## **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; 703-564-7357; e[mail: jdowney@jeffdowney.com](mailto:jdowney@jeffdowney.com)

Cadia Healthcare – Springbrook 12325 New Hampshire Avenue Silver Spring, MD 20904

# Characteristics:

* Nursing Facility with 99 beds
* [www.cadiahealthcare.com](http://www.cadiahealthcare.com/)
* Legal Business Name – Wye Oak Healthcare LLC
* Operation Control since April 2011 – Wye Oak Management LLC
* As of April 2019, Cadia Healthcare Springbrook is listed under the Medicare's Special Focus Facility Initiative, with 24 health citations in the last 12 months.

**Researching Nursing Homes**

# A note by attorney Jeffrey J. Downey:

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

The Maryland Department of Health inspects nursing homes including the Cadia Healthcare facility in Silver Spring, MD. Periodically they do inspections as complaint surveys which should be public record.

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.

If you have a concern or complaint about a nursing facility, there are three ways to file your complaint

1) Write to the Maryland Department of Health, Office of Health Care Quality, 7120 Samuel Morse Drive, Second Floor, Columbia, MD 21046-3422. (linkhttps://health.maryland.gov/ohcq/docs/complaint\_form.pdf)

2) Fax : 410-402-8179

3) Online - <https://fs30.formsite.com/OHCQ/OnlineComplaintForm/index.html>

## Having already researched Cadia Healthcare - Springbrook in Silver Spring, 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.

**Disclaimer:** Information is built using data sources published by Centers for Medicare & Medicaid Services (CMS) under Freedom of Information Act (FOIA). The information disclosed on the NPI Registry are FOIA-disclosable and are required to be disclosed under the FOIA and the FOIA amendments to the FOIA. There is no way to 'opt out' or 'suppress' the NPPES record data for health care providers with active NPls. Some documents may not be accurately copied or some results may have changed upon appeal, which may not be noted here.

