**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; e[mail: jdowney@jeffdowney.com](mailto:jdowney@jeffdowney.com)

Genesis Glade Valley (Glade Valley Center) 56 West Frederick Street Walkersville, MD 21793

Characteristics:

* Nursing Facility with 124 beds
* [www.genesishcc.com/GladeValley](http://www.genesishcc.com/GladeValley)
* Legal Business Name – 56 West Frederick Street Operations LLC
* Operation Control since December 2012 – Genesis Healthcare LLC
* As of 2018 Glade Valley Center was evaluated as a three-star facility on Medicare.gov

**Researching Nursing Homes**

A note by attorney Jeffrey J. Downey:

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

The Maryland Department of Health inspects nursing homes including Glade Valley Center in Walkersville, MD. Periodically they do inspections as complaint surveys which should be public record. You can write to the Office of Health Care Quality, 7120 Samuel Morse Drive, Second Floor, Columbia, Maryland 21046- 3422 or email [AL.HELP@maryland.gov](mailto:AL.HELP@maryland.gov) and [maryland.molst@maryland.gov](mailto:maryland.molst@maryland.gov)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **215313** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **09/18/2018** |
| NAME OF PROVIDER OF SUPPLIER  **GLADE VALLEY CENTER** | | | STREET ADDRESS, CITY, STATE, ZIP  **56 WEST FREDERICK STREET WALKERSVILLE, MD 21793** | |
| 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 0584  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few  F 0641  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few  F 0656  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few | **Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*  Based on surveyor observation and interview with staff, it was determined that the facility staff failed to maintain bedroom  and bathroom walls. This was evident for 1 of 26 resident bedrooms and bathrooms and 1 of 3 shower/bathing rooms observed during the survey.  The findings include:  On 9/12/18 at 9:21 AM, in room [ROOM NUMBER] the surveyor observed numerous white patches over the wall behind the head of the second bed and around window. In the corner of the wall above and to the left of the window where the wall met the  ceiling, was a black and gray area approximately 1 foot long along the crevice. The paint and border were separating from the wall and ceiling.  During observation on 9/12/18 at 11:59 AM, the surveyor observed that room [ROOM NUMBER] had multiple white patches scattered over the walls in bathroom. Small indentations were observed within the white patches. The surveyor observed the above areas with Staff #9 at 1:35 PM on 9/17/18. He indicated that the white patches on the bathroom walls in room # 122 were temporarily painted over until the areas were repaired. Staff #9 acknowledged the dark discoloration and damage to the  wall in room [ROOM NUMBER]. He indicated that there was a leak in the roof which caused the damage, that the leak had been repaired, and the area was dry. He indicated that the wall had not yet been repaired. When asked, Staff #9 indicated that  the roof had been repaired approximately 3 months prior.  Observation was made, on 9/13/18 at 8:20 AM, of the shower room by the janitor's closet on the Catoctin Unit. Observation of the second shower stall bench, on the left corner, had a 2 inch by 1 inch tear in the covering of the shower bench with the underneath padding exposed with rough edges. The bottom of the bench also had cracks in the covering. There was cracked grout in the corner of the shower and there was mold on the grout towards the bottom of the shower tile that was orange and black.  Observation was made on 9/14/18 at 9:20 AM in room [ROOM NUMBER] of a pillow sitting on a chair next to the bed. The blue covering of the pillow was split/torn in several locations.  **Ensure each resident receives an accurate assessment.**  Based on medical record review and staff interview, it was determined the facility staff failed to ensure that Minimum Data Set (MDS) assessments were accurately coded. This was evident for 1 (#110) of 1 residents reviewed for Death, 1 (#100) of 1 residents reviewed for hospice care, and 1 (#43) of 3 residents reviewed for dental.  The findings include:  The MDS is part of the Resident Assessment Instrument that was Federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned based on those individualized needs, and  that the care is provided as planned to meet the needs of each resident. The findings include:   1. Review of Resident #110's medical record on 9/14/18 revealed a nursing admission assessment, dated 6/11/18, which documented on the skin assessment section that the resident had a Stage 1 pressure ulcer on the sacral area and bilateral heel deep tissue injury (DTI).   Review of the 5-day Medicare MDS with an assessment reference date (ARD) of 6/13/18, Section M0100 Resident has a stage 1 or greater, a scar over boney prominence, or a non-removable dressing/device was marked no. Section M0210 unhealed pressure ulcers - Does this resident have one or more unhealed pressure ulcer(s) at Stage 1 or higher was coded no. Section M0300  Current number of unhealed pressure ulcers at each stage was not coded for Stage 1 and Unstageable - deep tissue injury was not coded.  The MDS Coordinator confirmed the errors on 9/14/18 at 1:09 PM.   1. Review of Resident #100's modification of admission MDS (minimal data set), with an assessment reference date (ARD) of 9/2/18, revealed that Section O, 0100. Special Treatments, Procedures, and Programs, K. Hospice care was not checked, indicating that Resident #100 did not receive Hospice care while a resident, which was inaccurate. Section O0100. M.   Isolation or quarantine for active infectious disease, 2. While a Resident, was checked, indicating that the resident was on isolation or quarantine for active infectious disease, which was inaccurate.  On 9/17/18, a review of Resident #100's medical record revealed that the resident was admitted to the facility at the end of (MONTH) (YEAR) and there was documentation that Resident #100 began receiving hospice services on 9/1/18. Continued review of Resident #100's medical record failed to reveal documentation that the resident had received isolation or quarantine for  active infectious disease while a resident.  On 9/17/18 at 12:30 PM, Staff # 21 and Staff #23 were advised of the above findings and confirmed the MDS inaccuracies.   1. Interview and observations of resident #43 on 9/11/18 revealed the resident did not have any teeth. Review of the 5-day Medicare MDS, with an assessment reference date of 7/3/2018 revealed that resident #43 did not have any issue with teeth/dentition. Section L Oral/Dental status (L0200) was inaccurately assessed as resident #43 was admitted to the facility without any teeth.   On 9/17/18 at 9:30 AM, Staff # 21 confirmed the MDS inaccuracies as indicated. Later in the day staff #21 indicated that a correction was made and that the assessment was resubmitted.  **Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*  Based on observation, medical record review and staff interview, it was determined that the facility failed to develop and implement comprehensive person-centered care plans. This was evident for 1 (#18) of 1 resident reviewed for behavioral-emotional status, 1 (#19) of 3 residents reviewed for pressure ulcers and 1 (#75) of 2 residents reviewed for discharge.  The findings include: | | | |

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

TITLE (X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99)

Previous Versions Obsolete

Event ID: YL1O11 Facility ID: 215313 If continuation sheet Page 1 of 6

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **215313** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **09/18/2018** |
| NAME OF PROVIDER OF SUPPLIER  **GLADE VALLEY CENTER** | | | STREET ADDRESS, CITY, STATE, ZIP  **56 WEST FREDERICK STREET WALKERSVILLE, MD 21793** | |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | |
| F 0656  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few  F 0684  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Some  F 0730  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Many  F 0756  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few | (continued... from page 1)  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   1. On 9/12/18 at 10:10 AM, in an interview, Resident #18 stated that he/she was depressed and taking medication for depression but didn't think it helped. On 9/18/18, a review of Resident #18's medical record was conducted and revealed a   4/12/18 physician order [REDACTED].#18 had a [DIAGNOSES REDACTED]. On 9/4/18 at 9:15 AM, in a psychotherapy progress note,  the physician documented [DIAGNOSES REDACTED].  Review of Resident #18's care plans failed to reveal a resident centered plan of care with measurable goals and individualized approaches to care that addressed Resident #18's depression and use of antidepressant medication. The Director of Nurses was advised of these findings on 9/18/18 at 9:45 AM.   1. On 9/17/18, a review of Resident #19's medical record was conducted and revealed that the resident had a pressure ulcer (an injury to the skin and underlying tissue resulting from prolonged pressure on the skin) on his/her left heel. Review of Resident #19's Skin Integrity Reports revealed that the nurse documented Resident #19 had an unstageable pressure ulcer (ulcer covered by slough or eschar (dead tissue) so depth cannot be measured) on 4/23/18, 4/30/18, 5/7/18, 5/14/18, 5/21/18, 5/28/18, 6/4/18, 6/11/18, 6/18/18, 6/29/18, 7/8/18, 7/20/18, 8/3/18, 8/10/18, 8/17/18, 8/24/18, 8/13/18, 9/6/18   and 9/17/18.  Review of Resident #19's care plans failed to reveal a resident centered plan of care with measurable goals and individualized approaches to care that addressed Resident #19's left heel pressure ulcer.  On 9/17/18 at 2:05 PM, during an interview, Staff # 24 was advised of the above findings and confirmed a care plan to address Resident #19's left heel pressure ulcer.   1. On 9/14/18 at 9:00 AM, during an interview, Resident #75 stated that last month the facility staff told the resident that he/she was ready for discharge from the facility even though resident did not think he/she should be discharged . Resident #75 stated that the facility staff later told the resident that he/she would not be discharged . On 9/14/18, at 10:11 AM, during an interview, Resident #75's representative stated that last month, in an email, he/she was told to find alternative placement for the resident because the resident was not longer eligible for nursing home care. The representative stated that the facility staff later apologized and stated they were wrong and the resident did not need to be discharged from the facility.   On 9/14/18, at 10:30 AM, a review of Resident #75's medical record was conducted. Review of Resident #75's care plans failed to reveal a resident centered plan of care with measurable goals and individualized approaches to care which addressed Resident #75's discharge goals and needs.  On 9/14/18 at 11:30 AM, during an interview, the Director of Nurses and SW were advised of the above findings and confirmed the facility failed to develop a care plan to address the residents discharge to the community, or short or long term stay  at the facility.  **Provide appropriate treatment and care according to orders, resident’s preferences and goals.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*  Based on medical record review and interview with facility staff, it was determined the facility failed to 1.) consistently obtain vital signs for (resident # 71), 2) discontinue weights for resident #86 as ordered by the physician and failed to initiate a blood thinning medication as ordered for resident #16. This was evident for 3 of 45 residents reviewed in the total sample. (#71, #86, #16)  The findings include:   1. The facility failed to consistently obtain vital signs for resident #71 as ordered by the physician.   Resident #71 was admitted to the facility with [DIAGNOSES REDACTED]. A [MEDICAL CONDITION] is a blockage of blood flow to  the heart muscle. Review of resident # 71's medical record on 9/14/18 at 11am revealed a physician's orders [REDACTED]. Review of the (MONTH) (TAR) Treatment Administration Record revealed that the vital signs were not signed off onsistently. Interview with the DON on 9/14/18, at 1:30 PM verified that the vital signs were not consistently documented on the TAR,  the vital sign record, or the medical record as consistently being done.   1. The facility failed to discontinue weights for resident #86 as ordered by the physician. Resident #86 was admitted to the facility with [DIAGNOSES REDACTED]. Palliative care- specialized medical care for patients with life limiting illnesses. Review of resident #86 medical record revealed a physician's orders [REDACTED]. Review of the medical record revealed that the resident's weight was obtained on 7/1/18. 2. Review of Resident #16's medical record on 9/17/18 revealed a physician's orders [REDACTED]. The medication was to start on 7/31/18. Eliquis is a blood thinner that helps prevent [MEDICAL CONDITION] and reduces bleeding common with anticoagulants such as [MEDICATION NAME].   Review of Resident #16's (MONTH) (YEAR) Medication Administration Record (MAR) did not have the Eliquis documented on the MAR. Review of the (MONTH) (YEAR) MAR revealed the Eliquis bid written as ordered, however, the 8/1/18 dose was written as a second dose, as each square which indicated the day, was labeled with the number of which dose it was. The 8/2/18 dose  was the third dose.  Resident #16 did not receive the first dose on 7/31/18. Staff #6 reviewed all the pages of the (MONTH) (YEAR) MAR and did not find any indication that the first dose was given. There were no nursing notes documenting that the first dose was  given, therefore, the resident only received 29 doses. Further review of Resident #16's medical record reveale the  physician ordered for [MEDICATION NAME] (a blood thinner) to be discontinued on (MONTH) 30, (YEAR), and the Eliquis 25 mg  BID to be started for 30 days.  The Director of Nursing was advised on 9/18/18 at 8:44 AM.  **Observe each nurse aide's job performance and give regular training.**  Based on review of Geriatric Nursing Assistant (GNA) personnel files and staff interview, it was determined the facility failed to conduct yearly performance reviews at least every 12 months for 6 out of 6 personnel files reviewed.  The findings include:  On 9/14/18, GNA personnel files were reviewed for yearly performance reviews.   1. Staff #11's Date of Hire (DOH) was 8/13/12. The last performance review found in the personnel file was dated 9/30/15. 2. Staff #12's DOH was 4/28/15. There was an Individual Performance Improvement Program (IPIP) dated 5/23/1,7 for unscheduled absences. There were no yearly performance reviews found in the personnel file. 3. Staff #13's DOH was 1/6/15. There were no yearly performance reviews found in the personnel file. 4. Staff #14's DOH was 10/23/13. There were no yearly performance reviews found in the personnel file. 5. Staff #15's DOH was 3/15/07. There was an IPIP, dated 11/27/17, for leaving a resident in a wet diaper for over 2 hours. There was an IPIP, dated 5/24/17, for 7 unscheduled absences in a rolling 12-month period. There was an IPIP, dated 7/9/17, for transferring a resident by herself when resident was a Hoyer 2 person assist. There was an IPIP, dated 9/22/11, related   to a resident who fell out of bed and the bed pad alarm was not turned on. The last yearly performance evaluation was done on 5/21/14.   1. Staff #16's DOH was 12/1/01. The last performance evaluation was on 5/23/14.   The payroll benefits coordinator was interviewed on 9/14/18 at 12:46 PM and stated, if they are not in the employee files then they were not done. The Director of Nursing came in the room at that time and also confirmed that yearly performance reviews were not done.  **Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\* | | | |

FORM CMS-2567(02-99)

Previous Versions Obsolete

Event ID: YL1O11 Facility ID: 215313 If continuation sheet Page 2 of 6

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **215313** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **09/18/2018** |
| NAME OF PROVIDER OF SUPPLIER  **GLADE VALLEY CENTER** | | | STREET ADDRESS, CITY, STATE, ZIP  **56 WEST FREDERICK STREET WALKERSVILLE, MD 21793** | |
| 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 0756  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few  F 0761  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few  F 0809  **Level of harm -** Potential for minimal harm  **Residents Affected -** Some  F 0812  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Many | (continued... from page 2)  Based on medical record review and staff interview, it was determined the facility failed to timely act on a pharmacy recommendation. This was evident for 1 (#16) of 5 residents reviewed for unnecessary medications.  The findings include:  Review of the medical record for Resident #16 on 9/17/18 revealed a pharmacy recommendation, dated 5/9/18, which stated receives a proton pump inhibitor (PPI) [MEDICATION NAME] 40 mg. twice daily. Recommendation: please consider changing to [MEDICATION NAME] 40 mg qd (every day) before food. The rationale for the recommendation was dosing more frequent than once  daily significantly increases the risk for adverse effects and medication cost. The risk of fracture was increased in patients who received high-dose, defined as multiple daily doses. Due to the increased risk of [MEDICAL CONDITION]  infection, the manufacturer recommends use of the lowest dose for the shortest duration appropriate to the indication. The (YEAR) Beers Criteria recommends avoiding scheduled use for greater than 8 weeks unless for high-risk patients due to increased risk of [MEDICAL CONDITION] infection and bone loss with fractures. The quality of evidence is high, and their recommendation is strong.  A second pharmacy recommendation, dated 6/8/18, stated, Repeated recommendation from 5/9/18. Please respond promptly to assure facility compliance with Federal regulations. The recommendation was accepted by the physician on 6/11/18 and the [MEDICATION NAME] was decreased to daily. By not addressing the recommendation timely, the resident received additional doses that were not recommended.  Staff #6 acknowledged that the pharmacy recommendation was not acted on timely on 9/17/18 at 10:32 AM. The Director of Nursing was advised on 9/18/18 at 8:44 AM.  **Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.**  Based on observation and staff interview, it was determined that facility staff failed to store medication according to professional standards. This was evident for 1 of 3 medication carts observed.  The findings include:  Observation was made, on 9/14/18 at 10:14 AM, of medication cart Catoctin A. In the top right drawer, there was a plastic medication cup which contained 5 pills. The medication cup was not labeled with the resident's name. The medications were not in individual packs. The medications were pre-poured and dispensed in the medication cup. Staff #22 walked up to the medication cart and the surveyor advised of the unlabeled medications. Staff #22 stated, oh the doctor wanted to see 2 forms.  The Director of Nursing was advised on 9/18/18 at 8:44 AM.  **Ensure meals and snacks are served at times in accordance with resident’s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.**  Based on review of facility records and interview with staff, it was determined that the facility failed to provide meals  with no more than 14 hours between a substantial evening meal and breakfast the following day. This was evident for 1 of 3 nursing units in the facility.  The findings include:  The facility's meal schedule was reviewed on 9/13/18 at 9:21 AM and revealed that Haven unit breakfast was to be served at 8:00 AM, lunch at 12:00 PM and dinner at 5:00 PM. This schedule reflects 15 hours between dinner and breakfast. During an interview on 9/14/18 at 12:17 PM Staff #6 indicated that the residents on Haven unit did not have a scheduled evening  snack. Staff #5 was made aware and confirmed these findings on 9/1/18 at 12:17 PM.  **Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*  Based on surveyor observation and interview with facility staff, it was determined that the facility staff failed to store, prepare, and distribute food in accordance with professional standards for food service safety by 1) failing to protect food during storage, 2) failing to discard expired food, 3) failed to ensure proper serving temperatures of food and 4) to protect food from exposure to potentially harmful organisms during preparation. This was evident during several observations in the main kitchen.  The findings include:  The following observations were made by the surveyor during the initial tour of the facility's kitchen on [DATE] at 9:25 AM.  1) Failed to protect food during storage: Moisture droplets were present within the walk-in refrigerator on the bottom of the compressor unit and dripping down the wall behind it. Wire shelving located directly below the compressor contained  corrugated cardboard cases of produce. On the top shelf was 1 5lb (pound) case of button mushrooms approximately ¾ full. The top and back of the case were soft and wet. The second shelf contained 3 open top cases of individual serving size cartons of Sysco shakes (chocolate, vanilla and strawberry) each case was approximately ,[DATE] - ½ full. Moisture droplets were observed on the surface of the cartons. The bottom shelf contained a covered cardboard case which was open in the center and contained bunches of celery. The case extended beyond the front of the shelving. Condensate was dripping from the compressor onto the top of the case and potentially onto the celery through the opening.  In the dry food storage room, the surveyor observed a shelving unit. On a shelf was a case containing 1 opened 10 lb. bag, approximately ,[DATE] full of Barilla thin spaghetti, beside the case was 1 opened 10 lb. bag, approximately ,[DATE] full of Barilla Fettuccine, and on the shelf below was 1 25 lb. opened case which held an open blue plastic bag of Origin Foods parboiled rice. None of the above were dated to reflect when they were opened, nor rewrapped to prevent potential exposure to pests or harmful organisms.  A wheeled refrigerator unit labeled Kitchen Line located beside the tray prep area contained droplets of condensation on the interior ceiling. The refrigerator also contained several plastic trays of individually plated portions cold foods and  deserts. The top tray was filled with desert plates of chocolate cake. The cake was not wrapped to prevent contact with the condensation droplets or other potentially harmful organisms. An uncovered bowl of applesauce was located on the second shelf.  A walk through was conducted on [DATE] at 10:00 AM with Staff #4 and the above concerns were pointed out.  During a subsequent observation of the kitchen, on [DATE] at 7:40 AM, the surveyor observed that the condensation was still present on the compressor and dripping down the wall as above. Metal sheet trays were located on the top shelf directly below the compressor, however, the compressor extended approximately 6 inches beyond the shelving unit and trays. On the bottom shelf, the surveyor observed cardboard cases containing celery and lettuce. The cases also extended beyond the front edge of the shelving and trays, with approximately 6 inches lying directly below the compressor. A puddle approximately 2.5 feet wide by 10 feet long was located on the floor below the shelving at the base of the wall behind the compressor. Within the walk-in freezer, frozen condensation was observed again on the compressor, the fan shields and the ceiling in front of  the compressor. The cardboard sheets were no longer located on the top shelf below the compressor. 4 icicles were observed | | | |

