Use as a 4/2 (total dependence of one staff). In interview with the Assistant Director of Nursing (ADON) on 10/20/15 at 9:13 AM, he/she stated nursing staff use lifts to transfer residents to ensure their safety and only therapists are permitted to pivot transfer residents. The ADON presented a Resident Care Communication Sheet (undated) that indicated the resident was to be transferred with 2 staff using a Hoyer (mechanical) lift.In interview with the Physical Therapist (PT) assigned to Resident #1 from the time of admission to present, on 10/20/15 at 12:25 PM he/she stated the resident only required moderate assistance of 1 staff person for transfers and was not totally dependent. The therapist reported that initially, during transfers the resident required more time to complete the task of transferring. In interview with MDS Coordinator on 10/20/15 at 12:56 PM, he/she indicated he/she and the physical therapist discussed the inaccuracy. The MDS Coordinator stated the MDS nurse who completed the assessment may not have included documentation from the therapy department in determining the resident's functional status.Review of the nursing assistant's Activities of Daily Living Flow Sheet for transfers indicated the resident required the total assistance of two staff on 3 occasions during the 7 day look back (assessment) period and was coded as needing total assistance of 1 staff member on 8 occasions during the assessment period. This was in contrast to therapy department's assessment of the resident's needs. Also, there was

	no evidence the resident was assessed for a Hoyer Lift. The PT assessment indicated it was not needed. The resident was not totally dependent all the time, therefore he/she could not be coded as dependent.Review of the facility's Lifting Machine Policy on 10/20/15 revealed staff are to review the resident's care plan to assess for any special needs of the

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F 0278 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) resident and 2 staff are required to operate the lifting device. Refer to F280
F 0280 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**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 and staff interview, it was determined the facility failed to 1) develop a clear and individualized plan to address the behaviors, infection control, and care needs of a resident (Resident #5) with a history of care refusal to include refusal of medications and wound care, comprehensive physical assessments to determine treatment needs and attendance to her/his physical environment to prevent infections and maintain safety, and 2) develop a care plan based on input from a multi-disciplinary team that addressed Resident #1's transfer status and was consistent with the resident's goals for discharge. This was evident for 2 of 5 residents reviewed during this complaint survey. The findings include: 1) Resident #5 was admitted to the nursing home in (MONTH) 2004 with multiple [DIAGNOSES REDACTED]. The resident had a history of [REDACTED].A Social Services note dated 5/12/15 documented the resident had a history of [REDACTED]. The note also stated education was provided and the resident was aware of the risk of refusing treatments. Medical record review on 10/22/15 revealed results of scalp wound cultures dated 6/12/15 and 10/22/15 (specimen collection dates) which indicated the presence of Staphylococcus Aureus (bacteria) and [MEDICATION NAME] Faecalis (a strain of bacteria that is normally found in the intestines). The [MEDICATION NAME] Faecalis is noted to be a [MEDICATION NAME] Resistant [MEDICATION NAME] (VRE). [MEDICATION NAME] resistant [MEDICATION NAME] (VRE) are a type of bacteria called [MEDICATION NAME] that have developed resistance to many antibiotics especially [MEDICATION NAME]. The resident was treated for [REDACTED].The quarterly MDS assessment completed on 7/31/15 revealed the facility entered a BIMS score of 15 out of 15 in Section C Cognitive Patterns. Brief Interview for Mental Status (BIMS) is an assessment that assists staff in determining a resident's cognitive understanding. A score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment. The Minimum Data Set (MDS) is a comprehensive assessment of the resident completed by the facility staff. The MDS is a multi-disciplinarian tool that allows many facets of the resident's care (cognition, behavior, mobility, activities of daily living, accidents, activities, weight, pain and medications to name a few) to be addressed. A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess and evaluate the effectiveness of the resident's care.A Social Services note dated 8/17/15 reported the Administrator, Social Worker and Ombudsman attempted to speak with the resident on 8/14/15 regarding the following: 1) the health of the resident was endangered by her/his continued stay in the facility, 2) the condition of the resident's room and the need for preventative safety measures, 3) the resident's refusal of care and medical interventions offered by the facility, and 4) the resident's rights.On 8/21/15 the facility issued a Notice of Proposed Involuntary Discharge (30-day notice) to Resident #5 due to the health of the resident being endangered by her/his continued stay at the facility. On 9/15/15 a settlement agreement was reached by the facility and the resident, with the assistance of legal counsel for the resident, that stated the facility would rescind the involuntary discharge notice if the resident agreed to several conditions. The conditions included: collaborating with the Social Worker to inventory all of the resident's belongings and transfer to another private room for no more than 3 days to allow the facility staff to deep clean the resident's room. The agreement was implemented during the week of (MONTH) 12, (YEAR) (13th, 14th, and 15th) and the resident returned to his/her room on 10/16/15. Although risks and infection prevention concerns remained evident for Resident #5 