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **215052** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **12/20/2018** |
| NAME OF PROVIDER OF SUPPLIER  **CADIA HEALTHCARE - SPRINGBROOK** | | | STREET ADDRESS, CITY, STATE, ZIP  **12325 NEW HAMPSHIRE AVENUE SILVER SPRING, MD 20904** | |
| 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 0610  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few  F 0689  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few | **Respond appropriately to all alleged violations.**  >  Based on surveyor review of the clinical record and interview of the facility staff and residents, it was determined that the facility failed to thoroughly investigate an allegation of misappropriation of resident property for resident #3 This finding was identified during an investigation of facility reported incident MD 329, and is related to the incident. The findings include:  On 12-19-18, review of the facility's Resident Concern/Compliment Form revealed that resident #3 complained to social services manager on 12-04-18 that the wireless/Bluetooth headphones and speaker were missing. The social services manager assigned the housekeeping manager to follow up. The housekeeping manager was unable to find the missing items in the laundry department on 12-07-18. Further review revealed the nursing staff, who were assigned to resident #3, were interviewed, but did not see the missing items on 12-04-18. Therefore, the facility offered to provide a locked drawer for resident #3 as a preventative measure.  However, there was no evidence that facility staff interviewed resident #3 to determine the location of the headphones and speaker before the items were missing, nor the last time they were seen. The brand name, model, color and size of the headphone and speaker were unknown.  On 12-20-18 at 9 AM, interview of resident #3 revealed the headphones and speaker were placed on the floor at the head of bed for charging on 12-04-18. Then, the resident went outside of the building after eating breakfast in the room. When the resident returned to the room, the headphone and speaker were gone. The resident stated the headphones and speaker were black. The brand name was Beats.  On 12-20-18 at 9:33 AM, interview of resident #3's roommate revealed the roommate saw the resident's headphones in the past. The roommate stated that resident #3 left the room after breakfast on 12-04-18. After that, a male housekeeping worker came in and cleaned the room. Then resident #3 returned to the room and discovered that the headphones and speaker were missing.  There was no evidence that the facility staff interviewed resident #3's roommate, who was alert and oriented, about the missing items.  On 12-20-18 at 12 noon, interview of the Administrator revealed no additional information.  **Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\* >  Based on surveyor review of the clinical record, interview of residents and the facility staff, and review of the facility's policy and procedure, it was determined that the facility staff failed to provide adequate supervision to resident # 2, who was identified at risk of elopement. This finding was identified during an investigation of MD 433. The finding include:  On 12-19-18, review of resident #2's care plan revealed the resident was identified at risk of elopement in (MONTH) (YEAR), but refused to wear a wanderguard bracelet. The WanderGuard alarm system is a monitoring system to ensure that an individual with wandering behavior be maintained in a safe and secured area. Due to resident's refusal to weari the WanderGuard bracelet, a new goal was developed in in (YEAR) to arrange staff or authorized person to accompany resident #2 with a physician's approval prior to leaving the facility. Further review revealed that resident #2 was deemed unable to  make informed decisions in (YEAR). Therefore, resident #4, who is resident #2's spouse, became the surrogate decision maker.  On 12-19-18, review of the nursing notes revealed that resident #4 reported to the evening supervisor on 12-06-18 at 8:30 PM that resident#2 did not return after they took a walk outside of the building. During the walk, resident #4 left resident  #2 on the street alone and came back to the facility first. The police were called for a missing person.  Per the hospital discharge summary, a bystander called the ambulance in the evening on 12-06-18 for resident #2 after the resident fell and hit his/her head on the crosswalk of a busy street. The resident was discharged back to the facility on [DATE].  On 12-19-18, review of the clinical record revealed that no physician's approval was obtained before resident #2 and #4 left the facility in the evening on 12-06-18 as stated on the plan of care. In addition, it was unknown when resident #2 and #4 left the building on 12-06-18, and when resident #4 returned to the facility alone.  On 12-19-11 at 11 AM, interview of resident #2 revealed that the resident ambulated with a cane. The resident stated that he/she was walking to a fast food store along the busy street in the evening on 12-04-18 after resident #4 left him/her alone on the street. Then, the resident fell on the street and was sent to a hospital.  On 12-19-18 at 11 AM, and 12-20-18 at 12 noon, interview of resident #4 revealed he/she stated that the facility staff knew they left the facility for a walk in the afternoon on 12-04-18. However, resident #4 did not know that resident #2 required a physician's approval before leaving the facility due to elopement risk.  On 12-20-18, review of the care plan, which was provided to resident #4 on 10-11-18, revealed no evidence that the plan of elopement risk was listed.  On 12-20-18, review of the facility's policy and procedure revealed that the facility staff are instructed to record the name of the resident, date and time of departure on the Leave of Absence Book. If residents are observed departing the facility without appropriate leave, the facility staff should refer to the supervisor for immediate follow up.  On 12-20-18 at 11:55 AM, interview of staff #1 and #2 revealed that they asked an individual or his/her responsible party to sign out on the Leave of Absence (LOA) book when leaving the facility. Then, documented the date, time of departure, and the anticipated returned time.  However, there was no evidence that resident #4 signed out in the afternoon on 12-06-18, nor did the facility staff document the date and time of departure for resident #2 and #4.  On 12-20-18 at 12 noon, interview of the Administrator revealed no additional information. | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

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FORM CMS-2567(02-99)