FORM CMS-2567(02-99)

Previous Versions Obsolete

Event ID: YL1O11 Facility ID: 215313 If continuation sheet Page 3 of 6

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **215313** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **09/18/2018** |
| NAME OF PROVIDER OF SUPPLIER  **GLADE VALLEY CENTER** | | | STREET ADDRESS, CITY, STATE, ZIP  **56 WEST FREDERICK STREET WALKERSVILLE, MD 21793** | |
| 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 0812  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Many  F 0842  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few | (continued... from page 3)  hanging from the top shelf and 1 on the second shelf, all approximately 3 inches long. 3 cardboard cases labeled frozen sweet Italian sausage links were located on the second shelf and had ice approximately 4 inches diameter ¼ inch thick in several places on their covers.  The tray line refrigerator also had condensation droplets on its interior ceiling and uncovered bowls of coleslaw, pudding and applesauce on the tray shelves. At 8:05 AM, the surveyor looked in the refrigerator again and observed that a white parchment paper sheet had been placed over each tray. Clear wet droplets were located on the surface of the paper covering the top shelf which contained coleslaw.   1. Failed to discard expired food: A case containing 12 - quart size cartons of [MEDICATION NAME] milk with imprinted expiration dates [DATE] was observed in the walk-in refrigerator also at that time. 2. Failed to ensure food is served at safe temperatures: The surveyor reviewed temperature logs for each meal service at the facility between (MONTH) 1, (YEAR) and (MONTH) 16, (YEAR). The logs failed to reveal that the facility staff checked the hot and/or cold foods being served to ensure safe serving temperatures for 41 of 48 meals served during the 16-day period reviewed. In addition, no hot or cold food temperatures were taken for dinners served 12 of the 16 days.   Staff failed to ensure safe serving temperatures for the following meals:  [DATE] = B (Breakfast) and D (Dinner) - cold foods [DATE] = B and L (Lunch) - cold foods  [DATE] = B - cold foods, D - hot and cold foods [DATE] = B and L - cold foods, D - hot and cold foods [DATE] = D - hot and cold foods  [DATE] = B, L and D - cold foods  [DATE] = B - cold foods; L and D - hot and cold foods [DATE] = B, L and D - hot and cold foods  [DATE] = B and L - cold foods, D - hot and cold foods [DATE] = B - cold foods, D - hot and cold foods [DATE] = B - and L cold foods, D - hot and cold foods [DATE] = B - and D cold foods, L - hot and cold foods [DATE] = B, L - cold foods, D - hot and cold foods [DATE] = L - cold food, D - hot and cold food [DATE] = B, L and D - hot and cold food  [DATE] = B, L and D - hot and cold food  On [DATE] at 8:30 AM, the above concerns were discussed and pointed out to Staff #5 as well as the concerns observed during the initial tour of the kitchen. Staff #5 indicated that condensation in the walk-in units has been an ongoing problem, and contractors had evaluated it and found nothing wrong with the refrigerators or freezer. She indicated that staff were  supposed to check hot and cold food temps during every meal service.   1. Failed to protect food during preparation: The lunch meal service was observed on [DATE] at 12:00 PM. After checking food temperatures as requested by the surveyor, Staff #5 was observed taking the thermometer to the 3 compartment sink and washing it, turning the spigot on and off with her gloved hands. Staff #5 then returned to the tray line and began making chicken salad sandwiches touching the bread, serving scoop and plates wearing the same gloves she had touched the spigot handles with. Staff #7 was observed grabbing and pushing a tray cart into position with her gloved hands then returning to   pick up plates of food placing her gloved thumb onto the plates and placing the plates onto the serving trays wearing the  same gloves she had just touched the tray cart with. Staff #8 was observed making chicken salad sandwiches. Her name badge was clipped to the chest pocket of her shirt. The name badge was dangling and touching Staff #8's gloved hands and the food she was handling.  A final observation of the walk-in freezer and refrigerator was made at that time. Icicles remained on the wire shelving below the cardboard. The trays located on the top shelf of the walk-in refrigerator were moved to extend approximately 6 inches over the front of the top wire shelf leaving a gap of approximately 6 inches at the rear of the shelf. Cartons of  celery and lettuce remained on the bottom shelf below the compressor. Condensation remained on the ceiling and compressors in both units.  At [DATE] at 12:17 PM, Staff #5 was made aware of the above observations.  All the above concerns were reviewed with the Administrator on [DATE] at 4:06 PM. Cross reference F 908  **Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*  Based on review of the medical record and facility documentation and interview with facility staff, it was determined that the facility failed to maintain complete and accurately documented medical records by failing to 1) document a full evaluation for resident after a fall (#70), 2) accurately document resident's skin condition after a fall (#70), 3) ensure accuracy of fall follow up notes (70), 4) to transcribe a physician's orders [REDACTED].#86), 5) to complete a discharge summary (#108), and 6) failed to administer a medication as prescribed (#16). This was evident for 4 (#70, #86, #108, and #16) of 45 residents reviewed in the total sample.  The findings include:   1. A review of Resident #70's medical record, on 9/13/18 at 3:31 PM, revealed a change in condition evaluation form, dated 8/29/18 related to a fall. The change in condition evaluation failed to include a full evaluation related to the resident's   fall including where he/she fell , what he/she was doing when the fall occurred, any contributing factors or presence or absence of injury to the resident. The form indicated View Progress note and See UDA for assessment details. During an interview on 9/13/18 at 4:02 PM, Staff #2 was unable to locate any additional fall assessment documentation in the resident's record related to Resident #70's fall on 8/29/18. Staff #2 did reveal an incident report related to Resident  #70's fall on 8/29/18 which indicated the fall occurred outside and that the resident was ambulating with GNA (Geriatric Nursing Assistant), appeared to trip over his/her feet, was lowered slowly to the ground landing on his/her knees, no redness noted. Staff #2 confirmed that this report was not part of the resident's record and this pertinent information was not documented in the resident's record.   1. Review of Resident #70's plan of care revealed an update on 8/30/18, Had fall 8/29/18. No injuries noted. The nursing change in condition follow up note, written 8/29/18 at 23:45 (11:45 PM), indicated No ill effects noted from fall at this   time. Skin Check documentation on 8/31/18 and 9/7/18 indicated no Skin injury/wounds were identified. However, the change in condition follow up notes, written on 8/30/18 at 7:45 AM, 8/30/18 at 18:27 (6:27 PM), 8/31/18 at 10:30 AM and 18:30 (6:30 PM), all noted Resident #70 had abrasions to his/her hands. Staff #2 was made aware of these findings.   1. Resident #70's change in condition follow up note, written on 8/30/18 at 18:27, indicated that the fall occurred on   8/27/18 and a follow up note on 9/1/18 at 10:45 AM indicated that the fall occurred on 8/28/18. No documentation was found to indicate that the resident had fallen on either date.   1. The facility failed to transcribe a physician's orders [REDACTED].#86). Review of resident #86 medical record revealed a physician's orders [REDACTED]. Palliative care is specialized medical care for patients with life limiting illnesses.   Review of the medical record revealed that the resident's weight was obtained on 7/1/18. Further review of the medical record revealed the physician's orders [REDACTED].  During interview with the Director of Nursing, on 9/17/18 at 2pm, s/he verified the findings.   1. Review of the medical record for Resident #108 on 9/13/18 revealed the resident was discharged from the facility on   7/7/18. A discharge summary from the physician was not found in the medical record. The Director of Nursing (DON) confirmed that there was no discharge summary.   1. Review of Resident #16's medical record on 9/17/18 revealed a physician's orders [REDACTED]. The medication was to start on 7/31/18.   Review of Resident #16's (MONTH) (YEAR) Medication Administration Record (MAR) did not have the Eliquis written on the MAR. | | | |

FORM CMS-2567(02-99)

Previous Versions Obsolete

Event ID: YL1O11 Facility ID: 215313 If continuation sheet Page 4 of 6

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **215313** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **09/18/2018** |
| NAME OF PROVIDER OF SUPPLIER  **GLADE VALLEY CENTER** | | | STREET ADDRESS, CITY, STATE, ZIP  **56 WEST FREDERICK STREET WALKERSVILLE, MD 21793** | |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | |
| F 0842  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few  F 0880  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few  F 0908  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Some | (continued... from page 4)  Review of the (MONTH) (YEAR) MAR revealed the Eliquis written as ordered, however the 8/1/18 dose was written as a second dose as each square, which indicated the day, was labeled with the number of which dose it was. The 8/2/18 dose was the  third dose.  Resident #16 did not receive the first dose on 7/31/18. Staff #6 reviewed all the pages of the (MONTH) (YEAR) MAR and did not find any indication that the first dose was given. There were no nursing notes documenting that the first dose was  given. Cross Reference F684  The DON was advised on 9/18/18 at 8:44 AM.  **Provide and implement an infection prevention and control program.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*  Based on observation and staff interview, it was determined that the facility staff failed to follow infection control practices and guidelines to prevent the development and transmission of disease by failing to label and store resident care equipment in a manner to prevent development and transmission of disease and infection, and by failing to follow hand  hygiene procedures by staff involved in direct resident contact. This was evident for 7 of 26 rooms observed on 2 units and 2 (#82, #43) of 4 residents observed during medication pass administration.  The findings include:   1. Observation was made, on 9/14/18 at 8:34 AM, of Staff #10 going in and out of resident rooms collecting soiled breakfast trays. Staff #10 went into room [ROOM NUMBER], #205, #204, and #201. Staff #10 proceeded to go back in room [ROOM NUMBER]   to deliver a clean towel and washcloth. Staff #10 came out of room [ROOM NUMBER] and walked into room [ROOM NUMBER] and  grabbed the wheelchair handles of the wheelchair and proceeded to push the resident down the hall. Staff #10 then walked  back up the hall and walked into room [ROOM NUMBER] and collected medication tubing and proceeded to put the tubing in the trash. Staff #10 did not sanitize his/her hands during the entire observation. The observation was made by 2 surveyors.   1. Observation was made, on 9/14/18 at 8:40 AM, of Staff #22 administering medications. Staff #22 started with medications for Resident #82. Staff #22 gave medications to Resident #82 and while in the resident's room, the resident laid a tissue down on a sheet of paper. Staff #22 picked up the tissue with bare hands and threw the tissue in the trash. Staff #22 then proceeded to go to the medication cart and pushed the cart to the next room, which was Resident #43. Staff #22 pushed the vital sign machine on wheels and proceeded to take Resident #43's vital signs. Staff #22 touched the thermometer probe with bare hands and then went back to the medication cart and dispensed the medications into a medication cup. Resident #43 handed Staff #22 a cup and spoon, that the resident had touched, and Staff #22 put the items in the trash. Staff #22 then touched the water pitcher handle and the applesauce lid. Staff #22 then signed off the medications as given and went to Resident #43's roommate and took vital signs from the vital sign machine. Staff #22 did not sanitize his/her hands between resident contact.   The Director of Nursing was advised of the observation on 9/18/18 at 8:44 AM.   1. On 9/11/18 at 12:01 PM, an observation of room [ROOM NUMBER]'s shared bathroom revealed there was a clear, plastic graduated container (a measuring container used to measure liquid such as urine), labeled 227-B and not covered, was on the top of the left sided hand rail located on the wall behind the toilet and there was a clear, plastic graduated container,   that was not labeled and not covered, on top of the right sided hand rail located on the wall behind the toilet. On  9/17/18, 2:30 PM, accompanied by Staff # 24, an observation of room [ROOM NUMBER]'s shared bathroom revealed a clear plastic graduated container that was unlabeled and uncovered on top of the left sided hand rail, located on the wall behind  the toilet. Staff #24 confirmed the findings at that time   1. On 9/11/18 at 1:22 PM, an observation of room [ROOM NUMBER]'s shared bathroom revealed a white, plastic, specipan (a specimen collection unit designed to collect urine and stool), that was unlabeled and uncovered on top of the left sided   had rail, located on the wall behind the toilet. There was a gray, plastic fracture bed pan that was uncovered and  unlabeled, on top of the right sided hand rail on the wall behind the toilet. room [ROOM NUMBER]'s shared bathroom was observed again on 9/13/18 at 10:19 AM, an observation of room [ROOM NUMBER]'s shared bathroom revealed a gray, plastic, fracture bed pan that was uncovered and unlabeled, located on top the right sided hand rail on the wall behind the toilet.  On 9/17/18 at 2:30 PM, accompanied by Staff #24, an observation of room [ROOM NUMBER]'s shared bathroom revealed a gray, plastic, fracture bed pan that was uncovered and unlabeled, located on top the right sided hand rail on the wall behind the  toilet. Staff #24 confirmed the findings at that time.   1. On 9/12/18 at 12:15 PM, an observation of room [ROOM NUMBER]'s shared bathroom revealed that, on top of a plastic drawer unit there was a gray plastic bed pan that was unlabeled and uncovered. On top of the bed pan was a gray, plastic basin   labeled 311-A that was uncovered. room [ROOM NUMBER]'s shared bathroom was observed again on 9/13/18 at 10:16 AM and revealed a gray, plastic bedpan that was unlabeled and uncovered on the top of a plastic drawer unit. On 9/17/18 at 2:30  PM, accompanied by Staff #24, an observation of room [ROOM NUMBER]'s shared bathroom revealed a gray, plastic bedpan that was unlabeled and uncovered on the top of a plastic drawer unit. On top of the uncovered bedpan, there was a plastic bed  pan contained in a paper wrap. Also, there were two soiled clothing items observed on the bathroom floor. Staff #24 confirmed the findings at that time  Staff # 24 advised of the above findings on 9/17/18 at 2:30 PM.  **Keep all essential equipment working safely.**  Based on surveyor observation and interview with staff, it was determined that the facility staff failed to ensure that the refrigerators and freezer in the kitchen were maintained in safe operating condition. This was evident during the initial tour and 2 subsequent observations in the kitchen.  The findings include:  During the initial tour of the kitchen, on 9/11/18 at 9:25 AM, the surveyor observed that the walk-in refrigerator had moisture droplets formed on the bottom of the compressor unit and dripping down the wall behind it. Wire shelving located  directly below the compressor contained cases of produce and Sysco shakes. Moisture was observed dripping onto the surface of the cartons.  The walk-in freezer had frozen droplets on the compressor, the fan shields on the front of the compressor, and on the ceiling in front of the compressor. The wall behind the compressor had ice, approximately 2 inches wide by 6 inches long and ½ inch thick, which ran along the top of the wall. The wire shelving directly below the compressor was covered with  cardboard sheets. 2 icicles each approximately 3 inches long were hanging from the top shelf below the cardboard. A wheeled refrigerator unit labeled Kitchen Line located beside the tray prep area contained droplets of condensation on the interior ceiling. The refrigerator also contained several plastic trays of individually plated portions cold foods and deserts. A  walk through was conducted on 9/11/18 at 10:00 AM with Staff #4, and the above concerns were pointed out.  During a subsequent observation, on 9/17/18 at 7:40 AM, the surveyor observed that the condensation was still present in the walk-in refrigerator on the compressor and dripping down the wall as above. A puddle, approximately 2.5 feet wide by 10 feet long, was located on the floor below the shelving at the base of the wall.  In the walk-in freezer, frozen condensation was observed again on the compressor, the fan shields and the ceiling in front  of the compressor. The cardboard sheets were no longer located on the top shelf below the compressor. Icicles were observed in 4 places, hanging from the top shelf and 1 place on the second shelf, all approximately 3 inches long.  The tray line refrigerator also had condensation droplets on its interior ceiling and uncovered bowls of coleslaw, pudding and applesauce on the tray shelves.  On 9/17/18 at 8:30 AM the above concerns were discussed and observed by Staff #5 as well as the concerns observed during the initial tour of the kitchen. Staff #5 indicated that condensation in the walk-in units has been an ongoing problem, and contractors had evaluated it and found nothing wrong with the refrigerators or freezer.  Another observation of the walk-in freezer, and refrigerator was made on 9/17/18 at 12:00 PM. Icicles remained on the wire shelving below the cardboard in the freezer. The condensation was still present on the ceiling and compressors in both walk-in units.  At 9/17/18 at 12:17 PM, Staff #5 was made aware of the above observations. The above concerns were reviewed with the Administrator on 9/17/18 at 4:06 PM.  Cross reference F 812. | | | |

FORM CMS-2567(02-99)

Previous Versions Obsolete

Event ID: YL1O11 Facility ID: 215313 If continuation sheet Page 5 of 6

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **215313** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **09/18/2018** |
| NAME OF PROVIDER OF SUPPLIER  **GLADE VALLEY CENTER** | | | STREET ADDRESS, CITY, STATE, ZIP  **56 WEST FREDERICK STREET WALKERSVILLE, MD 21793** | |
| 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 0908  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Some | (continued... from page 5) | | | |

FORM CMS-2567(02-99)

Previous Versions Obsolete

Event ID: YL1O11 Facility ID: 215313 If continuation sheet Page 6 of 6

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **215313** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **09/18/2018** |
| NAME OF PROVIDER OF SUPPLIER  **GLADE VALLEY CENTER** | | | STREET ADDRESS, CITY, STATE, ZIP  **56 WEST FREDERICK STREET WALKERSVILLE, MD 21793** | |
| 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 0600  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few  F 0657  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few | **Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\* >  Based on record review, facility investigation and resident and staff interviews, it was determined that the facility failed to keep a resident free from verbal abuse and neglect as evidenced by reports of a resident being verbally abused by a staff member. This was evident for 1 (#161) of 8 residents reviewed for abuse. The findings include:  Review of the medical record for Resident #161 on 9/17/18 documented that the resident had the [DIAGNOSES REDACTED]. Resident #161 was totally dependent on staff for all activities of daily living. Review of skin integrity reports revealed documentation that the resident had 3 open areas on the sacrum upon admission on 1/13/18, and as of 2/19/18 had 2 open areas, a Stage 3 pressure ulcer and an unstageable pressure ulcer on the sacrum.  Review of nursing notes for Resident #161 revealed that, on 2/23/18 at 16:03, Change in condition: Other change in condition, verbal abuse/neglect 2/22/18 in the afternoon. See UDA for assessment details. A 2/24/18 at 00:50 nursing note documented alert and not verbal. No events of neglect and verbal abuse occurred this shift. Pt was turned and repositioned q 2hrs. Nectar thick fluids given with spoon.  Review of the investigation for facility reported incident MD 409 revealed that Resident #18 was concerned about the way his/her roommate, Resident #161, was treated on the evening of 2/21/18. The Social Work Director documented on 2/22/18 that Resident #18 stated on the evening of 2/21/18, Staff #19 came into their room, greeted the resident and proceeded to go to Resident #161's side of the room and stated I'm not dealing with you. You[\*\*\*]your pants. I'm not bothering to change you now. The statement continued with Staff #19 came back into deliver meal trays and fed Resident #161 with the curtain  closed. Staff #19 did not come back in the room the remainder of the shift. The next aide who came on duty was the one who cleaned Resident #161 up.  Staff #18 was interviewed on 9/17/18 at 2:52 PM and stated, I walked into Resident #18's room and he/she told me I wish you would have worked last night, you wouldn't have believed what happened. When he/she explained all the stuff that Staff #19 did to Resident #161, I reported it and was told to get a statement from Resident #18. Staff #18 stated I went back in and  I asked Resident #18 what do you want me to write on the report and he/she told me that Staff #19 told Resident #161 that he/she should know how to feed him/herself and if he/she didn't know how to eat he/she would have to go hungry. Resident #18 also stated Staff #19 complained about Resident #161 laying in poop and he/she was making fun of the noises Resident #16 was making.  On 9/18/18 at 10:06 AM, Resident #18 was interviewed and told the surveyor I was so upset with the way he/she was treated.  During an interview with the Director of Nursing on 9/18/18 at 10:36 AM it was revealed, after the facility investigation was completed, the allegation was substantiated for  verbal abuse and neglect. Staff #19 was terminated and reported to the Board of Nursing (BON) on 3/9/18.  **Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.**  >  Based on resident and staff interview and medical record review, it was determined that the facility staff failed to evaluate and update a resident's plan of care. This was evident for 1 (#15) of 3 residents reviewed for accidents. The findings include:  On 9/12/18 at 12:09 PM, during an interview, Resident #15 stated that, while smoking, he/she had dropped a cigarette and burned his/her left leg. On 9/17/18, a review of Resident #15's medical record revealed that, on 8/11/18 at 2:44 PM, in a Change of Condition Evaluation, the nurse documented that the resident had a blister on the front of the thigh and the resident stated he/she burned his/her leg with a cigarette.  Review of Resident #15's care plans revealed a care plan initiated on 11/2/17, Patient may smoke independently per smoking assessment that had the goal Patient will smoke safely x 90 days and the interventions 1) Inform and remind patient of location of smoking area and times, 2) Ensure that appropriate cigarette disposal receptacles are available in smoking  areas and 3) Monitor patients compliance to smoking policy.  Review of Resident #15's medical record failed to reveal documentation that Resident #15's smoking plan of care had been assessed after the resident had burned themselves with a cigarette. The care plan should have been reviewed and the goal and interventions evaluated at that time.  On 9/17/18 at 10:08 AM, during an interview, the Director of Nurses confirmed the above findings. | | | |