and other resident of the facility, no plan was developed to better address the ongoing refusals to allow staff to manage the infectious process or to better manage the various unsanitary conditions. During an interview with Resident #5 on 10/20/15 at 2:40 PM, the resident stated he/she refused to allow staff to dress her/his head wound because some staff appeared to be afraid to dress the wound because it, looked like raw meat and bleeds a lot. The resident spoke of her/his preference for remaining in her/his room and declined to socialize with other residents or participate in activities. The resident stated he/she did not leave his room often because too much movement caused the wound to bleed. The resident stated she/he would not follow-up with a surgeon regarding the wound because she/he knows the recommendation will be to have more surgery and she/he was not willing to do that. The resident was asked if he/she would be willing to allow housekeeping to clean her/his room routinely but did not answer this question.When the surveyor asked the resident about the need for assistance with Activities of Daily Living the resident stated she/he was able to complete those tasks independently. Observation of the resident's socks at that time revealed them to be soiled and his/her feet were [MEDICAL CONDITION]. The resident also reported she/he had no interest in attending activities.During an interview of the Director of Social Services on 10/20/15 at 3:00 PM he/she discussed the challenges staff had in trying to provide care to the resident and maintain a clean environment in the resident's room. He/she stated a care plan meeting was scheduled for 11/5/15 but to date there was no formal agreement between the facility and the resident to address care refusal and maintenance and cleanliness of her/his environment in order to prevent future occurrences of the circumstances that lead to the issuance of the 30-day notice on 8/21/15.During an interview with the Administrator on 10/21/15 at 9:44 AM he reported that the resident was refusing to allow housekeeping staff into the room to clean and on occasion the door was, cracked open enough to see the bathroom and the toilet bowl appeared green. The Administrator also stated the resident was hoarding food and other items and maintenance staff were not able to enter the room to perform service on the heating and cooling unit which raised a concern that failure to change the filter in the unit would pose a fire hazard.The Administrator further stated that once housekeeping and maintenance staff were able to enter the resident's room, maintenance staff were instructed to discard the toilet and other fixtures and replace them with new fixtures. The floors were stripped and ceiling tiles were replaced. When asked if the resident agreed, going forward, to have the room cleaned regularly, the Administrator reported the resident had a good rapport with one of the housekeeping staff but there was no formal agreement/contract between the resident and the facility regarding a regular cleaning schedule to assist in maintaining an infection free environment. Although this strength where one staff was able to more effectively communicate with the resident, this strength was not documented or leveraged through a care planning process to better meet the needs of the resident and better safeguard infection concerns in the broader care environment. Regarding concern about resident's lower extremities [MEDICAL CONDITION], the Administrator reported that the resident spent most of her/his time sitting in a wheelchair and staff had been unsuccessful in trying to get the resident to sleep in her/his bed or use the recliner in order to elevate her/his lower extremities to decrease the [MEDICAL CONDITION]. The Administrator also reported the resident would not allow staff to examine her/his legs. During an interview with the Assistant Director of Nursing (ADON) on 10/22/15 at 8:31 AM he/she reported the resident also had a wound on her/his left leg that she/he refuses to allow facility staff to treat.During an interview with the resident's attending physician on 10/22/15 at 9:35 AM, the surveyor asked when the resident last had a thorough physical examination. The physician responded that he only did what the resident allowed and the examinations were generally limited to listening to the resident's heart and lungs. The physician further stated the resident keeps her/his room, locked up and wants to be left alone. When asked if she/he had

	examined the wound on the resident's leg, she/he responded that she/he had not seen the wound. The resident's physician further stated facility staff try to encourage the resident to elevate her/ his legs to reduce the [MEDICAL CONDITION] but the resident spends most of her/his time sitting in a wheelchair with his/her legs dependent and attempts to encourage the resident to allow staff to provide wound care to her/his head wound more frequently have been unsuccessful. Thus far the resident reportedly refused to have a surgical consult regarding her/his scalp wound due to her/his distrust of physicians, especially surgeons. The resident's physician reported that when the drainage from the head wound becomes foul smelling the drainage is cultured to determine the presence of an infection and treated, if necessary. The resident's physician maintained she/he had explained the risks of refusing the wound treatments. The resident is considered competent to make her/his own decisions and despite information about the risks of non-compliance, as noted by her/his physician continues to refuse treatments. Review of the Medication Administration Record [REDACTED]. The treatment was to be done every three days (Monday and Friday on the evening shift) and as needed. The resident refused this treatment 5 of 9 days in (MONTH) (YEAR); 7 of 9 treatments in (MONTH) (YEAR); 9 of 9 treatments in (MONTH) (YEAR); 6 of 9 treatments in (MONTH) (YEAR); and 6 of 9 treatments in (MONTH) (YEAR).