Previous Versions Obsolete

Event ID: YL1O11 Facility ID: 215052 If continuation sheet Page 1 of 1

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **215052** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **09/14/2018** |
| NAME OF PROVIDER OF SUPPLIER  **CADIA HEALTHCARE - SPRINGBROOK** | | | STREET ADDRESS, CITY, STATE, ZIP  **12325 NEW HAMPSHIRE AVENUE SILVER SPRING, MD 20904** | |
| 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 0692  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few  F 0806  **Level of harm -** Actual harm  **Residents Affected -** Few | **Provide enough food/fluids to maintain a resident's health.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\* >  Based on surveyor review of the resident's closed record and interview of the facility staff, it was determined that the facility staff failed to provide a clear liquid diet for resident #138 as planned by the resident's physician. This finding was identified during the investigation of complaint MD 889, and is valid. The findings include:  On 09-13-18, review of resident #138's closed record revealed that the resident was admitted to the facility on [DATE] following a hospitalization . The resident was alert, oriented, and capable of communicating his/her needs with the facility staff.  Further review of the attending physician's progress note, dated 09-04-18, revealed that resident #138 reported to the attending physician that he/she had multiple episodes of vomiting since admission, despite taking an antiemetic medication.  The attending physician's plan was to provide a clear liquid diet in the next 24 hours. However, there was no evidence that a clear liquid diet was provided to the resident until the resident left the faciity on [DATE].  On 09-14-18 at 11 AM, interview of the Director of Nursing (DON) revealed that the attending physician usually gives a verbal order to the nursing staff after the completion of the progress notes. However, the DON did not know who received the attending physician's orders [REDACTED].>  **Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\* >  Based on surveyor tour of the facility kitchen, review of the closed resident record and the facility's policy and procedure, and interview of the facility staff, it was determined that the facility staff failed to accommodate resident #140's food allergy. This finding was identified during the investigation of facility reported incident MD 570, and is valid. The findings include:  On 09-12-18, review of resident #140's closed record revealed that the resident was admitted to the facility following a hospitalization in (MONTH) (YEAR). Since the hospital transfer summary stated that the resident was allergic to seafood, an order was written to specify resident #140's food allergy upon admission. Review of the facility's policy and procedure regarding food allergies revealed that, once the food allergy has been identified, a meal ticket shall be generated for the  next meal service and the allergy will be reflected on the meal ticket.  Review of resident # 140's initial nutritional assessment, dated 08-20-18, revealed that seafood was listed as a food allergy. A new order was written on the same day to provide a sandwich at bedtime for the resident.  Further review of the clinical record and the facility's investigation revealed that resident #140 was found with a swollen tongue and slurred speech on 08-21-18 at 1 AM after the resident took a bite of a tuna sandwich prepared by kitchen staff. The resident reported difficulty breathing. Staff called 911 and the resident was transferred to the hospital.  On 09-12-18 at 12 noon, interview of staff #3 revealed that he/she put a tuna sandwich into resident #140's paper bag on 08-20-18 at 2 PM. He/she then stapled resident #140's meal ticket on the paper bag.  On 09-13-18 at 7:15 AM, interview of staff #2 revealed he/she adjusted resident #140's face mask on 08-21-18 at 12:45 AM and left the room. Then, staff #1 called him/her for assistance. Staff #2 observed that resident #140's tongue was swollen with slurred speech. The resident complained of difficulty breathing. 911 was called and the resident was sent to the hospital.  Staff #2 stated he/she observed a paper bag on the resident's bedside table on 08-21-18 at 1:07 AM. The meal ticket, which was stapled on the paper bag, listed that resident #140 was allergic to seafood.  On 09-13-18 at 7:30 AM, interview of staff #1 revealed he/she found resident #140 lying in bed on 08-21-18 at 1 AM. The resident handed him/her a sandwich and asked what the sandwich was made of. Staff #1 stated the sandwich had a fishy smell and observed a paper bag on resident #140's bedside table with a meal ticket stapled on the paper bag, which specified the resident was allergic to seafood. Staff #1 further stated that the resident's tongue was swelling and the resident  complained of difficulty breathing. He/she went to staff #2 and asked for assistance immediately.  Based on review of the hospital record, resident #140 was admitted to the hospital because of an allergic reaction.  On 09-12-18, review of the facility's investigation revealed that the Director of Nursing (DON) conducted an investigation on 08-21-18 and concluded that staff #3 failed to review resident #140's food allergy. As a result, a tuna sandwich was given to resident #140 who was allergic to seafood. An action plan was developed, which was as follows:   1. Training was provided by the food service manager on 08-21-18 to all the kitchen staff related to food allergies. 2. Training was provided by the Quality Assurance nurse on 08-21-18 to all the nursing staff related to food allergies and meal tray tickets. 3. An audit was completed on 08-22-18 to verify all residents with food allergies. 4. A new monitoring system was developed and implemented on 08-21-18. Nursing staff were required to review meal tickets and check the food items in the paper bags at 10 AM, 2 PM and 7 PM when delivered from the kitchen to the nursing station.   On 09-12-18 at 5 PM, a tour of the kitchen was done in the presence of the kitchen manager and staff #3. A tray, filled with 9 paper bags without meal tickets, was observed in the fridge. Staff #3 stated that these paper bags were prepared for the  residents, who were scheduled for the first shift of [MEDICAL TREATMENT] the following day. The kitchen manager then explained that the first shift of [MEDICAL TREATMENT] was 7 AM.  On 09-13-18, review of the audit report revealed no documentation that the nursing staff reviewed the meal tickets and checked the food items, which were in the paper bags when delivered from the kitchen at 7 AM.  On 09-13-18 at 7:15 AM, interview of staff #1 revealed that he/she did not sign off when the paper bags were delivered daily at 7 AM. Any nursing staff could deliver paper bags to residents listed on the paper bags.  On 09-13-18 at 8 AM, interview of the kitchen manager revealed no further information as to why there was no documentation that all the paper bags were being checked daily at 7 AM for food allergies.  On 09-13-18 at 12 noon, interview of the administrator revealed no additional information. | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