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

TITLE (X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99)

Previous Versions Obsolete

Event ID: YL1O11 Facility ID: 215313 If continuation sheet Page 1 of 1

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **215313** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **07/20/2018** |
| NAME OF PROVIDER OF SUPPLIER  **GLADE VALLEY CENTER** | | | STREET ADDRESS, CITY, STATE, ZIP  **56 WEST FREDERICK STREET WALKERSVILLE, MD 21793** | |
| 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 0578  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Some  F 0609  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few  F 0655  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few | **Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\* >  Based on record review and staff interview, it was determined that, for 11 days, the facility staff failed to 1) determine a resident's wishes regarding life sustaining treatment upon admission to the facility 2) have a resident's most recent MOLST in the medical record, and 3) follow the wishes of the surrogate decision maker regarding end of life care. This was evident for 2 (Resident #2, Resident #6) of 6 residents reviewed during a complaint survey. The findings include:  A [NAME]land MOLST (Medical Orders for Life-Sustaining Treatment) form is used for documenting a resident's specific wishes related to life-sustaining treatments. The MOLST form includes medical orders for Emergency Medical Services (EMS) and  other medical personnel regarding cardiopulmonary resuscitation and other life-sustaining treatment options for a specific patient.  1) 2) Resident #6 was admitted to the facility on [DATE]. Resident #6 was admitted to the facility without a MOLST form or a set of advance directives. On [DATE], Resident #6's physician assessed and deemed Resident #6 to have adequate  decision-making capacity, including decisions about life-sustaining treatments. A MOLST form was not completed at this time by Resident #6's physician. On [DATE], the facility nurse practitioner completed a MOLST form with Resident #6 that indicated Resident #6 wanted to be a Full Code, may use intubation and artificial ventilation indefinitely if medically indicated, may give blood [MEDICAL CONDITION], transfer to the hospital for any situation requiring hospital level care, may perform medical tests indicated to diagnose and/or treat a medical condition, may use antibiotics, may give fluids for  artificial hydration as a therapeutic trial, and do not give acute or chronic [MEDICAL TREATMENT]. On [DATE], the completed [DATE] MOLST was the only active MOLST to be found in Resident #6's medical record.  In an interview with the social worker (SW) #1 on [DATE] at 12:40 PM, SW #1 stated that the [DATE] MOLST in Resident #6's chart was not truly valid on [DATE] since the facility nurse practitioner completed a new MOLST form with Resident #6 on [DATE]. SW #1 stated that he/she was unable understand why the [DATE] MOLST was not in Resident #6's chart. SW #1 stated that he/she drew a line thru the [DATE] MOLST on [DATE] and placed the [DATE] MOLST in Resident #6's medical record.  Review  of Resident #6's [DATE] MOLST revealed that: Resident #6 wanted to be a No CPR, option A-2, do not intubate (DNI), Do not use any artificial ventilation, may give blood products, Transfer to the hospital, only perform limited medical tests  necessary for symptomatic treatment or comfort, may use antibiotics, may give fluids for artificial hydration as a  therapeutic trial, and do not give acute or chronic [MEDICAL TREATMENT]. SW #1 stated there was not a physician note or a nurse practitioner note for [DATE] as to why Resident #6's MOLST form was updated.  Review of a physician note, dated [DATE], indicated that Resident #6 was a Full Code which would have been correct, if not  for the [DATE] MOLST form the nurse practitioner completed indicating that Resident #6 was to be a No Code/DNI. On [DATE] and [DATE], Resident #6's physician noted Resident #6 to be a No Code/DNI. This would have been also true, except the staff failed to void and remove the [DATE] MOLST form from Resident #6's medical record on [DATE] when Resident #6 and the facility nurse practitioner completed a new MOLST form.  3) Review of Resident #2's closed medical record on [DATE], revealed a MOLST form, dated [DATE], that was created by Resident #2's physician and Resident #2 surrogate decision maker. The [DATE] MOLST indicated the following: NO CPR, Option B, Palliative and Supportive Care, Do not use any artificial ventilation (no intubation, [MEDICAL CONDITIONS]), Do not give blood products, do not transfer to hospital but treat with options available outside the hospital, Do not perform any  medical tests for [DIAGNOSES REDACTED].  Further review of Resident #2's closed medical record revealed the following physician orders [REDACTED]. [DATE] - X-ray left hand/left wrist/left hip. All results were negative for fracture.  [DATE] - X-ray right ribs and right hip. All results were negative for fracture.  [DATE] - Vitamin D 25 [MEDICATION NAME] Total lab test - 10.8 which was a low reading (,[DATE] ng/dl). [DATE] - Chest X-ray PA/LAT. Result showed changes. Urinalysis and C&S.  [DATE] - CBC and BMP due [DATE] - Results obtained on [DATE]. Urine and culture results were posted on [DATE]. The facility staff failed to honor Resident #2's wishes as evidenced by obtaining laboratory and radiology studies in the presence of a valid [DATE] MOLST that indicated Do not perform any medical tests for [DIAGNOSES REDACTED].  **Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.**  >  Based on review of facility administrative records and staff interview, it was determined that the facility failed to report the results of an investigation of an allegation of abuse within 5 working days as required to the State Survey Agency. This was evident for 1 (Resident #1) of 6 residents reviewed during a complaint survey. The findings include:  During a review of facility reported incident MD 694, which was related to an allegation of abuse involving Resident #1 that occurred on 06/24/18, it was revealed that the facility failed to forward the results of the abuse investigation within 5  days as required. In an interview on 07/17/18 at 1:13 PM, the DON confirmed that the 5 day follow up abuse report was not sent until 07/06/18, and that the delay was caused by a system email problem.  **Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted**  \*\*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 provide a resident with a summary of the baseline care plan and failed to develop a baseline care plan for a resident within 48 hours of admission to the facility. This was evident for 1 (Resident #5) of 6 residents reviewed during a complaint survey. The findings include: 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. | | | |

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

TITLE (X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99)

Previous Versions Obsolete

Event ID: YL1O11 Facility ID: 215313 If continuation sheet Page 1 of 3

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **215313** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **07/20/2018** |
| NAME OF PROVIDER OF SUPPLIER  **GLADE VALLEY CENTER** | | | STREET ADDRESS, CITY, STATE, ZIP  **56 WEST FREDERICK STREET WALKERSVILLE, MD 21793** | |
| 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 0655  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few F 0656  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Some  F 0689  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few  F 0697  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Some  F 0742  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Some | (continued... from page 1)  Review of Resident #5's medical record on 07/19/18 revealed that Resident #5 was admitted to the facility on [DATE]. Review of the medical record failed to reveal documentation that an initial baseline care plan was given to Resident #5 and/or  family within 48 hours of admission.  In an interview on 07/20/18 at 1:00 PM, the DON stated there was no documentation of a base line care plan nor any documentation that Resident #5 received a base line care plan from the facility.  **Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\* >  Based on medical record review and staff interview, it was determined the facility failed to create a plan of care for the use of a disposable heating device for a resident. This was evident for 1 (Resident's #6) of 6 residents reviewed during a complaint survey. The findings include:  In an interview on 07/19/18 at 2:18 PM, the facility activity director stated that he/she answered Resident #6's call light  on 07/18/18 between 9 - 9:30 AM. Resident #6 stated to the activities director that his/her back was hurting and requested a heat pack to help with the pain. The activities director stated that he/she informed Resident #6's nurse of Resident #6's request for a heat pack. The activities director stated that Resident #6's nurse instructed the activities director to go  ahead and get a heat pack for Resident #6. The facility activities director indicated that he/she then went to the unit supply closet, to find that the unit was out of heating packs. The activities director stated that he/she had to go to the next nursing unit to obtain a heating pack. The activities director stated he/she was able to give Resident #6 a heating pack at that time.  Reviews of Resident #6's alteration in comfort care plan failed to reveal any interventions regarding the use of heat therapy for Resident #6. Review of Resident #6's (MONTH) (YEAR) physician orders [REDACTED].#6's back.  In an interview on 07/20/18 at 12:14 PM, the facility DON stated there was not a care plan for the use of a heating device for Resident #6.  Cross Reference F 689  **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 observation, medical record review and staff interview, it was determined the facility failed to 1) ensure that a pressure sensory alarm was functioning for a resident with a history of falls, and 2) obtain a physician order [REDACTED]. This was evident for 2 (Resident's #1, #6) of 6 residents reviewed during a complaint survey. The findings include:   1. During an observation of the facility nursing units on 07/17/18 at 9:45 AM, the surveyor observed Resident #1 sitting in his/her wheelchair. Attached to Resident #1's wheelchair appeared to be a pressure sensory alarm. The wires that were attached to the box like alarm appeared to be frayed and exposed. The surveyor requested assistance from staff member #4 and asked staff member #4 to please check the functionality of the pressure sensory alarm. Staff member #4 was unable to get the alarm to alert staff and determined that Resident #1 had a nonfunctioning pressure sensory alarm. Staff member #4 also stated that the pressure alarm attached to Resident #1's wheelchair was the exact one that staff applied when Resident #1 was in bed. Review of Resident #1's fall prevention care plan revealed nursing interventions that included, but were not limited to: Alarming chair pressure alarm to chair/wheelchair to alert staff members of resident's need to ambulate, bed alarm to bed to alert staff members of resident's need to ambulate. The nursing staff failed to identify a nonfunctioning pressure alarm for Resident #1. 2. In an interview on 07/19/18 at 2:18 PM, the facility activity director stated that he/she answered Resident #6's call light on 07/18/18 between 9 - 9:30 AM. Resident #6 stated to the activities director that his/her back was hurting and requested a heat pack to help with the pain. The activities director stated that he/she informed Resident #6's nurse of Resident #6's request for a heat pack. The activities director stated that Resident #6's nurse instructed the activities director to go ahead and get a heat pack for Resident #6. The facility activities director indicated he/she then went to the unit supply closet to find that the unit was out of heating packs. The activities director stated thathe/she had to go to the next nursing unit to obtain a heating pack. The activities director stated that he/she was able to give Resident #6 a heating pack at that time.   Reviews of Resident #6's alteration in comfort care plan failed to reveal any interventions regarding the use of heat therapy for Resident #6. Review of Resident #6's (MONTH) (YEAR) physician orders [REDACTED].#6's back.  **Provide safe, appropriate pain management for a resident who requires such services.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\* >  Based on review of the medical record and staff interview, it was determined that the facility staff failed to follow a resident's care plan and document a post pain medication administration assessment. This was evident for 1 (Resident #4) of 6 residents reviewed during a complaint survey. The findings include:  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  Resident #4 was admitted to the facility on [DATE]. Review of Resident #4's medical record revealed a physician's orders [REDACTED]. This was an adjustment to Resident #4's pain management. On 05/11/18, the nursing staff initiated an alteration in comfort care plan related to acute pain, chronic pain, at a surgical site. Nursing interventions included: medicate  resident as ordered for pain and monitor for effectiveness, monitor for side effects, and report to the physician as indicated.  Review of Resident #4's (MONTH) (YEAR) Medication Administration Record [REDACTED].  In an interview on 07/20/18 at 12:14 PM, the facility DON confirmed that the staff were not following Resident #4's alteration in comfort care plan by not evaluating a post pain administration assessment on 05/13/18 at 9 PM, 05/14/18 at 8 AM, 05/15/18 at 11:45 AM, 05/16/18 at 5 AM.  **Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\* >  Based on medical record review and staff interviews, it was determined that the facility failed to implement person-centered approaches to care for a resident with a history of visual hallucinations. This was evident for 1 (Resident #1) of 6  residents reviewed during a complaint survey. The findings include:  Review of Resident #1's medical record revealed that Resident #1 was receiving the antipsychotic medication [MEDICATION NAME] for the indication of [MEDICAL CONDITION]. Resident #1 also had a history of [REDACTED].#1 continued to think that birds are attacking him/her. Further record review revealed that the nursing staff developed a care plan to address the  administration of the [MEDICAL CONDITION] drug [MEDICATION NAME], on 05/29/13, which included the following nursing revisions and interventions: the nursing staff shall complete a behavior monitoring flow sheet, monitor for changes in  mental status and functional level and report to the physician as indicated, and monitor for continued need of the medication as related to behavior and mood. Reviews of Resident #1's daily behavior monitoring records for (MONTH) and  (MONTH) (YEAR) failed to reveal the nursing staff were performing person-centered approaches and documenting observations of Resident #1's behaviors and possible side effects on the (MONTH) and (MONTH) (YEAR) behavior monitoring flow sheets. | | | |

FORM CMS-2567(02-99)

Previous Versions Obsolete

Event ID: YL1O11 Facility ID: 215313 If continuation sheet Page 2 of 3

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **215313** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **07/20/2018** |
| NAME OF PROVIDER OF SUPPLIER  **GLADE VALLEY CENTER** | | | STREET ADDRESS, CITY, STATE, ZIP  **56 WEST FREDERICK STREET WALKERSVILLE, MD 21793** | |
| 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 0742  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Some F 0760  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few  F 0773  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few | (continued... from page 2)  In an interview on 07/17/18 at 1:13 PM, the facility DON stated that the nursing staff were to be documenting behaviors daily on the behavior monitoring sheets.  **Ensure that residents are free from significant medication errors.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\* >  Based on complaint, staff interview, and reviews of the facility investigation, it was determined that the facility staff failed to ensure that a resident was free of a significant medication error. This was evident for 1 (Resident #3) of 6 residents reviewed during a complaint survey. The findings include:  Review of complaint MD 620 on 07/18/18 revealed an allegation that Resident #3 received a dose of [MEDICATION NAME], which was the wrong medication, on 05/15/18.  Resident #3 was admitted to the facility on [DATE]. Review of Resident #3's closed medical record on 07/18/18 revealed a physician order, dated 05/12/18, instructing the nursing staff to administer the hypnotic medication,[MEDICATION NAME] mg, orally, as needed at bedtime, for the indication of [MEDICAL CONDITION]. A review of Resident #3's (MONTH) (YEAR) medication administration records revealed that staff nurse #7 administered a dose [MEDICATION NAME] mg orally on 05/16/18 at 1 AM.  In an interview on 07/18/18 at 11:48 AM, staff member #7 stated that he/she administered the narcotic medication, [MEDICATION NAME] IR, 15 mg, orally instead of administering the hypnotic [MEDICATION NAME] mg orally as ordered to Resident #3. Staff member #7 stated that the medication error was identified during the shift change medication count the  morning of 05/16/18. Staff member #7 stated that Resident #3 did not suffer any side effects after receiving the wrong medication.  **Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\* >  Based on medical record review and staff interviews, it was determined the facility failed to ensure that laboratory services were obtained as ordered by a resident's physician. This was evident for 1 (Resident #1) of 6 residents reviewed during a complaint survey. The findings include:  Reviews of Resident #1's medical record on 07/17/18 revealed a physician's orders [REDACTED]. The lab tests were scheduled to be obtained during the months of March, June, September, and December.  In an interview on 07/17/18 at 2:25 PM, the DON confirmed that the facility did not obtain the physician ordered lad work for Resident #1 in (MONTH) (YEAR). The facility must ensure that laboratory tests are obtained as instructed by Resident #1's physician. | | | |

FORM CMS-2567(02-99)