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F 0280 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) Review of the physician's orders [REDACTED]. Review of the MAR indicated [REDACTED]. Medical record review on 10/21/15 revealed a care plan that addressed, non-compliance. The care plan update note dated 8/13/15 and 10/10/15 reported the resident continued to be non-compliant with wound treatments and medication and verbalized an understanding of the risks. The note stated facility staff would continue with the plan of care for 90 days. No evidence was found of staff assessing how to better meet the needs of the resident and how to address the increased risk for infectious outbreak related to this resident's ongoing refusals for treatment and services. Upon completion of the task outlined in the Notice of Involuntary Discharge, the notice was rescinded on 10/21/15. At the time of the survey, the facility did not have a contract or a plan in place with specific measurable goals and interventions to address the resident's continued care refusal, and an agreement to facilitate the maintenance of an environment that is safe and free of infection. The ongoing failure to develop effective care plan(s) for Resident #5, increased the risk for infectious outbreaks in the facility that placed all residents at increased risk for harm. 2. Review of Resident #1's medical record on 10/22/15 revealed the Resident was admitted to the facility on [DATE] for rehabilitation following repair of a right [MEDICAL CONDITION]. The MDS assessment completed on 9/17/15 revealed the facility staff coded the resident in Section G Functional Status G0110 B Transfers and Toilet Use as a 4/2 (total dependence of one staff). The Minimum Data Set (MDS) is a comprehensive assessment of the resident completed by the facility staff. The MDS is a multi-disciplinarian tool that allows many facets of the resident's care (cognition, behavior, mobility, activities of daily living, accidents, activities, weight, pain and medications to name a few) to be addressed. A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess and evaluate the effectiveness of the resident's care. In interview with the Assistant Director of Nursing (ADON) on 10/20/15 at 9:13 AM, he/she stated nursing staff use lifts to transfer residents to ensure their safety and only therapists are permitted to pivot transfer residents. The ADON presented a Resident Care Communication Sheet (undated) that indicated the resident was to be transferred with 2 staff using a Hoyer (mechanical) lift, which was inconsistent with the needs identified by the therapy department.In interview with the Physical Therapist (PT) assigned to Resident #1 from the time of admission to present, on 10/20/15 at 12:25 PM he/she stated the resident only required moderate assistance of 1 staff person for transfers and was not totally dependent. The therapist reported that initially, during transfers the resident required more time to complete the task of transferring. The goal for this resident was to increase his/her ability to function independently as she/he was expected to return to an independent living situation.Review of the nursing assistant's Activities of Daily Living (ADL) Flow Sheet, revealed the resident required the total assistance of two staff on 3 occasions during the 7 day look back (assessment) period and was coded as needing total assistance of 1 staff member on 8 occasions during the assessment period. This was in contrast to therapy department's assessment of the resident's needs. The care plan developed for the resident stated the resident was totally dependent for all ADL's, but did not accurately refelct the resident's actual needs. The resident care communication sheet stated that Resident #1 was independent in eating and only required assistance with bathing and dressing. Therefore the resident was not total care with all ADL's, and the care plan was not accurate or individualized. In interview with the MDS Coordinator on 10/20/15 at 12:56 PM he/she indicated that he/she and the physical therapist discussed the inaccuracy. The MDS Coordinator stated the MDS nurse who completed the assessment may not have include documentation from the therapy department in determining the resident's functional status. Further review of the care plan did not reveal adjustments to interventions that indicated the resident's ability to transfer fluctuated, thereby necessitating adjustments to the method of transfer. The plan lacked clarity regarding the resident's transfer status and need for assistance during transfers.