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FORM CMS-2567(02-99)

Previous Versions Obsolete

Event ID: YL1O11 Facility ID: 215052 If continuation sheet Page 1 of 1

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **215052** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **07/23/2018** |
| NAME OF PROVIDER OF SUPPLIER  **CADIA HEALTHCARE - SPRINGBROOK** | | | STREET ADDRESS, CITY, STATE, ZIP  **12325 NEW HAMPSHIRE AVENUE SILVER SPRING, MD 20904** | |
| 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 0610  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few | **Respond appropriately to all alleged violations.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\* >  Based on surveyor review of the clinical record, facility documentation, and facility staff interview, it was determined that the facility failed to thoroughly investigate an injury of unknown origin and potential abuse for resident #1. This  finding was evident for 1 of 3 residents reviewed during a complaint survey and was identified during the investigation of facility reported incident #MD 663. The findings include:  On 07-23-18, surveyor review of a facility investigation revealed that resident #1 was found with a bruise on the left shoulder area on 05-13-18. An x-ray was ordered and the results revealed that the resident had a displaced [MEDICAL CONDITION] shoulder bone.  On 05-14-18, the facility initiated an investigation into the cause of the fracture and to rule out abuse. The investigation included interviews of the nurses and the nursing assistants who cared for resident #1 on 05-12-18 and 05-13-18. However, there was no evidence that any other staff who worked on those days were interviewed to see if they had seen or heard anything that might contribute to the investigation.  In addition, the facility investigation did not include interviews with other resident's on the unit to find out if there were other concerns about care that could contribute to the investigation to rule out abuse.  Further review of the facility investigation revealed that resident #1 could move the left arm but it was stiff and contracted. However, there was no documented evidence that the facility investigated how the resident was transferred or moved in bed as a possible cause of the fracture.  Interview of the Director of Nursing on 07-23-18 at 3 PM revealed that the Director of Nursing had asked a nursing assistant to demonstrate transferring resident #1 and how they pulled the resident up in bed. The Director of Nursing stated that the nursing assistant transferred the resident with a gait belt and pulled the resident up in the bed with a draw sheet. There  were no interviews conducted with other residents or staff other than the nursing staff that worked with the resident. | | | |

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FORM CMS-2567(02-99)