Previous Versions Obsolete

Event ID: YL1O11 Facility ID: 215313 If continuation sheet Page 3 of 3

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **215313** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **01/26/2018** |
| NAME OF PROVIDER OF SUPPLIER  **GLADE VALLEY CENTER** | | | STREET ADDRESS, CITY, STATE, ZIP  **56 WEST FREDERICK STREET WALKERSVILLE, MD 21793** | |
| 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 | **Respond appropriately to all alleged violations.**  >  Based on review of facility documentation and interview with staff, it was determined that the facility failed to have | | | |
| harm or potential for actual | evidence that an alleged violation of abuse was thoroughly investigated. This was evident for 1 (#1) of 5 residents | | | |
| harm  **Residents Affected -** Few | reviewed for abuse. The findings include:  Facility reported incident #MD 087 was investigated on 1/24/18 at 1:24 PM. The facility's report revealed that, on 11/24/17, Resident #1 alleged that a GNA (geriatric nursing assistant) was rough with him/her, yanking the spoon out of his/her mouth while assisting him/her with eating. The Resident indicated that he/she attempted to hit the GNA who then grabbed his/her | | | |
|  | arms. The facility administrator documented in her conclusion of the facility's investigation that the nurse practice | | | |
|  | educator completed a full skin assessment with no marks found on resident. The facility's investigation documentation | | | |
|  | included statements from the accused GNA and another GNA who worked with the resident on the morning of the alleged | | | |
|  | incident. No statements from residents, residents' families, or other staff were obtained to determine if there were | | | |
|  | concerns related to behavior and/or care provided by the accused GNA or if anyone observed inappropriate interaction | | | |
|  | between the resident and the GNA that day. Review of Resident #1's medical record failed to reveal that an assessment of | | | |
|  | the resident for injuries was done immediately after the alleged incident. An assessment note, dated 11/26/17, indicated | | | |
|  | that a skin check was performed and noted previously identified skin injury/wounds - moisture associated skin damage on | | | |
|  | Resident #1's buttocks. The note, which was done 2 days after the date of the incident did not indicate that the assessment | | | |
|  | was done to assess the resident for any injuries related to the alleged incident. No note was found to indicate that an | | | |
|  | assessment had been performed by the Nurse Practice Educator. Cross reference F 842 | | | |
|  | On 1/24/18 at 3:10 PM, the Director of Nursing was made aware of the above findings. | | | |
| F 0725  **Level of harm -** Minimal | **Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.**  > | | | |
| harm or potential for actual | Based on review of facility documentation and interview with staff,+ it was determined that the facility failed to provide | | | |
| harm  **Residents Affected -** Some | sufficient number of staff to meet the needs of the residents by failing to answer call bells in a timely manner. This was evident for2 of 3 units (Sugarloaf and Catoctin) of the facility identified during investigation of anonymous complaint #MD  396. The findings include:  Anonymous complaint #MD 396 was investigated on 1/24/17 at 11:45 AM. The anonymous complainant alleged that call lights were | | | |
|  | not answered in a timely manner. During an interview, on 1/24/18 at approximately 12:30 PM, the DON (director of nursing) | | | |
|  | indicated that call bell response times continued to be an issue and that the facility had hired more staff and education | | | |
|  | had been provided to staff. The DON indicated that the residents had voiced an overall improvement in the response times, | | | |
|  | but that issues remained. When asked how the facility was measuring the response times for the call bells, the DON | | | |
|  | indicated that audits wer being completed of 10% of residents, randomly selected. The audit tool was reviewed and indicated | | | |
|  | that residents on the Sugarloaf and Catoctin units were asked if their call light was answered in a timely manner, or had | | | |
|  | their call light been answered within 20 minutes. The tool defined excessive wait time as greater than 15-20 minutes. | | | |
|  | Audits were conducted on the following dates with the indicated percentages of residents reporting excessive wait times for | | | |
|  | call bells to be answered: | | | |
|  | 7/27/17 60% | | | |
|  | 8/3/17 83% | | | |
|  | 8/6/17 73% | | | |
|  | 8/17/17 82% | | | |
|  | 9/8/17 50% | | | |
|  | 9/21/17 82% | | | |
|  | 10/6/17 33% | | | |
|  | 10/19/17 17% | | | |
|  | 11/3/17 45% | | | |
|  | 11/16/17 64% | | | |
|  | 12/1/17 33% | | | |
|  | 12/8/17 30% | | | |
|  | 12/14 & 15/17 45% | | | |
|  | 12/27/17 27% | | | |
|  | 1/5/18 64% | | | |
|  | The DON further indicated when asked that he call bell system does not have the capability to run an audit of response times | | | |
|  | and that actual observations of call bell response times had not been done. Cross reference F 867. | | | |
| F 0732  **Level of harm -** Minimal | **Post nurse staffing information every day.**  >  Based on surveyor observation and interview with facility staff, it was determined that the facility failed to post accurate | | | |
| harm or potential for actual | staffing information. This was evident for 1(Catoctin) of 3 nursing units observed.The findings include: | | | |
| harm  **Residents Affected -** Few | On 1/25/18 at 7:00 AM, the surveyor observed the posted staffing information on the Catoctin unit. The board listed the licensed and unlicensed nursing staff assigned to each room, however, the date on the board was 1/24/18. Staff #3 was present at that time and confirmed that the posted information was the previous dayshift assignment. Staff #3 was then asked if the previous evening and night shift staffing information had been posted. He/She stated I guess not. | | | |
| F 0842  **Level of harm -** Minimal | **Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.**  > | | | |
| harm or potential for actual | Based on review of facility documentation and interview with staff, it was determined that the facility failed to have | | | |
| harm  **Residents Affected -** Few | complete and accurate medical records by failing to document events, resident assessments and interventions related to a residents' allegation of abuse. This was evident for 1 (#1) of 5 residents reviewed for abuse. The findings include: | | | |

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

TITLE (X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99)

Previous Versions Obsolete

Event ID: YL1O11 Facility ID: 215313 If continuation sheet Page 1 of 2

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **215313** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **01/26/2018** |
| NAME OF PROVIDER OF SUPPLIER  **GLADE VALLEY CENTER** | | | STREET ADDRESS, CITY, STATE, ZIP  **56 WEST FREDERICK STREET WALKERSVILLE, MD 21793** | |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | |
| F 0842  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few  F 0867  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few | (continued... from page 1)  Facility reported incident #MD 087 was reviewed on 1/24/18 at 1:24 PM. The facility's report revealed that on 11/24/17 Resident #1 alleged a GNA (geriatric nursing assistant) was rough with him/her, yanking the spoon out of his/her mouth while assisting him/her with eating. The Resident indicated that he/she attempted to hit the GNA who then grabbed Resident #1s' arms. A statement from the GNA involved indicated that the resident became verbally hostile and threatening, swung at the GNA striking his/her arm and called the GNA derogatory racial names. 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. Review of  Resident #1's care plan indicated that the resident exhibits socially inappropriate behavior such as making demanding and derogatory statements toward staff, accusing staff of theft and occasionally kicking/hitting staff. Further review of the record failed to reveal that a progress note had been written regarding the incident including the residents' allegation,  an assessment for injury, Resident #1's behavior and any interventions that were implemented as a result. On 1/24/18 at 3:10 PM, the Director of Nursing was made aware of the above findings and confirmed that no progress note was found in Resident #1's record related to the incident. Cross reference F 610.  **Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.**  >  Based on Review of facility documentation and interview with staff, it was determined that the facility failed to implement appropriate plans of action to correct identified quality deficiencies related to sufficient nursing staff. This was  evident for 2 of 3 nursing units identified investigation of anonymous complaint #MD 396. The findings include:  Anonymous complaint #MD 396 was investigated on 1/24/17 at 11:45 AM. The anonymous complainant alleged that call lights were not being answered in a timely manner. Review of the facility's previous annual recertification survey conducted (MONTH)  12-16, (YEAR) revealed that the facility was cited for insufficient nursing staff. A plan was developed to correct this deficient practice, identifying a completion date of 7/20/17. During the complaint survey, sufficient nursing staff was again cited due to excessive wait times for call bells to be answered. The facility failed to implement effective quality improvement measures to correct the deficient practice. Cross reference F 725. | | | |

FORM CMS-2567(02-99)

Previous Versions Obsolete

Event ID: YL1O11 Facility ID: 215313 If continuation sheet Page 2 of 2

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **215313** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **06/16/2017** |
| NAME OF PROVIDER OF SUPPLIER  **GLADE VALLEY CENTER** | | | STREET ADDRESS, CITY, STATE, ZIP  **56 WEST FREDERICK STREET WALKERSVILLE, MD 21793** | |
| 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 0244  **Level of harm -** Minimal | **Listen to the resident or family groups or act on their complaints or suggestions.**  >  Based on staff and resident interviews, it was determined that the facility staff failed to respond to grievances from the | | | |
| harm or potential for actual | resident council related to slow call light response times and providing fresh water to residents mid day. This was evident | | | |
| harm  **Residents Affected -** Some | for 3 resident council meetings of 3 meetings reviewed. The findings include:  Interview of Resident #83, on 6/13/17 at 9:30 AM, revealed that grievances brought up by the resident council are not being addressed appropriately. Resident #83 stated the same issues come up each month at the monthly meeting. Review of the | | | |
|  | Resident Council Minutes provided by the facility on 6/14/17 documented the following: | | | |
|  | 3/27/17 under the caption Discussion of Old/Unfinished Business - waters in resident rooms need changed mid day and call | | | |
|  | light respond time in evening is slow. | | | |
|  | 4/27/17 under the caption Discussion of Old/Unfinished Business - waters are not always changed mid day. Then under | | | |
|  | Patient/Resident Requests/Concerns is noted - Call light respond time 3-11 is poor. | | | |
|  | 5/25/17 under the caption Discussion of Old/Unfinished Business - call light respond time 3-11 is poor. | | | |
|  | Resident interviews during stage 1 of the survey process revealed that 7 of 21 residents interviewed had concerns with call | | | |
|  | light response times (#59, #41, #83, #35, #167, #65, #115). | | | |
|  | Interview of the Director of Nursing (DON), on 6/16/17 at 1:30 PM, found they discuss the concerns that the resident council | | | |
|  | brings up in their meetings during the next morning meeting (a facility meeting with department heads). The response to the | | | |
|  | Resident Council's concerns were not evident. The same concerns appeared 3 months in a row with no noted responses or | | | |
|  | rationales provided. The DON, during the interview on 6/16/17 at 1:30 PM, stated that going forward, they would be able to | | | |
|  | demonstrate their response and rationale. | | | |
| F 0253  **Level of harm -** Minimal | **Provide housekeeping and maintenance services.**  >  Based on observations, it was determined that the facility failed to provide housekeeping and maintenance services to keep | | | |
| harm or potential for actual | the residents environment clean and in good repair. This was evident on 2 of 3 nursing units. The findings include: | | | |
| harm  **Residents Affected -** Some | 1. Observation, on 6/13/17 at 12 noon, revealed that the resident bathroom shared by Residents #41 and #66 had several large, (the size of softballs), unpainted areas to the wall in front of one as you enter the bathroom, and the wall to the left as you enter. 2. Observation, on 6/13/17 at 10:15 AM, revealed several areas where the wall was gouged between the 2 dressers the | | | |
|  | televisions sit on, in Resident #43 and #82's bedroom. The areas varied from 1 inch wide by 5 inches long to 1 inch wide | | | |
|  | and 3 inches long. | | | |
|  | 3) Observation, on 6/13/17 at 10:15 AM, revealed gouges in the wall at the head of Resident #82's bed, behind it, and to the | | | |
|  | right, approximately 2 inches wide and 12 inches long. | | | |
|  | 4) Observation, on 6/13/17 at 11:30 AM, revealed in Resident #79's bathroom, to the right as one enters, 2 large areas, the | | | |
|  | size of softballs, spackled and not painted. Also noted, were 1 inch by 10 inch gouges in the wall at the head of Resident | | | |
|  | #79's roommate's bed. | | | |
|  | 5) Observation, on 6/13/17 at 1:50 PM, revealed in resident # 70's bathroom, multiple spackled areas noted to the walls. The | | | |
|  | bathroom floor corners were noted to be dirty. | | | |
|  | 6) Observation, on 6/13/17 at 9:02 AM, revealed in resident #123's bathroom, multiple scrape marks noted on the floor. | | | |
|  | A tour with the Director of Plant Operations, on 6/16/17 at 1:00 PM, confirmed these findings. | | | |
| F 0278  **Level of harm -** Minimal | **Make sure each resident receives an accurate assessment by a qualified health professional.**  > | | | |
| harm or potential for actual | Based on medical record review and staff interview, it was determined the facility staff failed to ensure that Minimum Data | | | |
| harm  **Residents Affected -** Few | Set (MDS) assessments were accurately coded. This was evident for 1 (#137) of 41 residents reviewed during stage 2 of the Quality Indicator Survey.  The findings include:  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. At the end of the MDS assessment the interdisciplinary team develops a plan for the resident to | | | |
|  | obtain optimal care. | | | |
|  | On 6/16/17, review of Resident #137's quarterly MDS with an ARD (Assessment Reference Date) of 5/9/17, Section N, | | | |
|  | Medications, N0419 Medications Received, B Antianxiety, has a zero entered for the number of days received. Review of | | | |
|  | Resident #137's Medication Administration Record [REDACTED]. | | | |
|  | Interview of MDS Coordinator #1, on 6/16/17 at 1:30 PM, confirmed that the 0 entered on the MDS with the ARD of 5/9/17 was | | | |
|  | an error, and would be corrected. | | | |
| F 0279  **Level of harm -** Minimal | **Develop a complete care plan that meets all of a resident's needs, with timetables and actions that can be measured.**  > | | | |
| harm or potential for actual | Based on record review and interviews with family and staff, it was determined that the facility staff failed to develop a | | | |
| harm  **Residents Affected -** Few | plan of care for a resident with a contracture. This was evident for 1 (#80) of 2 residents reviewed for Range of Motion. A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess and evaluate the effectiveness of the resident's care.  The findings include: | | | |
|  | During interview ,on 6/13/17 at 12:04 PM, Licensed Practical Nurse #5 indicated that Resident #80 had bilateral contractures | | | |
|  | (resistance to passive stretch of a muscle) and that he/she refused Range of Motion services or splints. The MDS (Minimum | | | |
|  | Data Set) is a complete assessment of the resident which provides the facility with the information necessary to develop a | | | |
|  | plan of care, provide the appropriate care and services to the resident, and to modify the care plan based on the | | | |

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

TITLE (X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99)