F 0309 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	Refer to F278 **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 staff and resident interviews it was determined that the facility staff failed to conduct a thorough investigation, to include assessment of potential risks and formulate a plan, for an incident in which a resident (Resident #2) was found with unidentified pills. This was evident for 1 of 5 residents reviewed during this complaint survey.The findings include:Facility staff failed to address potential immediate risks associated with the possession of the unidentified substances and formulate a plan to address the risks associated with acquisition of unauthorized substances for Resident #2. Resident #2 was transferred to the nursing home from hospital on [DATE] with a [DIAGNOSES REDACTED]. The resident was also receiving treatment for [REDACTED]. On 7/6/15 a care plan was initiated for behavioral symptoms (agitation). There was no evidence that the care plan was revised to include interventions to address possible drug seeking behavior or measures to prevent the resident from obtaining unidentified substances while in the nursing facility. A Psychiatric Progress Note dated 7/23/15 documented the resident had a history of [REDACTED]. It was also noted the resident was angry with staff for limiting pain medication. A psychiatric progress note dated 8/11/15 reported, staff are concerned about the resident demonstrating pain medication seeking behavior. The medical record did not contain physician's notes that referenced or addressed the resident's medication seeking behavior. A nursing progress note dated 8/16/15 5:12 PM reported the resident was noted with an unlabeled bottle with about 4 different types of medication, in her/his pocket. The medication was retrieved by nursing staff and given to the Assistant Director of Nursing. Documentation did not indicate the physician was notified, that the resident was asked to identify the medications, if he ingested any pills and if so how much, or the source of the medications. In interview with the Director of Nursing and Assistant Director of Nursing on 10/21/15 at 8:57 AM, he/she reported that on 8/16/15 nursing staff confiscated an unlabeled bottle with 4 different types of medications from the resident. According to the ADON the resident denied taking the medications (this was not documented) and further stated she/he believed a family member brought the medications to the nursing home. Documentation did not reveal this issue was addressed with the resident's family. The facility failed to adjust the interventions in the care plan based on a comprehensive assessment of the resident's medication seeking behavior, risks associated with this behavior and adjust care plan interventions to ensure the resident's safety while in the nursing home.
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 and staff interview it was determined the facility staff failed to maintain records that documented the resident's nutritional status in a readily accessible manner. This was evident for 1 of 4 residents (Resident #4) reviewed during this complaint survey. The findings include: Review of Resident #4's medical record on 10/22/15 failed to reveal ongoing documentation of the resident's nutritional status by a dietitian for the year (YEAR).

	Review of the resident's MDS assessment dated [DATE] Section K Nutritional Status listed the resident's weight as 178 pounds which was 17 pounds less than a measurement entered on a discharge MDS dated [DATE]. In interview with the Dietitian on 10/22/15 at approximately 2:15 PM, he/she stated the resident was reweighed and the measurement was 193.2 pounds. The surveyor requested the nutritional assessments and notes for the period (MONTH) (YEAR) to (MONTH) (YEAR). The Dietitian produced a Nutritional Evaluation dated 10/21/13 and a nutritional care plan initiated 7/24/14. The surveyor requested the same information from the Assistant Director of Nursing (ADON). The ADON produced two nutritional notes dated 1/20/14 and 4/18/14 respectively. At the time of the survey documentation of the resident's nutritional status for the period (MONTH) (YEAR) to (MONTH) (YEAR) was not evident or provided.

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F 0514 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3)

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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 0323 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** Based on observation and interview with staff, it was determined that the facility failed to securely store oxygen tanks. This was evident for one out of six units observed and one resident room.The findings include:During the initial tour on 5/13/2015 at 8:35 AM surveyor entered the clean utility room located on the first floor. Upon entering the room the surveyor observed 2 oxygen tanks standing alone behind the door unsecured. Both tanks had approximately 1800 PSI (oxygen pressure in tank). 2000 PSI is considered a full tank.At 8:45 AM maintenance arrived on the unit to remove the unsecured oxygen tanks. He acknowledged having unsecured tanks can be dangerous.Further tour of the first floor revealed another unsecured oxygen tank inside room 109 beside the resident bathroom. During an interview with Staff #1, she acknowledged that the oxygen tank should not be in the resident's room unsecured. Staff # 1 removed the oxygen from the resident's room and took it to the oxygen storage room. Observation of the oxygen storage room revealed 2 empty oxygen holders.On 5/13/15 at 3:30 PM the Administrator and the Director of Nursing were informed of the 3 oxygen tanks that were not in holders even though holders were close by for staff to place the tanks in.