Previous Versions Obsolete

Event ID: YL1O11 Facility ID: 215052 If continuation sheet Page 1 of 1

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **215052** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **05/01/2018** |
| NAME OF PROVIDER OF SUPPLIER  **CADIA HEALTHCARE - SPRINGBROOK** | | | STREET ADDRESS, CITY, STATE, ZIP  **12325 NEW HAMPSHIRE AVENUE SILVER SPRING, MD 20904** | |
| 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 0624  **Level of harm -** Minimal | **Prepare residents for a safe transfer or discharge from the nursing home.**  >  Based on surveyor review of the closed record and interview of the facility staff, it was determined that the facility staff | | | |
| harm or potential for actual | failed to prepare and provide documentation for resident #2 before and upon transfer to another facility. This finding was | | | |
| harm  **Residents Affected -** Few | identified during a complaint investigation of MD 689. The findings include:  On 05-01-18, review of the closed record revealed a new order, written on 02-20-18, to apply a right leg brace for resident  #4 four hours per day for contracture prevention. The nursing staff documented daily between 02-20-18 and 04-16-18 that 15 minutes of passive range of motion (PROM) exercises were done on both of the resident's lower extremities. | | | |
|  | On 04-16-18, resident #2 was transferred to another facility on 04-16-18 per the request of the resident's guardian of | | | |
|  | person. The facility's discharge planner documented that all the discharge instructions were given to the driver who | | | |
|  | transported resident #2 to the other facility on 04-16-18. However, it was unclear what the discharge instructions | | | |
|  | included. | | | |
|  | On 05-01-18 at 4 PM, interview of the discharge planner revealed that a copy of resident #2's (MONTH) (YEAR) Medication | | | |
|  | Administration Record [REDACTED]. The discharge planner assumed that the social services worker had provided the schedule | | | |
|  | for the application of the right knee brace in (MONTH) (YEAR). | | | |
|  | On 05-01-18 at 7:30 PM, the facility administrator provided the documentation that was sent to the other facility in (MONTH) | | | |
|  | (YEAR) by the social services worker. However, there was no information related to the resident's right brace or PROM sent | | | |
|  | at that time. The facility administrator stated that a discharge note, dated 04-16-18, which indicated that the resident | | | |
|  | required physical therapy's evaluation and treatment, was adequate to address the need for the right knee brace. | | | |
|  | On 05-02-18 at 10 AM, telephone interview of resident #2's guardian of person revealed that no leg brace was sent to other | | | |
|  | facility on 04-16-18. | | | |
| F 0655  **Level of harm -** Minimal | **Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted**  > | | | |
| harm or potential for actual | Based on surveyor review of the closed record and interview of the facility staff, it was determined that the facility staff | | | |
| harm  **Residents Affected -** Few | failed to provide a baseline care plan to resident #1 and the family in a timely manner. This finding was identified during investigation of MD 485. The findings include:  On 05-01-18, review of the closed record revealed that resident #1 was admitted to the facility in (MONTH) (YEAR) following a hospitalization . A week later, the resident was sent to a hospital per the family's request. However, it was unknown | | | |
|  | when the resident's baseline care plan was completed and when the resident and the family received the baseline care plan. | | | |
|  | On 05-01-18 at 5 PM, interview of the director of nursing (DON) revealed that resident #1's baseline care plan was completed | | | |
|  | in the first 24 hours after admission. Even though the baseline care plan was done and available, the resident and family | | | |
|  | would wait until a care conference, which was about 2-3 weeks after admission, to receive it. When asked about the | | | |
|  | rationale, the DON stated that the social services director made this arrangement per his/her own preference. | | | |
|  | On 05-01-18 at 7:45 PM, interview of the facility administrator and director of nursing revealed no additional information. | | | |
| F 0657  **Level of harm -** Minimal | **Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.**  > | | | |
| harm or potential for actual | Based on survey review of the closed record and interview of the facility staff, it was determined that the facility staff | | | |
| harm  **Residents Affected -** Few | failed to develop a plan of care for resident #2 related to contracture management. This finding was identified during a complaint investigation of MD 689. The findings include:  On 05-01-18, review of the closed record revealed a new order (written on 02-20-18) to apply a right leg brace for resident  #2 four hours per day for contracture management. An additional order was written to provide 15 minutes of passive range of | | | |
|  | motion (PROM) exercises to the resident's lower extremities daily. | | | |
|  | Interview of staff #1 on 05-01-18 at 3:30 PM revealed that the guardian of person was informed about resident #2's | | | |
|  | contracture management on 02-20-18. In addition, the social services director documented on 02-20-18 that a quarterly care | | | |
|  | conference was held with the resident's guardian of person. | | | |
|  | Further review of a quarterly Minimum Data Set (MDS), which was completed in Feb (YEAR), revealed that resident #2 had an | | | |
|  | impairment of one lower extremity. MDS is an assessment tool to reflect an individual's physical and functional status. | | | |
|  | However, there was no care plan developed related to resident #2's contracture management after 02-20-18. The resident was | | | |
|  | transferred to another facility on 04-16-18 per the request of the resident's guardian of person. | | | |
|  | On 05-01-18 at 7:30 PM, interview of East Wing unit manager revealed no additional information. | | | |
|  | On 05-01-18 at 7:50 PM, interview of the facility administrator and director of nursing revealed no additional information. | | | |
| F 0691  **Level of harm -** Minimal | **Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services.**  > | | | |
| harm or potential for actual | Based on surveyor review of the closed record and interview of the facility staff, it was determined that the facility staff | | | |
| harm  **Residents Affected -** Few | failed to provide proper ostomy care to resident #1. This finding was identified during a complaint investigation of MD  485. The findings include:  On 04-30-18, review of the closed record revealed that resident #1 was admitted to the facility in (MONTH) (YEAR) following a hospitalization . On the day after admission, the director of nursing (DON) documented that the resident had a | | | |
|  | nephrostomy tube on each kidney. A Nephrostomy tube is a plastic tube that is inserted into a kidney to drain out urine | | | |
|  | into a collecting bag. | | | |
|  | Further review of resident #1's history and physical assessment, which was also done on the day after admission, revealed | | | |
|  | the attending physician's plan was to flush the nephrostomy tubes every shift to avoid clotting. | | | |
|  | On 04-30-18 at 3:40 PM, interview of resident #1's attending physician revealed the purpose of flushing the resident's | | | |