Previous Versions Obsolete

Event ID: YL1O11 Facility ID: 215313 If continuation sheet Page 1 of 4

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **215313** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **06/16/2017** |
| NAME OF PROVIDER OF SUPPLIER  **GLADE VALLEY CENTER** | | | STREET ADDRESS, CITY, STATE, ZIP  **56 WEST FREDERICK STREET WALKERSVILLE, MD 21793** | |
| 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 0279  **Level of harm -** Minimal | (continued... from page 1)  resident's status. Resident #80's Annual MDS with an Assessment Reference Date of 4/27/17, Section G Functional Limitation in Range of Motion, identified that he/she had upper extremity impairment on one side. A review of the resident's plan of | | | |
| harm or potential for actual | care failed to reveal that a plan of care had been developed to identify the care and services that were to be provided to | | | |
| harm  **Residents Affected -** Few | the resident for his/her contracture. Unit Manager #1 was interviewed on 6/15/17 at 3:08 PM, and confirmed that the resident had contractures of his/her right arm and hand. He/She indicated that the resident was receiving hospice services and comfort measures, that his/her overall goal was to achieve maximum comfort and that the resident's family did not want the resident to receive therapy or to use splints. He/She was asked for Resident #80's individualized plan of care which | | | |
|  | reflected the care the resident was to receive and preferences of the resident/family related to his/her contracture. | | | |
|  | He/She indicated that he/she was not able to find one. The facility's Administrator was made aware of these findings on | | | |
|  | 6/16/17 at 4:20 PM. | | | |
| F 0282  **Level of harm -** Minimal | **Provide care by qualified persons according to each resident's written plan of care.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\* >  Based on review of the medical record and staff interview, it was determined that the facility staff failed to follow a | | | |
| harm or potential for actual | resident's care plan by administering antianxiety medication to Resident #137 without adequate indication of use and | | | |
| harm  **Residents Affected -** Few | without adequate monitoring. This was evident for 1 (#137) of 5 residents reviewed for unnecessary medications. The findings include:  Resident #137 had a physician's orders [REDACTED]. Resident #137 had a form for (MONTH) of (YEAR) titled Behavior Monitoring | | | |
|  | and Interventions, noting that anxiety was the behavioral symptom being monitored. There were no documented incidents of | | | |
|  | anxiety on this form. | | | |
|  | Resident #137's MAR (Medication Administration Record) for (MONTH) of (YEAR) revealed that Resident #137 received the as | | | |
|  | needed [MEDICATION NAME] on 26 (5/2/2017 @ 8 PM, 5/3/17 @ 7:30 PM, 5/6/17 @ 8 PM, 5/7 @ 8 PM, 5/8/17 at 8 PM, 5/9/17 | | | |
|  | at 8 | | | |
|  | PM, 5/9/17 at 8 PM, 5/10/17 at 7:30 PM, 5/11/17 at 6:30 AM, 5/11/17 @ 7:30 PM, 5/12/17 at 8 PM, 5/13/17 at 7:30 PM, 5/14/17 | | | |
|  | @8 PM, 5/15/17 @ 8 PM, 5/16/25/17 @ 8 PM, 5/17/17 @ 9 PM, 5/18/17 @8 PM, 5/19/17 @8 PM, 5/21/17 @ 8 PM, 5/22/17 @ 8 | | | |
|  | PM, | | | |
|  | 5/23/17 @ 8 PM, 5/25/17 @ 8 PM, 5/26/17 @ 8 PM, 5/27/17 @ 8 PM, 5/28/17 @ 8 PM, 5/29/17 at 8 PM, 5/30/17 @ 8 PM, 5/31/17 | | | |
|  | @ | | | |
|  | 7:30 PM) of the 31 days in May, and twice on (MONTH) 11th, (YEAR). Of the 27 total doses administered, 8 (5/3/17, 5/8/17, | | | |
|  | 5/9/17, 5/13/17, 5/14/17, 5/16/17, 5/17/17, 5/18/17) had documentation that the medication were effective. Review of the | | | |
|  | progress notes for (MONTH) (YEAR) failed to reveal any information as to why the medication was administered, or its | | | |
|  | effectiveness, for any date that it was administered. Review of Resident #137's care plan (a guide that addresses the | | | |
|  | unique needs of each resident and is used to plan, assess and evaluate the effectiveness of the resident's care) for | | | |
|  | anxiety initiated 11/23/16 and last revised on 5/2/17 lists as an intervention to Medicate resident per physician's orders | | | |
|  | [REDACTED]. Cross reference F 278 and F 282. | | | |
|  | Interview of the Director of Nursing, on 6/16/17 at 11:30 AM, confirmed the findings and no additional information was | | | |
|  | available. | | | |
| F 0309  **Level of harm -** Minimal | **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 administrative record review and interviews with facility staff, it was determined the facility staff 1) Failed to | | | |
| harm or potential for actual | report an incident of a resident being accidentally bumped onto the bed by a GNA (Geriatric Nurse Assistant), 2) Failed to | | | |
| harm  **Residents Affected -** Few | report a resident complaint of pain to the nurse before providing care to the resident and 3) Failed to follow physician's orders [REDACTED]. This was evident for 2 of 10 facility reports reviewed and 1 resident (# 43) complaint during the facility's annual Medicare/Medicaid survey.  Findings include: | | | |
|  | Failed to report an incident of a resident being accidentally bumped onto the bed, by a GNA | | | |
|  | 1) Facility report # MD 886 was reviewed on 6/15/17. The facility's investigation revealed that, on 8/9/16, resident # 9 | | | |
|  | reported to staff that he/she was beat up on the previous night. Staff interviews revealed that resident # 9 was bumped by | | | |
|  | staff when he/she was getting out of bed unattended as GNA # 1 responded to his/her alarm. | | | |
|  | Statement submitted by GNA # 1 on 8/10/16 revealed that he/she heard a sound and found resident # 9 talking by her herself, | | | |
|  | confused and trying to walk. GNA # 1 went to grab the resident and tripped on the pad on the floor. GNA # 1 bumped into | | | |
|  | resident # 9, and the resident fell on to the bed. According to GNA # 1's statement, he/she put resident # 9 back to bed, | | | |
|  | and when he/she returned later to get the resident up, he/she was okay. | | | |
|  | An interview was conducted with the Director of Nursing (DON) and the Nursing Home Administrator (NHA) on 6/15/17 at 2:20 | | | |
|  | PM, and both stated that GNA # 1 did not make the nurse aware of the incident and agreed that the nurse should have been | | | |
|  | notified, and the resident should have been assessed by the nurse. The DON stated the next day following the incident, that | | | |
|  | resident # 9's skin was assessed by staff and was found to have no injuries. Abuse was unsubstantiated. | | | |
|  | Failed to report a resident complaint of pain to the nurse before providing care to the resident. | | | |
|  | 2) Facility report # MD 949 was reviewed on 6/15/17. The facility's investigation revealed that, on 4/14/17, resident # 164 | | | |
|  | stated that GNA # 2 came in to change his/her incontinence pad. Resident # 164 went on to say the GNA did not explain what | | | |
|  | they were doing, grabbed his/her arm to roll over. Resident # 164 further stated that the GNA did not wait when he/she was | | | |
|  | asked to grab the side rail, and felt the GNA was rough. | | | |
|  | Statement submitted by GNA # 2 on 4/14/17 revealed that he/she went into resident room to change him/her. Resident # 164 | | | |
|  | told GNA # 2 not to touch his/her arm because it was hurting. GNA # 2 used the bed pad to roll resident # 164 over so that | | | |
|  | he/she wouldn't be touching the resident arm. GNA # 2 stated that, after changing resident # 164, he/she told the nurse | | | |
|  | about the resident's pain and the nurse gave him/her Tylenol. | | | |
|  | An interview was conducted with the DON and the NHA on 6/15/17 at 2:20 PM to discuss the concerns identified with this | | | |
|  | incident. The DON stated that GNA # 2 should have notified the nurse of the resident's pain and that an assessment should | | | |
|  | have been done, and pain medication provided, before continuing with resident care. Abuse was unsubstantiated. | | | |
|  | The facility failed to follow physician's orders [REDACTED].#43. | | | |
|  | 3) Resident #43 complained to this surveyor, on 6/16/17 at 1:10 PM, that they were catheterized incorrectly on 6/15/17 and | | | |
|  | that they tried to tell the nurse, but she would not listen. A foley catheter is a thin tube inserted through the urethra | | | |
|  | into the bladder for the purpose of urinary drainage. It is held in place with a small balloon that is inflated after | | | |
|  | insertion. Review of physician's orders [REDACTED].#43 had orders for their foley catheter to be irrigated twice a day | | | |
|  | (push a physician ordered solution through the catheter into the bladder to clear the tube) and, as needed (prn) to | | | |
|  | maintain its patency due to sediment, and to change the foley catheter monthly. | | | |
|  | Interview of LPN #4, on 6/19/17 at 1:42 PM, via telephone revealed that she irrigated the foley catheter on 6/15/17 at | | | |
|  | approximately 2 AM at Resident #43's request and 10 minutes later the resident called and stated the catheter had come out. | | | |
|  | LPN #4 continued that she went in room to replace the catheter and grabbed the wrong [MEDICATION NAME]. Resident #43 had a | | | |
|  | physician's orders [REDACTED]. Continued interview of LPN #4 revealed that she had grabbed a solution of [MEDICATION | | | |
|  | NAME], | | | |
|  | not the ordered jel. The [MEDICATION NAME] jel is a thicker substance, like a lubricant with numbing action, and coats the | | | |
|  | beginning portion of the urethra, so that when the foley catheter is inserted and pushed through the jel, it helps to ease | | | |
|  | the discomfort. A [MEDICATION NAME] solution is like water and would not be as effective since it would just run off or out. | | | |
|  | Resident #43 experienced increased pain from the foley catheter insertion due to not using the correct [MEDICATION NAME] | | | |
|  | form. | | | |
| F 0329  **Level of harm -** Minimal | **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\*\* > | | | |
| harm or potential for actual | Based on review of the medical record and staff interview, it was determined that the facility staff administered | | | |
| harm  **Residents Affected -** Some | antianxiety medication to Resident #137 without adequate indication of use and without adequate monitoring. This was evident for 1 (#137) of 5 residents reviewed for unnecessary medications.  The findings include: | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **215313** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **06/16/2017** |
| NAME OF PROVIDER OF SUPPLIER  **GLADE VALLEY CENTER** | | | STREET ADDRESS, CITY, STATE, ZIP  **56 WEST FREDERICK STREET WALKERSVILLE, MD 21793** | |
| 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 0329  **Level of harm -** Minimal | (continued... from page 2)  Resident #137 had a physician's orders [REDACTED]. Resident #137 had a form for (MONTH) of (YEAR), titled Behavior Monitoring and Interventions, noting that anxiety was the behavioral symptom being monitored. There were no documented | | | |
| harm or potential for actual | incidents of anxiety on the form. | | | |
| harm  **Residents Affected -** Some | Resident #137's MAR (Medication Administration Record) for (MONTH) of (YEAR) revealed that Resident #137 received the as needed [MEDICATION NAME] on 26 (5/2/2017 @ 8 PM, 5/3/17 @ 7:30 PM, 5/6/17 @ 8 PM, 5/7 @ 8 PM, 5/8/17 at 8 PM, 5/9/17  at 8  PM, 5/9/17 at 8 PM, 5/10/17 at 7:30 PM, 5/11/17 at 6:30 AM, 5/11/17 @ 7:30 PM, 5/12/17 at 8 PM, 5/13/17 at 7:30 PM, 5/14/17 | | | |
|  | @8 PM, 5/15/17 @ 8 PM, 5/16/25/17 @ 8 PM, 5/17/17 @ 9 PM, 5/18/17 @8 PM, 5/19/17 @8 PM, 5/21/17 @ 8 PM, 5/22/17 @ 8 | | | |
|  | PM, | | | |
|  | 5/23/17 @ 8 PM, 5/25/17 @ 8 PM, 5/26/17 @ 8 PM, 5/27/17 @ 8 PM, 5/28/17 @ 8 PM, 5/29/17 at 8 PM, 5/30/17 @ 8 PM, 5/31/17 | | | |
|  | @ | | | |
|  | 7:30 PM) of the 31 days in (MONTH) and twice on (MONTH) 11th, (YEAR). Of the 27 total doses administered, 8 (5/3/17, | | | |
|  | 5/8/17, 5/9/17, 5/13/17, 5/14/17, 5/16/17, 5/17/17, 5/18/17) had documentation that the medication were effective. Review | | | |
|  | of the progress notes for (MONTH) (YEAR) failed to reveal any information as to why the medication was administered, or its | | | |
|  | effectiveness, for any date that it was administered. Review of Resident #137's care plan (a guide that addresses the | | | |
|  | unique needs of each resident and is used to plan, assess and evaluate the effectiveness of the resident's care) for | | | |
|  | anxiety initiated 11/23/16, and last revised on 5/2/17, lists as an intervention to Medicate resident per physician's | | | |
|  | orders [REDACTED]. Cross reference F 278 and F 282. | | | |
|  | Interview of the Director of Nursing, on 6/16/17 at 11:30 AM, confirmed the findings, and no additional information was | | | |
|  | available. | | | |
| F 0353  **Level of harm -** Minimal | **Have enough nurses to care for every resident in a way that maximizes the resident's well being.**  > | | | |
| harm or potential for actual | Based on interviews with residents, the Ombudsman and facility staff and review of facility documentation, it was determined | | | |
| harm  **Residents Affected -** Some | that the facility failed to ensure that sufficient staff were available to meet resident needs. This was evident for 8 of 21 resident's or 38.1% of residents interviewed during Stage 1 of the survey.  The findings include:  During interviews conducted during Stage 1 of the survey, the residents were asked if they felt there were enough staff | | | |
|  | available to make sure they get the care and assistance they need, without having to wait a long time. | | | |
|  | Resident #65 revealed that,on 6/13/17 at 8:51 AM, they have to wait, whenever they feel like waiting on you they do. | | | |
|  | On 6/13/17 at 9:01 AM, Resident #83 indicated that there was not enough staff available during meals to take residents to | | | |
|  | the bathroom so they have to wait until after meals, that staff would come turn the call lights off, and say they were | | | |
|  | getting help but no one comes. He/She indicated that the facility was short of help in the evenings. | | | |
|  | Resident # 45 indicated, at 10:39 AM on 6/13/17, that some staff didn't want to shower him/her. | | | |
|  | On 6/13/17 at 11:42 AM, Resident #41 indicated that it takes a long time to answer call lights, mostly in the evening. | | | |
|  | Resident #115 indicated that, on 6/13/17 at 2:28 PM they have to wait 1 1/2 hours at times. | | | |
|  | On 6/13/17 at 2:21 PM, Resident #59 revealed that he/she has to wait a long time, especially in the evenings. | | | |
|  | Resident #167 indicated, at 9:22 AM on 6/14/17, -sometimes there are only 3 girls to take care of all of these folks on our | | | |
|  | unit, they need some help. | | | |
|  | On 6/14/17 at 10:42 AM, Resident #35 revealed that sometimes there are only 3 girls for the whole unit .and they really work | | | |
|  | hard it seems they could bring some more in to help, but call outs may be the issue. | | | |
|  | On 6/16/17 at 9:56 AM, the Ombudsman indicated during an interview, that several residents have voiced concerns to him/her | | | |
|  | about not having enough staff on the evening shift. | | | |
|  | A review of the Resident Council meeting minutes on 6/16/17 at at 10:42 AM revealed that concerns were voiced at the | | | |
|  | Resident council meetings held on 3/27/17, 4/27/17 and 5/25/17 about call light response time on evening shift being | | | |
|  | slow/poor. | | | |
|  | The Director of Nursing was made aware of these concerns during an interview on 6/16/17 at 1:26 PM. He/She indicated that | | | |
|  | the call bell system in the facility was not capable of running an electronic audit of response times, and that the call | | | |
|  | bell response time concerns from the Resident Council meeting had been discussed at the general staff meetings. | | | |
|  | Cross reference F 244 | | | |
| F 0356  **Level of harm -** Potential | **Post nurse staffing information/data on a daily basis.**  >  Based on observation and interview with staff, it was determined that the facility staff failed to post accurate nurse | | | |
| for minimal harm  **Residents Affected -** Some | staffing information. This was evident for 3 of 3 nursing units observed during the initial tour of the facility.The findings include:  On 6/12/17, an initial tour of the facility was conducted at 6:00 PM. The surveyor observed the staffing assignment on Sugarloaf unit, posted on a dry erase board. The assignment board did not indicate the shift it represented, or what hours | | | |
|  | the assigned staff were working. LPN (Licensed Practical Nurse) #6 was present and was asked which shift was posted on the | | | |
|  | board. He/She indicated that it was day shift. At 6:05 PM, the surveyor observed the posted staffing assignment board on | | | |
|  | Haven Court unit. This board also did not indicate the shift, nor the hours that the assigned staff were working. At 6:10 | | | |
|  | PM, the surveyor observed the Catoctin Court unit's staffing assignment board. The assignment board failed to reflect the | | | |
|  | shift or the actual hours that the staff were working. LPN #2 was present and was asked which shift the board represented. | | | |
|  | He/She indicated that the posted staff were working both shifts. The Director of Nursing was made aware of the above | | | |
|  | findings on 6/12/17 at 7:55 PM. On 6/13/1,7 the Daily Staffing Sheet for 6/12/17 was reviewed. It reflected that most of | | | |
|  | the staff were working from 7:00 AM - 7:00/7:30 PM, however, 6 of the staff that were listed on the assignment boards at | | | |
|  | 6:00 PM on 6/12/17 were on the Daily Staffing Sheet as working only 7:00 AM - 3:00 or 3:30 PM, including 3 staff on | | | |
|  | Catoctin Court and were not working at 6:00 PM on 6/12/17. The Director of Nursing was made aware of these findings. | | | |
| F 0371  **Level of harm -** Minimal | **Store, cook, and serve food in a safe and clean way**  >  Based on observation and interview during the initial tour, and observation of the main kitchen, it was determined that the | | | |
| harm or potential for actual | facility staff failed to prepare & store foods under sanitary conditions. | | | |
| harm  **Residents Affected -** Few | The findings include:  On 6/12/2017 at 6:20 PM during the initial tour of the main kitchen, it was found that the walk-in freezer was leaking condensate from the bottom of the compressor, 6 inch piles of frozen condensate (6) were forming on card board that the staff has placed under the unit, to keep it from dripping onto the cases of food stored on shelves under the unit. The | | | |
|  | foodservice director stated that many refrigerator people have been called in to try to fix it, but it continues to leak. | | | |
|  | On 6/12/2017 at 6:28 PM during the initial tour of the main kitchen, it was found that the hot side of the cooking bank | | | |
|  | where the ovens, stove and steamer ares located was excessively soiled, with built up food debris on the non-food contact | | | |
|  | surfaces. The areas included sides, tops, back, handles and doors. These areas contained grease and food debris particles. | | | |
|  | In addition, the floors of both the walk-in refrigerator and walk-in were soiled with food debris and spills. | | | |
|  | On 6/12/2017 at 6:30 PM during the initial tour of the main kitchen, it was found that the plastic lids for large clear | | | |
|  | storage containers were found with broken corners, and serving trays used to setup the resident's meal trays, the ones with | | | |
|  | a photo on them, have many with broken damaged corners, at least three dozen were observed. | | | |
|  | On 6/12/2017 at 6:55 PM during the initial tour and observation of the main kitchen, it was found that inverted milk crates | | | |
|  | were being used as storage dunnage racks in the walk-in refrigerator. and crates of Chocolate milk was being store upon | | | |
|  | them. This is not the intended use for milk crates and they are not NSF (National Sanitation Foundation) approved. and | | | |
|  | cannot be easily sanitized. | | | |
|  | On 6/12/2017 at 7:10 PM during the initial tour and observation of the main kitchen. the ice scoop was found in the ice | | | |
|  | machine storage chest. | | | |
|  | The facility staff failed to prepare & store foods under sanitary conditions. | | | |

FORM CMS-2567(02-99)

Previous Versions Obsolete

Event ID: YL1O11 Facility ID: 215313 If continuation sheet Page 3 of 4

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **215313** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **06/16/2017** |
| NAME OF PROVIDER OF SUPPLIER  **GLADE VALLEY CENTER** | | | | STREET ADDRESS, CITY, STATE, ZIP  **56 WEST FREDERICK STREET WALKERSVILLE, MD 21793** | |
| 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 0371 | ( | continued... from page 3)  **Maintain drug records and properly mark/label drugs and other similar products according to accepted professional standards.**  >  Based on surveyor observation and interview with staff, it was determined that the facility staff failed to properly store medications, by leaving a medication cart unlocked while unattended, and failing to properly label medications. This was evident for 1 of 3 medication storage areas observed during medication storage review. The findings include:  On 6/12/17 at 6:25 PM, the surveyor observed a medication cart (a locking cart which contains medications for the residents) located on the Catoctin Unit. The cart was against the front right of the nurses station and had a medication  administration book on it's top, labeled for rooms 217 - 223B, except 219. The lock on the cart was in the unlocked position. The surveyor observed several staff walking past the cart. At 6:35 PM after observing the cart unattended for 10 minutes, the surveyor walked up to the medication cart, opened several drawers and found the following inside the top drawer:  1 - 3 ml (milliliter) vial of Humalog insulin loose in the drawer, the seal was opened. It was not labeled to indicate when it was opened nor to whom it belonged.  1 - 3 ml vial of Humalog insulin in a brown pharmacy jar labeled for Resident #282, it was not dated as to when it was opened.  1 - Levimir Flextouch insulin pen which was not dated when opened, labeled by pharmacy for Resident #114.  1 - Advair HFA inhaler 60 metered doses with 55 doses left on it's counter. The inhaler was labeled for Resident #282 and was not dated when opened.  Licensed Practical Nurse #1 came out of the charting room located behind nurses station at 6:45 PM. He/She was asked which nurse was assigned to the medication cart. He/She indicated that it was him/herself and another nurse, then acknowledged that he/she had left it open and indicated that he/she knew better. He/She was made aware at that time that the medication  cart had been observed opened and unattended since 6:25 PM (20 minutes), and of the unlabeled and undated medications found inside. Failing to properly secure medications places the residents at risk of gaining access to potentially harmful  medications. Failing to properly label medications places the residents at risk of receiving medications of others and of receiving expired medications. The Director of Nursing was made aware of these findings at 7:55 PM on 6/12/17.  **Keep all essential equipment working safely.**  >  Based on observations, interviews with staff during the initial tour and observation of the main kitchen, it was determined that the facility staff failed to maintain all essential mechanical, electrical, equipment in safe operating condition in  the kitchen.  The findings include:  On 6/12/2017 at 6:20 PM during the initial tour of the main kitchen, it was found that the walk-in freezer was leaking condensate from the bottom of the compressor, 6 inch piles of frozen condensate (6) were forming on card board that the staff has placed under the unit to keep it from dripping onto the cases of food stored on shelves under the unit. The foodservice director stated that many refrigerator people have been called in to try to fix it, but it continues to leak.  On 6/12/2017 at 6:22 PM, it was found that the(NAME)steamer was broken, both sides of the unit were removed, and the interior component were exposed. The side of the unit was leaning up against the wall next to it. The foodservice director stated that it had been broken for more than two months, and that they were cooking everything on the stovetop, and in the tilt skillet. The foodservice director also said that the parts were on order.  On 6/16/2017 at 10:15 AM, the director of plant operations was interviewed, and he also stated that several companies have been called out to look at the freezer compressor, but that it was still leaking, and that he also had parts on order for  the steamer.  The facility staff failed to maintain all essential mechanical, electrical, equipment in safe operating condition in the kitchen. | | | |
| **Level of harm -** Minimal harm or potential for actual harm |  |
| **Residents Affected -** Few |  |
| F 0431 |  |
| **Level of harm -** Minimal harm or potential for actual harm |  |
| **Residents Affected -** Few |  |
| F 0456 |  |
| **Level of harm -** Minimal harm or potential for actual harm |  |
| **Residents Affected -** Few |  |

FORM CMS-2567(02-99)

Previous Versions Obsolete

Event ID: YL1O11 Facility ID: 215313 If continuation sheet Page 4 of 4

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **215313** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **07/22/2016** |
| NAME OF PROVIDER OF SUPPLIER  **GLADE VALLEY CENTER** | | | STREET ADDRESS, CITY, STATE, ZIP  **56 WEST FREDERICK STREET WALKERSVILLE, MD 21793** | |
| 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 0253  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Some  F 0278  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few | **Provide housekeeping and maintenance services.**  Based on surveyor observation, it was determined that the facility staff failed to provide housekeeping and maintenance services as necessary to maintain a sanitary, orderly and comfortable homelike environment. This was evident for multiple resident bedrooms and bathrooms observed during stage 1 and 2 of the facility's annual Medicare/Medicaid Survey.The findings include:  An observation was made of Room # 305 on 7/19/16 at 10:45 AM and the following concerns were identified:  In the bathroom along the baseboards was a dark gray colored paint that appeared to have spread onto the floor, as the floor was noted to have dark gray splotches protruding from the baseboards out onto the floor. Walls were noted to have marring present in the bathroom and in the bedroom. Inside of the bathroom, there were two geri sleeves hanging on a rack on the wall, with multiple dried up dark spots noted on them and a large dark spot that was noted on the front of the toilet seat.  The maintenance assistant was made aware on 7/22/16 at 12:15 PM. The following observations were made on the Haven Unit:  In Room H124B on 7/18/16 at 12:23 PM in the bathroom, there were 2 areas on each side of the wall at the entrance where paint was missing.  In Room H105B on 7/18/16 at 1:33:27 PM, there was an area on the wall by the window missing paint and drywall was exposed. In Room H111A on 7/18/16 at 1:34 PM, the entire length of the left and right wall going into the room was marred with black marks and scrapes in the drywall which resulted in missing paint. In the bathroom, the area above the paper towel dispenser  had spackle on the wall and was not painted.  In Room H109B on 7/18/16 at 1:37 PM in the bathroom, there was an area above the paper towel dispenser on the wall that was spackled and not painted.  On 7/19/16, the surveyor observed the following resident rooms:  Room #304 was observed at 9:50 AM the area of the second bed had several holes in the wall board behind and above the head of the resident's bed. The surface of the floor in front of the window around the foot of the second bed was gray.  Room # 306 was observed at 10:00 AM. The first bed in the room had gouges in the floor tile near the foot of the bed. The wall across from the bathroom door was marred. Inside of the bathroom, all walls had marred areas with scrapes into the  drywall. Spackling covered some areas but had not been painted over. The corner of the bathroom across from the doorway had tan drip marks running down the wall. The bathroom floor was sticky and was gray under the sink.  Room #311's bathroom was observed at 10:37 AM. The wall beside the toilet had scrapes into the paint.  Room #302 was observed at 11:37 AM. The wall across from the bathroom door to the right of the closet had a long deep scrape approximately 2 feet long into the drywall. Within the bathroom, all walls were marred, 5 areas below the light switch and paper towel dispenser had spackle but had not been painted. In the walls to the left of the toilet and sink were 5 areas  with patches approximately 1 inch wide and 2-3 inches long with paint missing. The floor surface was gray under the sink, around the toilet and along the walls and was sticky.  Room #313 was observed at 12:17 PM. 3 areas behind the head of the second bed had been spackled but not painted over. Room #317 was observed at 12:34 PM. Scrapes were observed in the wall below the window. The shelf in the nightstand for the second bed was falling down.  The following observations were made:  In the bathroom adjacent to Room #215 on 7/18/16 at 12:02 PM, there were scuff marks on the lower left wall and on the wall next to the sink. There was an area of paint missing on the lower wall next to sink.  In Room #227 on 7/18/16 at 12:45 PM, there was an area with paint missing and exposed wall board on the wall behind Bed A. In the bathroom adjacent to Room #227 on 7/18/16 at 12:55 PM, there were wall scuffs on the front wall and scuff marks on the left wall near the sink. On the left lower wall there was an area, approximately 4 inches in length with paint missing,  and exposed wall board.  In Room #213 on 7/19/16 at 12:24 PM, there were 2 patched, unpainted areas on the wall above Bed B. There was a large scuffed area with paint missing on the wall under the window and to the right of the heater/ac unit. There was a patched, unpainted area on the wall above Bed A. Multiple scuff marks were observed on the bottom of the right wall.  In the bathroom adjacent to Room #213, on 7/19/16 at 12:30 PM, there was a 1 inch scrape with paint missing on the wall next to the sink. There were (3) 1 inch areas with paint missing and exposed dry wall observed on the wall across from the  toilet.  In the bathroom adjacent to Room #219 on 7/19/16 at 1:20 PM, nicks and scuff marks were observed on the lower part of the bathroom walls.  In the bathroom adjacent to Room #223 on 7/19/16 at 2:48 PM, there was an area, approximately 5 inches x 3 inches, with paint missing on the lower part of the wall next to the sink. There were scuffs and scrape marks with missing paint along the lower part of the wall next to the toilet.  In the bathroom adjacent to Room #218 on 7/19/16 at 1:50 PM, there were holes and cracks in the caulk behind the sink. There were scrapes with missing paint located above the baseboard on the wall next to the sink. There were wall scuffs and an  area with paint missing, approximately 3 inches in diameter on the wall next to the door.  In the bathroom adjacent to Room #224 on 7/19/16 at 3:14 PM, there was an area with paint missing, approximately 4 inches by 1 1/2 inches, on the wall near the door, next to the sink. On the lower wall next to the door, there was an area with paint missing, approximately 6 inches in length, that included an area of exposed wallboard. There were (2) 1 inch diameter areas with paint missing on the wall next to the toilet.  In the bathroom adjacent to Room #226 on 7/19/16 at 3:22 PM, there was a scraped area, approximately 10 inches in length with paint missing on the wall across from the toilet.  **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 review of medical record documentation and staff interview, it was determined the facility failed to ensure that  Minimum Data Set (MDS) assessments were accurately coded. These concerns with inaccuracy were evident for 2 of 32 (Resident #11, #191) residents reviewed during stage 2 of the Quality Indicator Survey.The findings include:  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 | | | |