F 0371 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Store, cook, and serve food in a safe and clean way** Based on observation, interview with staff and review of kitchen documentation it was determined that the facility staff failed to monitor the cooling of potentially hazardous meat products after cooking, putting all residents who consume food from the kitchen at risk for food borne illness. The findings include: On 5/13/15 the surveyor toured the kitchen between 8:35 AM - 9:10 AM. During this tour the surveyor observed the cook preparing a large piece of meat. Interview with the cook (staff #3) revealed that she was preparing to cook a roast beef for that day and that it was to be used in a pot roast, which was on the menu for tomorrow. The cook also shared with the surveyor the Cooling of Cooked Foods form which had been started that morning which included: Food Item - Beef, Date cooked - 5/13/15. It was noted that there were spaces for the following: Temperature after cooking; Time placed in cooler; Temperature after 2 hours; Temperature after 4 hours; Proper cooling procedure achieved? - yes or no (circle one); and a space at the bottom for a signature and date. On 5/14/15 at 8:30 AM surveyor again toured the kitchen. During this tour review of the Cooling of Cooked Foods form that had been observed on 5/13/15 for the roast beef revealed that the temperature after cooking was 165 and that the meat was placed in the cooler at 2:30 PM. No additional documentation was found to indicate any temperatures had been taken during the cooling process of the roast beef. The sections of the form for the documentation of the temperature after 2 hours and after 4 hours were blank, the answer to the Proper cooling procedure achieved? - yes or no (circle one), was not completed; and the space at the bottom for a signature and date was also blank. On 5/14/15 at approximately 8:45 AM, after reviewing the 5/13/15 Cooling of Cooked Foods form with the surveyor, the Food Service Director (FSD) reported that the evening cook should have monitored the cooling process and then the FSD went on to state that she would be discarding the beef. Further review of the Cooling of Cooked Foods forms revealed the following instructions: Cool cooked food from 140*F or higher to 70*F - in 2 hours. Cool cooked food from 70*F degrees to 40* F - in an additional 4 hours. Total cooling time to reach temperature of 40*F - no more than 6 hours. Review of the facility's Hazard Analysis Critical Control Points (HACCP) plan revealed the following: If not cooled within six hours, reheat rapidly to 165*. If not cooled after six hours - discard. No information was found on the Cooling of Cooked Foods form or the HACCP plan regarding actions to be taken if food was not cooled from 135* to 70* in two hours. Further review of other Cooling of Cooked Foods forms revealed the following: 1) On 3/17/15 pork was cooked, the documented temperature two hours after being placed in the cooler was 100* and the documented temperature after four hours was 72*. The section for the answer to the Proper cooling procedure achieved? - yes or no (circle one), was not completed; and the space at the bottom for a signature and date was also blank. 2) On 3/22/15 pork was cooked, the documented temperature two hours after being placed in the cooler was 70* and the documented temperature after four hours was 53*. The section for the answer to the Proper cooling procedure achieved? - yes or no (circle one), was circled as yes; and the space at the bottom for a signature and date was blank. 3) On 5/3/15 corn beef was cooked, the documented temperature two hours after being placed in the cooler was 140* and the documented temperature after four hours was 120*. The section for the answer to the Proper cooling procedure achieved? - yes or no (circle one), was circled as yes; and the space at the bottom for a signature and date was blank. 4) On 5/5/15 a turkey was cooked, there were no documented temperatures after the turkey was placed in the cooler. The section for the answer to the Proper cooling procedure achieved? - yes or no (circle one), was not completed; and the space at the bottom for a signature and date was blank. On 5/15/15 at 3:30 PM the above listed Cooling of Cooked Foods forms were reviewed with the FSD director. She reported that she had not seen the form for the 5/5/15 turkey and stated that it was not right. She went on to confirm that these forms had not been completed correctly. On 5/15/15 at 4:15 PM, the surveyor informed the Administrator of the concern regarding staff failure to monitor the cooling of potentially hazardous meat products after cooking.

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.