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TITLE (X6) DATE

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Event ID: YL1O11 Facility ID: 215052 If continuation sheet Page 1 of 2

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **215052** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **05/01/2018** |
| NAME OF PROVIDER OF SUPPLIER  **CADIA HEALTHCARE - SPRINGBROOK** | | | STREET ADDRESS, CITY, STATE, ZIP  **12325 NEW HAMPSHIRE AVENUE SILVER SPRING, MD 20904** | |
| 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 0691  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few | (continued... from page 1)  nephrostomy tubes every shift was to maintain patency, however, the attending physician could not recall to whom he/she gave the verbal order for flushing on 12-21-17.  On 12-22-17, staff #2 emptied out 150 ml of bloody drainage from the left collecting bag and 300 ml from the right collecting bag.  However, there was no evidence that the nursing staff flushed resident #1's nephrostomy tube between 12-21-17 and 12-26-17 as planned by the attending physician. The director of nursing explained, on 05-01-18 at 5 PM, that no physician's order  was written until 12-27-17 to flush the nephrostomy bag with 100 ml of sterile water every day. Therefore, the nursing staff started flushing the nephrostomy tube as ordered starting on 12-27-17.  There was also no evidence that the nursing staff monitored resident #1's urine output and emptied the collecting bag between 12-23-17 and 12-26-17 to ensure patency.  On 12-27-17, the attending physician documented to flush nephrostomy tube q (every) day, clots noted. On 05-01-18 at 7:45 PM, interview of the director of nursing revealed no additional information. | | | |

FORM CMS-2567(02-99)

Previous Versions Obsolete

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(Tags:  Trial attorney, nursing home lawyer, nursing home attorney, overmedication, medication error, pressure sores, bed sores, sepsis, wrongful death, wounds, falls, attorney handling medication errors, nursing home abuse attorney, assisted living attorney, assisted living accidents, dehydration, malnutrition, Maryland abuse attorney, prince Georges nursing home attorney, nursing home injury, skilled rehab injury, skilled rehab attorney, drugs, pharmaceutical drugs, antipsychotic drugs, negligence attorney, nursing home abuse attorney, adult protective service lawyer, overdose, legal liability for overdose, nursing home abuse lawyer, , nursing home chains, statistics on nursing home abuse, Maryland abuse attorney, silver spring nursing home attorney, cadia healthcare, wye Oak healthcare, wrongful death Cadia healthcare, pressure sore at Cadia Healthcare