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

TITLE (X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99)

Previous Versions Obsolete

Event ID: YL1O11 Facility ID: 215313 If continuation sheet Page 1 of 3

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **215313** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **07/22/2016** |
| NAME OF PROVIDER OF SUPPLIER  **GLADE VALLEY CENTER** | | | STREET ADDRESS, CITY, STATE, ZIP  **56 WEST FREDERICK STREET WALKERSVILLE, MD 21793** | |
| 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 0278  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few  F 0279  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few  F 0280  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few  F 0371  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Many  F 0387  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Some  F 0431  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few | (continued... from page 1)  identify health problems. At the end of the MDS assessment the interdisciplinary team develops a plan for the resident to obtain optimal care.   1. Review of Resident #11's quarterly MDS with an ARD (assessment reference date) of 6/2/16 J1900A (number of falls since admission/entry or reentry or prior assessment) was coded 0 for no injuries and 1 for injury (except major). Review of the medical record revealed that the resident had 2 falls, 1 fall on 4/24/16 with no injury and 1 fall on 5/19/16 with an   injury. J1900A (fall with no injury) should have been coded 1.  On 7/20/16 at 1:42 PM, the MDS Coordinator confirmed the error.   1. Review of Resident #191's quarterly MDS assessment with an ARD of 7/10/16, Urinary Tract Infection [MEDICAL CONDITION] (last 30 days) was left blank.   Review of Resident #191's medical record revealed urine laboratory results which were positive for a UTI, a physician's progress note dated 7/3/16 which documented the resident's symptoms of urinary burning and frequency and an antibiotic and medication (Cipro and [MEDICATION NAME]) for treatment of [REDACTED].  On 7/21/26 at 3:09 PM, the MDS coordinator confirmed that the UTI should have been coded.  **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 comprehensive care plans for 1 of 5 (Resident #191) residents reviewed for medication administration.  The findings include:  Review of Resident #191's medical record revealed physician progress notes [REDACTED].#191's (MONTH) (YEAR) Medication Administration Record [REDACTED].  There was no care plan that would indicate if further interventions were put in place to help relieve the nausea. On 7/22/16, the Director of Nurses was advised.  **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 that the facility failed to timely update the care plan to reflect the use of a self release alarm seat belt. This was evident for 1 of 3 (Resident #11) residents reviewed for accidents. The findings include:  Review of Resident #11's (MONTH) (YEAR) physician's orders [REDACTED]. The original order was written on 4/28/15. Review of the 5/16/16 progress note stated seatbelt alarm in place, which pt remains noncompliant with. Review of the care plan on  7/21/16 at risk for falls failed to include the use of the seatbelt alarm. Discussed with the Director of Nursing (DON) and  Unit Manager #2 on 7/21/16 at 1:09 PM. On 7/22/16 at 10:10 AM the DON showed the surveyor a previous care plan that was initiated in (MONTH) (YEAR), however the seatbelt was initiated on 4/28/15.  **Store, cook, and serve food in a safe and clean way**  Based on observations and staff interview, it was determined that the facility staff failed to store food under sanitary conditions in the main kitchen. This was evident during the initial tour of the kitchen.  The findings include:  A tour of the facility's kitchen was conducted on 7/18/16 at 8:00 AM.  Observed in the Dry Storage Room were four (4) 1 gallon containers of Lemon Herb Condiment with a use by date of 5/11/16. There were two (2) 1 gallon containers of Fine Red Wine Vinegar with a best used by date of 5/22/16. Dietary Aide #1 was advised of the findings at that time.  In the walk-in refrigerator there was 1 open Liquid Whole Egg 32 ounce carton, not labeled with date opened, and 1 yam was observed on the floor under the left side storage rack.  On a freestanding rack in the walk-in refrigerator there was a tray with 5 plates containing tuna salad, tomatoes and cucumbers covered with plastic wrap, not labeled with a date. There was a tray with nine blue dessert cups containing gelatin with topping, covered loosely with plastic lids, not labeled with a date. There was a tray with 3 sandwiches, 4 salad bowls, 4 cottage cheese, 1 pudding and 3 apple sauces, all not labeled with a date. There was a tray with 19 individual serving size containers of pudding, apple sauce and fruit, not labeled with a date.  In the freestanding refrigerator, located in the center of the kitchen, there were 3 trays of beverages and 4 trays of fruit that were not labeled with a date.  In the main kitchen, there was a 2 foot area of brown spillage observed under the freestanding refrigerator located in the center of the kitchen. The front of the tea and coffee dispensers had areas of corrosion. There was noticeable dust on the utensil rack and the electric cords that were hanging above the food prep table containing uncovered bread rolls.  The kitchen walls and floors were dirty and plastic lids were observed in the floor drain. On 7/18/16 at 8:45 AM the Dietary Manager was made aware.  **Make sure that doctors visit residents regularly, as required.**  Based on medical record review and staff interview, it was determined that the facility failed to have a resident seen by a physician for a required face to face visit, at the minimum of a 60 day interval This was evident for 2 of 6 (Resident #136, #68) residents reviewed on the Haven Unit.  The findings include:   1. During a review of Resident #136's medical record on 7/21/16, it was noted that there was a gap of time, from 9/30/15 to 12/30/15 and from 12/30/15 to 3/16/16, when the resident was not seen by a physician. Unit Manager #2, on 7/21/16 at 12:01 PM, could not determine why the resident was not seen by the physician. 2. Review of Resident #68's medical record revealed that the resident was not seen by a physician from 9/23/15 to 1/27/16 and from 4/13/16 to 7/1316. The resident entered Hospice care on 4/19/16. The Director of Nursing and Unit Manager #2 confirmed the finding on 7/21/16 at 1:00 PM.   **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 surveyor observation and staff interview, it was determined that the facility staff failed to properly store and  label Tuberculin test solution. This was evident in 1 of 2 medication carts observed during the survey. The finding include: On 7/18/16 at 8:15 AM, the surveyor observed the Catoctin D medication cart. Located in the top drawer was a vial of Applied 10 test Mantou PPD (purified protein derivative) solution (solution that is injected under the skin to test for exposure to  [DIAGNOSES REDACTED]). The vial contained a very small amount of the solution - approximately ½ to 1 ml (milliliters). The vial had a hand written date written in blue ink indicating when the vial had been opened. The writing was smudged and the  date was unreadable. A sticker label was on the vial which read refrigerate do not freeze. LPN (licensed practical nurse)  #1 was present and confirmed that the PPD solution was not refrigerated. He/She was also unable to determine the date that the vial had been opened. The DON (director of nursing) and facility administrator were made aware of these findings on 7/20/16 at approximately 2:00 PM. | | | |

FORM CMS-2567(02-99)

Previous Versions Obsolete

Event ID: YL1O11 Facility ID: 215313 If continuation sheet Page 2 of 3

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **215313** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **07/22/2016** |
| NAME OF PROVIDER OF SUPPLIER  **GLADE VALLEY CENTER** | | | STREET ADDRESS, CITY, STATE, ZIP  **56 WEST FREDERICK STREET WALKERSVILLE, MD 21793** | |
| 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 0431  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few F 0441  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Some  F 0456  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Many | (continued... from page 2)  **Have a program that investigates, controls and keeps infection from spreading.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*  Based on observations, it was determined that the facility failed to adhere to infection control practices and guidelines  when administering medications, maintaining resident care equipment and ensuring that a resident bathroom toilet seat was clean. This was evident during observations made of resident rooms and during medication administration observation.The findings include:   1. An observation was made of Room # 305, on 7/19/16 at 10:45 AM, and in the bathroom hanging on a wall rack were a pair of geri sleeve that had multiple dried dark colored stains present and on the toilet seat there was a medium size dark brown   stain located near the front.   1. An observation was made,bx on 7/22/16 at 8:48 AM, while License Practical Nurse (LPN) # 2 administered medications to Resident # 165. LPN # 2 gave Resident # 165 her cup of medications. In doing so, an alcohol prep pad packet fell from her hand onto the floor. LPN # 2 picked the alcohol prep pad packet up from the floor, opened it and used it to wipe the resident's abdomen (stomach) just before giving her an injection of medication per sliding scale for control of her   diabetes . LPN # 2 then gave Resident # 165 her scheduled eyedrops. LPN # 2 did not wash or sanitize her hands and used the alcohol prep pad packet after it had fallen onto the floor.  The Director of Nursing (DON) was made aware on 7/22/16 at 11:00 AM. The facility staff failed to properly store and label resident care equipment.  On 7/19/16 at 10:14 AM, the surveyor observed the resident's bathroom in room [ROOM NUMBER]. On the floor in the corner opposite the door, was a gray unlabeled wash basin on the floor. Inside of the basin was a gray bed pan labeled 213 B . LPN (licensed practical nurse) #2 was interviewed at approximately 10:20 AM in the hallway and indicated when asked that bed pans are not shared, that they should be wrapped in a plastic bag after cleaning, and stored in the resident's bedside  table. He/She observed the wash basin and bedpan and was asked why a bedpan for a resident in 213 B would be in the bathroom for room [ROOM NUMBER]. After looking at a resident record, LPN#2 indicated that one of the resident's in room [ROOM NUMBER] had previously resided in #213 B. The bedpan was not clearly labeled to indicate to whom it belonged.  At 10:38 AM the same day, the surveyor observed the bathroom in room [ROOM NUMBER]. A bedpan, labeled 311 A was on the floor  behind and to the left of the toilet. An unlabeled fracture bedpan (a wedge shaped bedpan) was between the safety grab bar to the right side of the toilet with the open side against the wall. An unlabeled female urinal was on the back of the  toilet. Unit Manager #1 was made aware of the findings in room [ROOM NUMBER] and in room [ROOM NUMBER]'s bathrooms at that  time.  At 10:54 AM on 7/19/16, the surveyor observed the bathroom for room [ROOM NUMBER]. A fracture bed pan was between the safety  grab bar and the wall to the left side of the toilet. Unit Manager #1 was made aware of this finding at that time.  On 7/19/16 at 11:40 AM, room [ROOM NUMBER]'s bathroom was observed with a fracture bedpan lodged between the safety grab bar  and the wall. The opening of the bedpan was against the wall. The bedpan was not labeled as to whom it belonged. Unit Manager #1 was made aware of this additional finding at that time.  The DON (director of nursing) and facility administrator were made aware of these findings on 7/20/16 at approximately 2:00 PM.  Failure to properly label and store the resident's personal care items placed the residents at risk of exposure to potentially harmful organisms from other resident's, the floor or from exposure to unsanitary wall and safety grab bar surfaces.  **Keep all essential equipment working safely.**  Based on observation and staff interview, it was determined that the facility staff failed to maintain all essential mechanical and electrical equipment in safe operating condition in the kitchen.  The findings include:  On 7/18/16 at 9:00 AM, during the initial tour and observation of the main kitchen, it was found that there were small ice formations on the ceiling above the compressor fans and on the door in the walk in freezer.  In the Dry Storage Room, there was 1 inverted milk crate storing boxes of Dinex domes. The drain rack in front of the tea dispenser was bent on the corner.  There was a 1 ½ inch slice in the gasket above the handle and a 2 inch slice in the gasket below the handle of the freestanding refrigerator, located in the center of the kitchen.  The Dietary Manager was made aware of the findings on 7/18/16 at 8:45 AM. | | | |

FORM CMS-2567(02-99)

Previous Versions Obsolete

Event ID: YL1O11 Facility ID: 215313 If continuation sheet Page 3 of 3

\11**G\ane Va\\ 1c ,t l**

* + ... "' **Genesis** HealthCare"'

#### 56 West Frederick Street Walkersville, MD 21793

Tel 301-898-4300

Fax 301-898-4343

###### Ms. Patti Melodini

Health Facili ties Survey Coordinator Long Term Care

Spring Grove Center Bland Bryant Bldg. 55 Wade Avenue

Cat onsvill e, MD 21228-4663

February 11, 2015

,*r --*. *-*

*' I*

I,.

I *l*

I• • -

-: - ;: - \_--,

' , . ·..

* I I

I

I

*I* ' \_'

r '' .

###### Dear Ms. Melodini:

We are enclosing the Amended Plan of Corr ection for the survey conducted on January 30,

2015.

A hard copy will follow by mail.

If you have any quest ion s, please do not hesit ate to give me a call.

Thank You.

Sincerely,



Carole Grisso m, NHA Administrator

STATE OF MARYLAND

DHMH

# Maryland Department of Health and Mental Hygiene

### Office of Health Care Quality

Spring Grove Center • Bland Bryant Building

55 Wade Avenue• C ville, :1W;'Jand 21228-4663

LawrenceJ. Hogan, Jr., Governor w,p'iR lli;-Yot <( Lt.Governor- Van T. Mitchell, Secn:tary

### Ms .Car ole Grissom, Administrator

Glade Valley Center

56 West Frederick Street Walkersville, MD 21793

**PROVIDER# 215313**

**RE:NOTICE OF CURRENT DEFICIENCIES AND POSSIBLE IMPOSmON OF REMEDIES**

Dear Ms. Grissom:

On January 30, 2015, a survey was conducted at your facility by the Office of Health Care Quality to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey was also conducted for the purpose of State licensure. This survey found that your facility was not in substantial compliance with the participation requirements.

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations (C.F.R.), COMAR Title 10, and the State Government Article.

1. PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within 10 days after the facility receives its Form CMS 2567. Failure to submit an acceptable PoC within the above time frames may result in the imposition of a civil money penalty twenty (20) days after the duedate for submission of the PoC.

Your PoC must contain the following:

* + What corrective action will be accomplished for those residents found to have been affected by the deficient practice;
  + How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;

Toll Free l-877-4MD-DHMH - TI Y/MarylandRelay Service 1-800-735-2258 Web Site: [www.dhmh.maryland.gov](http://www.dhmh.maryland.gov/)

* + What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
  + How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place and;
  + Specific date when the corrective action will be completed.
  + References to a resident(s) by Resident # only as noted in the previously supplied Resident Roster. This applies to the PoC as well as any attachments to the PoC. It is

un-acceptable to include a resident(s) name in these documents since the documents are released to the public.

1. -IMPOSITION OF REMEDIES

The following remedies will be recommended for imposition by the Center for Medicare and Medicaid Services (CMS) Regional Office if your facility has failed to achieve substantial compliance by March 16, 2015. Informal dispute resolution for the cited deficiencies will not delay the imposition of the enforcement actions recommended on this date. A change in the seriousness of the noncompliance may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

If you do not achieve substantial compliance within 3 months after the last day of the survey (i.e.April 30, 2015 ) identifying non-compliance, we must deny payments for new admissions. (§488.417(a)) Also, if the denial of payment for new admissions sanction is imposed, your facility is prohibited from operating a nurse aide training program for two years from the last day of the survey. (§483.151)

If your facility has failed to achieve substantial compliance by July 30, 2015, your Medicare provider agreement will be terminated.

Ill. ALLEGATION OF COMPLIANCE

If you believe.that the deficiencies identified in the CMS form 2567 have been corrected, you may contact me at the Office of Health Care Quality, Spring Grove Center, Bland Bryant Building, 55 Wade Avenue,Catonsville, Maryland 21228 with your written credible allegation of compliance **(i.e. attached lists of attendance at provided training and/or revised statements of policies/procedures and/\_or staffing patterns with revisions or additions).**

If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance **and credible evidence** of your allegation of compliance until substantiated by a revisit or other means. In such a case, the previously proposed remedy(ies) will not be imposed at that time.

## If, upon the subsequent revisit, your facility has not achie ved substantial compliance, we may impose remedies previously mentioned in this letter beginning January 30, 2015 and will continue until substantial compliance is achieved. Additionally, we may impose a revised remedy(ies), based on changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

1. INFORMAL DISPUTE RESOLUTION

In accordance with §488.331, you have oneopportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request, along with the specific deficiency(ies) being disputed, and an explanation of why you are disputing those deficiencies, to Dr. Patricia Tomsko Nay, Executive Director, Office of Health Care Quality, Bland Bryant Building, Spring Grove Center, 55 Wade Avenue, Catonsville, Maryland 21228, fax 410-402-8234. This request must be sent during the same 10 days you have for submitting a PoC for the cited deficiencies. An incomplete infonnal dispute resolution process will not delay the effective date of any enforcement action. ·

1. LICENSURE ACTION

As you are aware, the cited Federal deficiencies have a counter part in State regulations. These deficiencies are cited on the enclosed State Form. Please provide a plan of correction for these deficiencies within IO days of receipt of this letter. In the event a revisit determines that substantial compliance has not been achieved, appropriate administrative action may be taken against your State license.

If you have any questions concerning the instructions contained in this letter, please contact me at 410-402-8201 or fax 410-402-8234.

Sincerely,

*r?JJ1-lbJ :*

## Patti Melodini

Health Facilities Survey Coordinator Long Tenn Care

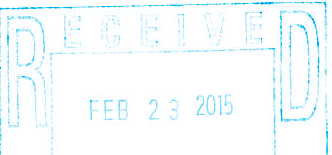
Enclosures: CMS 2567

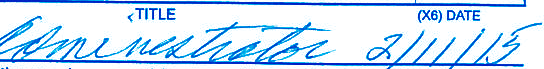
State Fonn

cc: Alice Hedt Jane Sacco

File II

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  **215313** | (X2) MULTIPLE CONSTRUCTION  A. BUILDIN\_G \_ \_ \_ \_ \_ \_ \_  B. WIN\_G \_ \_ \_ \_ \_ \_ \_ \_ \_ | | | (X3) DATE SURVEY COMPLETED  C  **01/30/2015** | |
| NAME OF PROVIDER OR SUPPLIER  **GLADE VALLEY CENTER** | | | | STREET ADDRESS, CITY, STATE, Z.IP CODE  **56 WEST FREDERICK STREET**  **WALKERSVILLE, MD 21793** | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACHDEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | IO PREFIX TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCEDTO THE APPROPRIATE DEFICIENCY) | | (XS )  COMPLETION DATE |
| F 000  F225  **SS=E** | INITIAL COMMENTS  On January 30, 2015 an investigation was conducted at this facility, by the Office of Health Care Quality, of two facility reported incidents MD00088651 and MD00088600 and one complaint MD00088650. Survey activities consisted of a review of residents' medical records, facility documentation and interviews of the facility staff, residents and family members.  The following deficiencies are a result of the investigation.  483.13(c)(1)(ii)-(iii), (c)(2) - **(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS**  The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for ervice as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.  The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency}.  The facility must have evidence that all alleged | | F 000  F225 | | - - - - - - · J  \_l.\_\_  Resident# 3, 4, *5,* 6, 7, and 8 had no bad outcome from thisdeficient practice  No other residents affected  Administrator, Director of Nursing, Social Worker and Unit Manager will review concerns of allegations of abuse, neglect, injuries of unknown origin, and misappropriation of property and will report this to the state.  The concerns from the previous month will be review in Quality Assurance meeting monthly for three months. | |  |
| March 16 |



Any deficiency statement ending with an asterisk (•) denotes a deficiency which the institution may be excused from correcting providing it is etenni d 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID : H VWE11 Facility ID: 10015 If continuation sheet **Page** 1 of 4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

**GLADE VALLEY CENTER**

(X1) PROVlDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

**215313**

(X2) MUL TIPLE CONSTRUCTION

A . BUILDING

B.WING

STREET ADDRESS, CITY, STATE, ZIP CODE 56 WEST FREDERICK STREET WALKERSVLI LE, MD 21793

(X3) DATE SURVEY COMPLETED

C

**01/30/2015**

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDEDBY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE

CROSS-REFERENCEDTO THE APPROPRIATE

DEFICIENCY)

(X5) COMPLETION DATE

###### F 225 Continued From page 1

violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:

Based on review of facility documents and staff interview, it was determined that the facility staff failed to notify the State survey and certification agency of allegations of abuse for 6 of 8 residents (#3, #4, #5, #6, #7 and #8) reviewed for allegations of abuse.

The findings include:

1. Review of the G rievance/ConcernForm log book, on 1/20/15, revealed that resident #3 reported to facility staff on 9/12/14 that- GNA (geriatric nursing assistant) ws very mea n and

F225

rough wit.h and flung round. The facility

had documentation that they investigated the incident. However, the facility failed to report this allegation of abuse to the State survey and certification agency.

1. Review of the Grievance /Concern Form log book, on 1/20/15, revealed that resident #6's dau hter reportedto facility staff on 8/4/14, that

.... . her ad told her someone had poked-

FORM CMS-2567(02-99) Previous Ve1Sions Obsoleel

Event ID:HVWE11 Facility ID: 10015 If continuation sheet Page 2 of 4

###### CENTERS FOR MEDICARE & MEDICAID SERVICES 0MB NO 0938-039·

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

**GLADE VALLEY CENTER**

()(1) PROVIDER/SUPPLIER/CUA IDENTIFICAITON NUMBER:

**215313**

(X2) MULTIPLE CONSTRUCTION

1. BUILDING \_
2. **WING \_**

STREET ADDRESS, CITY, STATE, ZIP CODE **56 WEST FREDERICK STREET WALKERSVILLE, MO 21793**

**()**DATE SURVEY COMPLETED

C

**01/30/2015**

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BYFULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE

CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY)

(X51 COMPLETION DATE

F 225 Continued From page 2 in the eyes and pinche.d

on the arm , and that

###### F225

it wasn't the first time this had happened. The

facility had documentation that they investigated the incident. However, the facility failed to report this allegation of abuse to the State survey and certification agency.

1. Review of the Grievance/Concern Form log book, on 1/20/15, revealed that resident #7 reported to thil'lity, on5/23/14, that - aide would not give ater when sked - that would make go to the bathroom again. Resident #7 told the aide. could not wipe
   * and the aide took arm and tried to get ipe Resident#7, according to the

Grievance/Concern Form showed staff bruising **onlllfinge rs .** The facility had documentation that they investigated the incident. However, the facility failed to report this allegation of abuse to the State survey and certification agency.

1. Review of the Grievance/ConcernForm log book, on 1/20/15, revealed that resident #4. reported to facility staff, on th.at.a staff member was rough during care with- shoulder and peri area. The facility had documentation that they did an inservice regarding proper transfer techniques . However, the facility failed to report this allegation of abuse to the State survey and certification agency.
2. Review of the Grievance/Concern Form log book, on 1/20/15, revealed that resident #5 reported to facility staff on 7/9/14 that

Ill

wanted to tell me something, patient stated that

* + was almost raped last night." The facility had documentation that they investigated the incident. However, the facility failed to report this allegation

FORMCMS-2567(D2-99) Previous versions Obsolete Eve nt ID:HVWE11 Facility ID:10015 If continuation sheet Page 3 of 4

CENTERS FOR MEDICARE & MEDICAID SERVICES 0MB NO 0938-0391

STATEMENT OF DEFIC IENCIES

**ANDPLAN**OF CORRECTION

(X1) PROVDI ER/SUPPLIER/CUA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

1. BULI DING

()(3) DATE SURVEY

COMPLETED

##### C

NAME OF PROVIDER OR SUPPLIER

GLADE VALLEY CENTER

**215313**

. NG I

STREET ADDRESS, CITY, STATE, ZIP CODE

56 WEST FREDERICK STREET

WALKERSVlLLE, MD 21793

**01/30/2015**

**(X4)** ID PREF IX TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYINGINFORMATION)

ID PREFIX TAG

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE

C R O SS-R EFE RENCED TO THE APPROPRIATE DEFICIENCY)

(X5)

COMPLETION

DATE

F 225 Continued From page 3

of abuse to the State survey and certification agency.

1. Review of the Grievance/Concern Form log book on 1/20/15 revealed that resident #8 reported to facility staff on 5/8/14 that "resident concerned with attitude/response of **GNA.,**

was left on BSC (bedside commode) without call light." The facility had documentation that they investigated the incident. However the facility failed to report this allegation of neglect to the State survey and certification agency.

Interview of the Director of Nursing, on 1/31115 at 1:30PM, revealed that they investigate any allegation made by residents, but had not reported the incidents since their investigation determined that abuse had not occurred. Review of the facility policy on abuse, page 3 under the title PROCESS number 6 states "Upon receiving information concerning a report of suspected or alleged abuse, the Administrator or designee will :

6.1 Report the alleged abuse to the OHCQ/Long Term Care Unit within 24 hours." This is the State survey and certification agency which was not notified of the above allegations.

F 225

FORM CMS-2567(02-99P) revious Versions Obsolete Event ID: HVWE11 Facility 10: 10015 If continuation sheet Page 4 of 4

###### Office of Health Care Qualit\

STATEMENT OF DEFICIENCIES ANO PLANOF CORRECTION

(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION-NUMBER:

**215313**

(X2) MULTIPLE CONSTRUCTION

A.BUI LD I NG: \_

1. WING

(X3) DATE SURVEY COMPLETED

C

**01/30/2015**

NAME OF PROVIDER OR SUPPLIER

GLADE VALLEY CENTER

STREET ADDRESS. CITY, STATE, ZIP CODE

**56 WEST FREDERICK STREET WALKERSVILLE, MD 21793**

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE

CROSS-REFERENCED TOTHE APPROPRIATE

DEFICIENCY)

(XS) COMPLETE DATE

###### S ooo 10.07.02 Initial comments

On January 30, 2015 an investigation was conducted at this facility, by the Office of Health Care Quality, of two facility reported incidents MD00088651 and MD00088600 and one complaint MD00088650. Survey activities consisted of a review of residents' medical records, facility documentation and interviews of the facility staff, residents and family members.

The following deficiencies are a result of the investigation.

S000

S6310 10.07.09.15 AAbuse;Policies/Procedures

.15 Abuse of Residents.

A A nursing facility shall develop and implement policies and procedures prohibiting abuse and neglect of residents.

This Regulation is not met as evidenced by: Refer to CMS 2567

F 225

S6322 10.07.09.15 C (1) (b) Abuse;Report to Dept

.15 Abuse of Residents.

1. Reports of Abuse.

(1) A person who believes that a resident has been abused shall promptly report the alleged abuse to the:

1. Licensing and Certification Administration within the Department; or

S6310

S6322

j SeeF225

##### See F225

###### March 16

March 16

OHCQ

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'SSIGNATURE TITLE (XS) DATE

STATE FORM HVWE11 If continuation sheet 1 of 2

Office of Health Care Qualiti

STATEMENT OF DEFICIENCIES AND PLANOF CORRECTION

(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:

**215313**

(X2) MULTIPLE CONSTRUCTION

A. BUILDING: \_

B. W I NG \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

(X3) DATE SURVEY COMPLETED

##### C

**01/30/2015**

NAME OF PROVIDER OR SUPPLIER

**GLADE VALLEY CENTER**

STREETADDRESS, CITY, STATE, ZIP CODE

56 WEST FREDERICK STREET WALKERSVILLE, MD 21793

**(X4)** ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATOI N)

ID PREFIX TAG

PROVIDER'S PLANOF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE

CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETE DATE

##### S6322 Continued From page 1

Thi s Regulation is not met as evidenced by: Refer to CMS 2567

F225

S6322

S6324 10.07.09.15 C (1) (c) Abuse; Report to Office on S6324 Aging

.15 Abuse of Residents.

C. Reports of Abuse.

(1) A person who believes that a resident has been abused shall promptly report the alleged abuse to the:

1. The Office on Aging.

See F225 **March 16**

##### This Regulation is not met as evidenced by: Refer to CMS 2567

F225

OHCQ

STATE **FORM** HVWE11 If continuation sheet 2 of 2

:I]: **Glade Valley Center**

* + • **Gen esis** HealthCare·

#### 56 West Frederick Street Walkersville, MD 21793

Tel 301-898-4300

Fax 30l-898-4343

###### Ir-

I j \ 11

I\ ] '

. l '. ·

' '

I ! •,

-·-- ,. -- . ....,-

1 JUL - 7 2015

###### July 06, 2015

Ms. Patti Melodini

Health Facilities Survey Coord inator Long Term Care

Spring Grove Center

Bland Bryant Bldg.

55 Wade Avenue

Catonsville, MD 21228-4663 Dear M s. Melodini:

We are enclosing the Plan of Correction for the survey conducted on June 08-12, 2015.

If you have any questions, please do not hesitate to give me a call.

Thank You.

Sincerely,



Paula Boyer Director Of Nursing

STATE OF MARYLAND

DHMH

# Maryland Department of Health and Mental Hygiene

*Larry Hogan, Governor* - *Boyd Rutherford, Lt. Governor* - *Van Mitchell, Secre*

## June 24, 2015

Ms. Carole Grissom, Administrator

Glade Valley Center

56 West Frederick Street Walkersville, MD 21793

**PROVIDER# 215313**

**RE:NOTICE OF CURRENT DEFICIENCIES AND POSSIBLE IMPOSITION OF REMEDIES**

## Dear Ms. Grissom:

On June 8, 9, 10, 11 and 12, 2015, a QIS Medicare/ Medicaid recertification survey was conducted at your facility by the Office of Health Care Quality to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey was also conducted for the purpose of State licensure. This survey found that your facility was not in substantial compliance with the participation requirements.

All references to regulatory requirements contained in this letter are found in Title 42; Code of Federal Regulations (€.F.R.), COMAR Title 10, and the State Government Article.

1. PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within 10 days after the facility receives its Form CMS 2567. Failure to submit an acceptable PoC within the above time frames may result in the imposition of a civil money penalty twenty (20) days after the due date for

submi sion of the PoC.

Your PoC must contain the following:

What corrective action will be accomplished for those residents found to have been affected by the deficient practice;

How you will identify other residents having the potential to be affected by the same

\_ deficient practice and what corrective action will be taken;

201 W. Preston Street-Baltimore, Maryland 21201

Toll Free 1-S77-4MD-DHMH-1TY/Maryland Relay Service 1-800-735-2258

Web Site: [www.dhmh.maryland.gov](http://www.dhmh.maryland.gov/)

What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place and;

Specific date when the corrective action will be completed.

References to a resident(s) by Resident# only as noted in the previously suppliedResident Roster. This applies to the PoC as well as any attachments to the PoC. It is un-acceptable to include a resident(s) name in these documents since the documents are released to the public.

1. IMPOSITION OF REMEDIES

The following remedies will be recommended for imposition by the Center for Medicare and Medicaid Services (CMS) Regional Office if your facility has failed to achieve substantial compliance by July 27, 2015. Informal dispute resolution for the cited deficiencies will not delay the imposition of the enforcement actions recommended on this date. A change in the seriousness of the noncompliance may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

If you do not achieve substantial compliance within 3 months after the last day of the survey (i.e.September 12, 2Q.15) identifying non-compliance, we must deny payments for new admissions. (§488.417(a)) Also, if the denial of payment for new admissions sanction is imposed, your facility is prohibited from operating nurse aide training program for two years from the last day of the survey. (§483.151)

a

If your facility has failed to achieve substantial compliance by December 12, 2015, your Medicare provider agreement will be tenn inated.

Ill. ALLEGATION OF COMPLIANCE

If you believe that the deficiencies identified in the CMS form 2567 have been corrected, you may contact me at the Office of Health Care Quality, Spring Grove Center, Bland Bryant Building, 55 Wade Avenue, Catonsville, Maryland 21228 with your written credible allegation of compliance **(i.e. attached lists of attendance at provided training and/or revised statements of policies/procedures and/or staffing patterns with revisions or additions).**

## If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance **and credible evidence** of your allegation of compliance until substantiated by a revisit or other means. In such a case, the previously proposed remedy(ies)

will

not be imposed at that time.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we may impose remedies previously mentioned in this letter beginning June 12, 2015 and will continue until substantial compliance is achieved. Additionally, we may impose a revised remedy(ies), based on changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

1. INFORMAL DISPUTE RESOLUTION

In accordance with §488.331, you have one opportunity to question cited deficiencies through an infonnal dispute resolution process. To be given such an opportunity, you are required to send your written request, along with the specific deficiency(ies) being disputed, and an explanation of why you are disputing those deficiencies, to Ms. Margie Heald, Deputy Director, Office of Health Care Quality, Bland Bryant Building, Spring Grove Center, 55 Wade Avenue, Catonsville, Maryland 21228, fax 410-402-8234. This request must be sent during the same 10 days you have for submitting a PoC for the cited deficiencies. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

1. LICENSURE ACTION

As you are aware, the cited Federal deficiencies have a counter part in State regulations. These deficiencies are cited on the enclosed State Form. Please provide a plan of correction for these deficiencies within 10 days of receipt of this letter.In the event a revisit determines that substantial compliance has not been achieved, appropriate administrative action may be taken against your State licen e. ·

If you have any questions concerning the instructions contained in this letter, please contact me at 410-402-8201 or fax 410-402-8234.

Sincerely,

·

Patti Melodini

Health Facilities Survey Coordinator Long Term Care

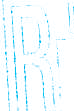
Enclosures: CMS 2567

State Form

cc: Alice Hedt Jane Sacco

File II

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| STATEMENT OF DEFICIENCIES AND PlAN OFCORRECTION | | (X1) PROVIDER/SUPPLIERICLIA IDENTIFICATION NUMBER:  **215313** | (X2} MULTIPLE CONSTRUCTION  A. BUILDING  8WING | | | (X3) DATE SURVEY COMPLETED  C  **06/12/2015** | |
| NAME OF PROVIDER OR SUPPLIER  **GLADE VALLEY CENTER** | | | | STREET ADDRESS, CITY, STATE, ZIP CODE  56 WEST FREDERICK STREET  **WALKERSVILLE, MD 21793** | | | |
| {X4} ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGUlATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | | PROVIDER'S PlANOFCORRECTION (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (XS) COMPLETION DATE |
| F 000  F 253  SS=E | INITIAL COMMENTS  On June 8, 9, 10 and 11, 2015 an annual Medicare/MedicaidQuality Indicator Survey was conducted at this facility which has 124 licensed beds and a census of 117 by the Office of Health Care Quality. Survey activities consisted of a review of 70 medical records in Stage 1, interviews with residents, families, facility staff and the ombudsman as well as observations of residents and staff practices. Administrative reports, facility policies and procedures were revi wed as well.  As a part of this survey in Stage 2, Facility Reported Incidents MD00090681, MD00090286, MD00089979 and MD00089181 were  investigated.  There were no deficiencies as a result of the investigation of the Facility Reported Incidents.  The following deficieicies are a result of the Stage 2 investigation of 35 resident record **reviews.**  483 .15(h)(2) HOUSEKEEPING &  **MAINTENANCE SERVICES**  The facility must provide housekeeping and maintenance services necessary to maintain a  :aritary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by:  Based on surveyor observation, it was determined that the facility staff failed to provide services for a a sanitary, orderly, and comfortable interior by failing to maintain: 1) a counter top, 2) | | F 000  F253 | | ., I ---;-.: - \ Ir-:-·\-\·\  -, I 'I  ,  1: l I  JUL - 7 2015 *' :*  \  I ·-. i ,1\' \_ \_j  \ (·.,I· ·, , , .  i  L - -  In Haven unit shower room the counter top between the 2 storage cabinets has been ordered and will be replaced when received. The missing ceramic tiles in the shower stall, have been replaced, grouted and cleaned. The *1* hand held shower bracket was replaced. 'IJle 1 wire brackets for the shampoo and body wash were also replaced.  The missing plaster in room #306, 303, 307  and 308 has been repaired. . The damage veneer on the beds in room #3081 has been replaced. | | July 24 |

LABORATORY ECTOR'S ORPROVIDER/SUPPLIERREPRESENTATIVE'S SIGNATURE TITLE (X6)DATE

*J/* - - *0 t r e c.1-,,... a J\_* ,{/ Lf, 'J ,;\_ ,- 7 / *l./ 1,;-*

Any deficienc!y statement endingwith an asterisk (•) denotes a deficiency which the institution may be excused from correcting proviaing 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 provide<!. 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 8G5011 Facility ID: 10015 If continuation sheet Page 1 of 8

!

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:  **215313** | (X2) MULTIPLE CONSTRUCTION  A. BUILDING | | | (X3) DATE SURVEY COMPLETED  C  **06/12/2015** | |
| B. WING | |  |
| NAME OF PROVIDER OR SUPPLIER  GLADE VALLEY CENTER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE  **56 WEST FREDERICK** STRE.ET  **WALKERSVILLE, MD 21793** | | | |
| (X4) ID PREFIX TAG | SUMMARY $TATEM.ENT OF DEFICIENCIES (EACHDEFICIENCY MUST BE PRECEDED BY FULL REGULATORYOR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCEDTO THE APPROPRIATE DEFICIENCY) | | (XS) COMPLETION DATE |
| f 253 | Continued From page 1  ceramic wall and floor tiles, 3) a h\_and held shower head bracket, 4) wall brackets for shampoo/body wash, 5) intact interior wall surfaces and 6) resident beds.  This was evident in 1 of 1 shower rooms and 4 of 33 resident rooms observed during stage 1 of the survey.  The findings include:  During an initial tour of the facility on 6/8/15 at 9:25 AM, the surveyor observed the shower room on the Haven unit.   1. Along the back wall of the room was a counter top which extended approximately 6 feet between two storage cabinets. The counter had chipped and missing veneer along the entire front top edge exposing the underlying particle board. 2. In the right side shower stall the surveyor observed that the grout between the wall tiles, in the back right corner of the shower, near the floor, was dark in places, and appeared to be missing in places. T ere was1 wall tile approximately 4 inches by 4 inches just above the floor that was loose from the wall and leaning into the shower. The juncture of the floor and wall tiles below the privacy curtains between the 2 shower stalls had a build up of a tan substance approximately 12 inches long, the underlying grout was dark and appeared to be missing in places.   J) The hand held shower head, in the right side shower stall, was observed to be laying on a safety grab bar. The adjustable wall bracket appeared to be broken.  4) In both shower stalls were wall mounted wire brackets which contained 1 gallon pump containers labeled shampoo/body wash. Both wire brackets appeared damp and covered with dark brown corrosion. | | F 253 | | Housekeeping staff and nursing staff have | |  |
| been re inserviced on reporting all needed  repairs to maintenance during the morning and evening clinical rounds or using the "maintenance book" placed at each nursing station '  i  Maintenanc·e Director/Designee will conduct I monthly rounds to check if any repairs are needed. Findings will be reported at the monthly Quality Assurance Meeting for a  period of 3 months | | |
|  | |  |
|  |

I

i

I

'

. FORM CMS-2567(02-99) Previous Versions Obsolete Event ID:8G5011 FacilityID: 10015 If continuation sheet Page 2 of 8

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVlDER/SUPPLIER/CUA IDENTIFICATIONNUMBER:  **215313** | (X2) MULTIPLE CONSTRUCTION (   1. BUILDING 2. WING | | | )DATE SURVEY COMPLETED  C  **06/12/2015** | |
| NAME OF PROVIDER OR SUPPLIER  **GLADE VALLEY CENTER** | | | | STREETADDRESS, CITY, STAT,E ZIP CODE  **56 WEST FREDERICK STREET**  **WALKERSVILLE, MD 21793** | | | |
| **(X4)** ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUSTBE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYINGINFORMATION) | | 10  PREFIX TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE |
| F 253  F 278 | Continued From page 2   1. On 6/8/15 at 2:20 PM, the surveyor observed room 306. The wall corner to the right of the bathroom entrance had plaster missing about 1 foot long along the edge exposing the underlying metal. There were deep horizontal scuffs into the drywall located on the wall between the wardrobe and dresser for bed A. A hole was observed in the drywall approximately 2 inches wide and 6 inches long located approximately 2 feet to the left of the heating/Air conditioning unit. Inside the bathroom, the wall directly across from the bathroom door had deep scuffs breaking the surface of the drywall.   Room 303 was observed on 6/9/15 at 8:54 AM.  The wallto the left of thebathroom door had an area approximately 1 foot long at the bottom of the wall that was missing plaster exposing the underlying metal strip.  Room 307 was observed on 6/9/15 at 9:17 AM. The corner of the wall to the right of the bathroom door had an area approximately 1 inch wide by 3 inches long, near th€ bottom of the wall, that was missing plaster. The underlying metal strip was exposed.  Room 308 was observed on 6/9/15 at 10:02 AM. The corner of the wall to the left of the bathroom door was observed to be missing plaster over an area approximately 1 foot long, exposing the underlying metal strip.   1. During the same observation of room 308, both beds were observed to have veneer peeling off the *t9p* and side edges of the foot boards exposing particle board.   On 6/11/15 at 4:17 PM, a tour was conducted with the Maintenance Director who was made aware of the above findings.  483.20(g) - U) ASSESSMENT | | f 253  F278 | |  | |  |

FORM CMS-2567(02-99) Previous Versions Obsolele Event IO:BG5011 Facility ID: 10015 If continuation sheet Page 3 of 8

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  **215313** | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  BWING | | | (X3) DATE SURVEY COMPLETED  C  **06/12/2015** | |
| NAME OF PROVIDER OR SUPPLIER  **GLADE VALLEY CENTER** | | | | STREET ADDRESS, CITY,STATE, ZIP CODE  **56 WESTFREDERICK** STREET  **WALKERSVILLE, MD 21793** | | | |
| (X4)ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | | PROVIDER'S PLAN Of CORRECTION (EACHCORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | **{X5)** COMPLETION DATE |
| F 278  SS=D | Continued From page 3  **ACCURACY/COORDINATION/CERTIFIED**  The assessment must accurately reflect the resident's status.  A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.  A registered nurse must sign and certify that the assessment is completed.  Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.  Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and fal e statement in a resident assessment is subject to a civil money penalty of not more than  $1,000 for each assessment; or an individual who willfully and knowingly causes another individual  to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.  Clinical disagreement does not constitute a material and false statement.  This REQUIREMENT is not met as evidenced by:-  Based on medical record review and interviews with facility staff, it was determined the facility · failed to accurately document MOS coding for 1 of 35 residents reviewed during stage 2 of the survey.  Findings include: | | F278 | | There were no negative outcome for resident #4. The section Hof the MOS has been coded accurately and a correction was submitted  Section Hof the MDS's was audited to check for accuracy of coding prior to transmission  Education on section H using the RAI manual | | July24 |
| was provided to the nursing staff including the: MOS coordinator.  Director ofNursing/Designee will audit section Hof the MOS prior to transmission to check for accuracy of coding. Findings will be reported at the Monthly Quality Assurance  Meeting for a period of 3 months ·1 | | |
|  | |  |

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID; BG5011 Facility ID: 10015 If continuation sheet Page 4 of 8

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  **215313** B | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  WING \_ \_ \_ \_ \_ \_ \_ \_ \_ | | | (X3) DATE SURVEY COMPLETED  C  **06/12/2015** | |
| NAME OF PROVIDER OR SUPPLIER  **GLADE VALLEY CENTER** | | | | STREET ADDRESS, CITY, STATE, ZIP CODE  66 WEST FREDERICK STREET WALKERSVILLE, MD 21793 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUSTBE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE |
| F 278  F 280 SS=D | Continued From page 4  The MOS (Minimum Data Set) is a complete assessment of the resident which provides the facility with the information necessary to develop a plan of care, provide the appropriate care and services to the resident, and to modify the care plan based on the resident's status.  A review of the MOS for resident # 4 was done on 6/11/15 at 8:45 AM. Upon review, resident# 4 was coded (2) frequently incontinent on the 5 day admission assessment on On the 90 day assessment done on 4/15/15, the resident was coded a (3) always incontinent.  An interview was conducted with MOS Coordinator# 2 on 6/11/15 at 9:20 AM. She stated that she coded the resident incorrectly and will submit a correction.  The Director of Nursing was made aware on 6/11/15 at 11:30 AM.  483.20(d)(3), 483.10(k)(2) RIGHT TO  PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care planmust be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's | | F 278  F 280 | | Resident #110 no longer resides at the facility An audit was conducted on residents with I  pressure ulcers to verify that a care plan was in place. 1  I  Nursing staff and the Wound Nurse were , educated on the care plan process including I  placing in the medical record\_!\_care plan for actual skin breakdown as  appropriate based on the resident skin condition | | July 24 ! |

FORM CMS-2567(02-99)Previous Versions Obsolete Event ID:8G5011 Facility ID: 10015 If con tinuation sheet Page 5 of 8

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X 1) PROVIDER/SUPPLIERICLIA IDENTIFICATION NUMBER:  **215313** | (X2) MULTIPLE CONSTRUCT ION   1. BUILDING \_ \_ \_ \_ \_ \_ \_ \_ 2. WING | | | (X3) DATE SURVEY COMPLETED  C  **06/12/2015** | |
| NAMEOF PROVIDER OR SUPPLIER  **GLADE VALLEY CENTER** | | | | STREET ADDRESS. CITY, STATE. ZIP CODE  56 WEST FREDERICK STREET  WALKERSVILLE, MD 21793 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE  CROS-S REFERENCEDTOTHE APPROPRIATE DEFICIENCY) | | (X5)  COMPLETION  DATE |
| F 280 | Continued From page 5  legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.  This REQUIREMENT is not met as evidenced by:  Based on medical record review and interviews with facility staff, it was determined the facility staff failed to update a care plan for a resident with a pressure ulcer. This was evident for 1 (#  110) of 2 residents reviewed for pressure ulcers. Findings include;  A review of resident# 11O's careplan was done on 6/10/15 at 11:30 AM. The care plan was initiated on 3/26/15 and revealed that resident# 110 was at risk of skin breakdown.  An interview was conducted with MOS (Minimum Data Set) Coordinater # 1 on 6/10/15 at 2:00 PM. MOS Coordinator #1 stated that resident #110 had a stage 2 pressure area **tollllright** buttock. She submitted a copy of a nurse progress note dated 4/5/15, and a skin integrity sheet to the surveyor.  Review of the nurse progress note dated - indicated that resident# 110 was noted to have stage 2 pressure ulcer to - right buttock.  Further review of resident #11O's careplan revealed that the resident did not have a care plan in place for a right buttock pressure ulcer. During another interview with MOS Coordinator# 1 on 6/11/15 at 9:45 AM, it was revealed that a care plan was not initiated for resident # 11O's right buttock pressure ulcer.  The Director of Nursing was made aware on 6/11/15 at 10:30 AM. | | F 280 | | Director ofNursing/Designee will conduct audit on resident with pressure ulcer to check if a care plan is in place. Findings will be reported at the Monthly Quality Assurance Meeting for a period of3 months | |  |

FORMCMS-2567(02-99)Previous Versions Obsolete Event ID:8G5O11 Facilily ID: 10015 If continuation sheet Page 6 of 8

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| STATEMENT OF DEFICIENCIES AND PlANOFCORRECTION | | (X1) PROVlOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  **215313** | (X2 ) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | | (X3) DATE SURVEY COMPLETED  C  **06/12/2015** | |
| NAME OF PROVIDER OR SUPPLIER  **GLADE VALLEY CENTER** | | | | STREET ADDRESS, CITY, STAT, E ZIP CODE  **56 WEST FREDERICK STREET**  **WALKERSVILLE, MD 21793** | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY) | | (XS) COMPLETOI N DATE |
| F 431  SS=D | 483.60(b), (d), (e) DRUG RECORDS, LABELJSTORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when  appli ble.  In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permi1"nly authorized personnel to have access to the keys.  The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit Rackage drug distribution systems in which the quantity stored is minimal and a missing dose can be .readily detected.  This REQUIREMENT is not met as evidenced  **by:**  Based on observations during an initial tour of | | F 431 | | The Gabapentin bottle and the insulin **vials**  were immediately discarded and replac\_ed  Medicine rooms cabinets and refrigerators from the 3 units were checked for any expired drugs none were found  Nursing staff received education on checking expiration dates on medications including expiration dates on Insulin  Director ofNursing/Designee will conduct random rounds in the medicine rooms to check for compliance. . Findings will be reported at the Monthly Quality Assurance Meeting for a period of 3 months | | July 24 |

FORM CMS-2567(02-99) Previous Versions Obsolete Event I0 :8G5011 Facility ID: 10015 If continuation sheet Page 7 of 8

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| STATEMENT OF DEFICIENCIES AND PlANOFCORRECTION | | (X1} PROVlDER/SUPPLIER/CLIA IDENTIFICATIONNUMBER:  **215313** | **(X2}** MULTIPLE CONSTRUCTION  A. BUILDING  **B. WING \_ \_ \_ \_ \_ \_ \_ \_ \_** | | | **(X3}** DATE SURVEY COMPLETED  **C**  **06/12/2015** | |
| NAME OF PROVIDER OR SUPPLIER  **GLADE VALLEY CENTER** | | | | STREET ADDRESS, CITY,STATE, ZIP CODE  **56 WEST FREDERICK STREET**  **WALKERSVILLE, MD 21793** | | | |
| **(X4)** ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | | PROVIDER'S PLANOF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY) | | (XS) COMPLETION DATE |
| F 431 | Continued From page 7  the facility, it was determined the facility staff failed to discard expired medications. This was evident for 1 of 3 medication storag-e rooms and 2 of 3 medication carts observed.  Findings include:  A tour of the facility was conducted on 6/8/15 at 9:05 AM, and the following concerns were identified: Inside of the medication storage room refrigerator on the Catoctin Unit, there was a bottle of Gabapentin Solution 250 mg (milligram) for resident # 41,with an expiration date of 5/20/15 on the bottle. Unit Manager# 1 was made aware on 6/8/15 at 9:20 AM, and it was removed.  Inside of the medication cart on the Sugarloaf Unit, there was a bottle of Humalog 10 ml (milliliter) for resident# 51 with an expiration date of 6/6/15. LPN# 1 wasmade aware on 6/8/15 at 9:40 AM, and it was removed.  Inside of the medication cart on the Haven Unit, there was a bottle ofiLantus for resident # 56 with an expiration date of 5/14/15. LPN# 2 was made aware on 6/8/15 at 10:00 AM and it was removed. | | F 431 | |  | |  |

FORM CMS-2567(02•99} Previous Versions Obsolete Event ID: 8G5011 Facliity ID: 10015 If continuation sheet Page 8 of 8

Office of Health Care Qualih1

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| STATEMENT OF DEFICIENCIES AND PLANOF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  **215313** | {X2) MULTIPLE CONSTRUCTION   1. BUILDING: \_ 2. WING | | (X3) DATE SURVEY COMPLETED  C  **06/12/2015** | |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE  **56 WEST FREDERICK STREET**  **GLADE VALLEY CENTER WALKERSVILLE, MD 21793** | | | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLANOF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (XS) COMPLETE DATE |
| s ooo  s 510 | 10.07.02 Initial comments  On June 8, 9, 10 and 11, 2015 an annual Medicare/Medicaid Quality Indicator Survey was conducted at this facility which has 124 licensed beds and a census of 117 by the Office of Health Care Quality. Survey activities consisted of a review of 70 medical records in Stage 1, interviews with residents, families, facility staff and the ombudsman as well as observations of residents and staff practices. Administrative reports, facility policies and procedures were reviewed as well.  As a part of this survey in Stage 2, Facility Reported Incidents MD00090681, MD00090286, MD.00089979 and MD00089181 were  investigated.  There were no deficiencies as a result of the investigation of the Facility Reported Incidents.  The following deficiE'ij'lcies are a result of the Stage 2 investigation of 35 resident record reviews.  10. 07.02.12 Q Nsg Svcs;Charge Nurse  .12 Nursing Services.  Q. Charge Nurse. At least one licensed nurse shall be on duty at all times and shall be  designated by the director of nursing to be in charge of the nursing activities during each tour  of duty. The charge nurse or nurses shall have the ability to recognize significant changes in the condition of patients and to take necessary action. | | S000  S 510 | See F431 | | July 24 |

ECTOR'$ OR PROVIDER/SUPPLIER REPRESENTAilVE'SSIGNATURE

*D,r-ec./---...,...\_*

TITLE

6 *L u* L.*r .s* .,,...

(X6)0ATE

*7/l,ltr*

8G5011 Ir continuation sheet 1 of 4

###### Office of Health Care Qualit11

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| STATcMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATIONNUMBER:  **215313** | (X2) MULTIPLE CONSTRUCTION  A.BUI LDI NG:  BWING | | | (X3) DATE SURVEY COMPLETED  C  **06/12/2015** | |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIPCODE  **GLADE VALLEY CENTER** 56 WEST FREDERICK STREET  **WALKERSVILLE, MD 21793** | | | | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCEDTO THE APPROPRIATE DEFICIENCY) | | | (X5) COMPLETE DATE |
| s 510 | Continued From page 1 | | **S510** |  |  | |  |
|  | This Regulation is not met as evidenced by: Refer to CMS 2567 Form  F-431 | |  |  |  | |  |
| s 512 | 10.07.02.12 R Nsg Svcs; Charge Nurse Daily Rounds | | **S 512** |  |  | |  |
|  | .12 Nursing Services. | |  | SeeF431 |  | | July24 |
|  | R. Charge Nurses' Daily Rounds. The charge nurse or nurses shall make daily rounds to all nursing units for which responsible, performing such functions as:   1. Visiting each patient; 2. Reviewing clinical records, medication orders, patient care plans, and staff assignments; 3. To the degree possible, accompanying physicians when visiting patients. | |  |  |  | |  |
|  | This Regulation is r\Pt met as evidenced by: Refer to CMS 2567 Form  F-431 | |  |  |  | |  |
| S1652 | 10.07.02 .34 B (1) Hskpg pest ctrl, laundry;cleanliness | | S1652 |  |  | |  |
|  | .34 Housekeeping Services, Pest Control, and Laundry. | |  | * See F253 | I  ! | | July24 I |
|  | B. Cleanliness and Maintenance. The following shall be'observed: | |  |  |  | |  |
|  | (1) The building and all its parts and facilities shall be kept in good repair, neat and attractive. The safety and comfort of the patients shall be the first consideration. | |  |  |  | |  |

OHCQ

STATE FORM 8G5011 If continuationsheet 2 of 4

Office of Health Care Qualitv

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVlOER/SUPPLIER/CLIA IDENTIFICATIONNUMBER:  **215313** | (X2) MULTIPLE CONSTRUCTION  A BUILDING: \_  B. WING \_ \_ \_ \_ \_ \_ \_ \_ \_ | | (X3) DATE SURVEY COMPLETED  C  **06/12/2015** | |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE  **GLADE VALLEY CENTER 56 WEST FREDERICK STREET WALKERSVILLE, MD 21793** | | | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACHDEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (XS) COMPLETE DATE |
| s1652 | Continued From page 2 | | **S1652** |  |  |  |
|  | Agency Note: Refer to Regulation .26S of this chapter for window screening requirements. | |  |  |  |  |
|  | This Regulation is not met as evidenced by: Refer to CMS 2567  F-253 | |  |  |  |  |
| S1686 | 10.07.02.36 D Resident Status Assessment; assessments | | S1686 |  |  |  |
|  | .36 Resident Status Assessment. | |  | See F278 |  | July24 |
|  | D. The facility shall complete all assessments in accordance with the provisions of 42 CFR  §§483.20 and 413.343. | |  |  |  |  |
|  | **C** | |  |  |  |  |
|  | This Regulation is not met as evidenced by: Refer to CMS 2567 Form  F-278 | |  |  |  |  |
| S1740 | 10.07.02.37 F Care Planning;updates at least quarterly | | **S1740** | See **F280** | , | )uly 24 |
|  | -?,7 Care Planning. | |  |  |  |  |
|  | F. Disciplines shall update the care plans as the resident's assessment warrants, but not less than quarterly. | |  |  |  |  |
|  | This Regulation is not met as evidenced by: Refer to CMS 2567 Form  F-280 | |  |  |  |  |

OHCQ

STATE FORM 8G5011 If continuatoi n sheet 3 of 4

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Office of Health Care Qualit\ | |  | | | | |
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIOERISUPPLIER/CLIA IDENTIFICATION NUMBER:  **215313** | (X2) MULTIPLE CONSTRUCTION  A BUILDING: \_  B. WING | | (X3) DATE SURVEY COMPLETED  C  **06/12/2015** | |
| NAMEOF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE  **GLADE VALLEY CENTER 56 WEST FREDERICK STREET WALKERSVILLE, MD 21793** | | | | | | |
| **(X4)** ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BYFULL REGULATORY OR LSCIDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVEACTION SHOULD BE  CROSS-REFERENCED TOTHEAPPROPRIATE DEFICIENCY) | | (XS) COMPLETE DATE |
|  |  | |  |  | |  |

OHCQ

STATE FORM 8G5011 rr continuation sheet 4 of 4

(Tags:  Trial Attorney, nursing home lawyer, Maryland nursing home attorney, overmedication, medication error, pressure sores, bed sores, falls, attorney handling medication errors, nursing home abuse attorney, assisted living attorney, assisted living accidents, dehydration, malnutrition, 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, hip fracture, Maryland abuse attorney, nursing home neglect and abuse