**FOIA Data Base** - The Law Office of Jeffrey Downey, serving clients in Washington D.C., Virginia and Maryland

##### If you have been injured in a nursing home or assisted living facility, call the law office of Jeffrey J. Downey for a free consultation.

Phone: 703-564-7318; email: [jdowney@jeffdowney.com](mailto:jdowney@jeffdowney.com)

Forestville Health and Rehabilitation

7420 Marlboro Pike, Forestville, MD 20747

**Characteristics:**

* A For Profit Corporate Nursing Facility with 160 beds
* [www.communicarehealth.com](http://www.communicarehealth.com/)
* Legal Business Name – Marlboro Leasing Co., LLC
* As of August 2019, Medicare has listed Forestville Health and Rehabilitation Center as a Four-Star Facility

**Researching Nursing Homes**

## A note by attorney Jeffrey J. Downey:

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

The Maryland Department of Health inspects nursing homes including the Forestville Health and Rehabilitation Center in Forestville, MD. Periodically they do inspections as complaint surveys which should be public record.

##### I am interested in any additional information you may have on this facility. Please call me with any question about this or any other facility you may be interested in searching or prosecuting civilly for patient neglect or abuse.

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

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

2) Fax : 410-402-8179

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

Having already researched Forestville Health and Rehabilitation in Forestville, MD and obtained FOIA responses, I am posting these statements of deficiencies here, in a searchable format. Keep in mind that these surveys have been altered during the conversion process and you should update your search results.

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

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **215020** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **07/24/2018** |
| NAME OF PROVIDER OF SUPPLIER  **FORESTVILLE HEALTH & REHABILITATION CENTER** | | | STREET ADDRESS, CITY, STATE, ZIP  **7420 MARLBORO PIKE**  **FORESTVILLE, MD 20747** | |
| 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 0573  **Level of harm -** Potential for minimal harm  **Residents Affected -** Some  F 0686  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few  F 0693  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few  F 0756  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few | **Let each resident or the resident's legal representative access or purchase copies of all the resident's records.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\* >  Based on interview of facility staff it was determined the facility failed to provide Resident #2's representative with a  copy of the resident's medical record in a timely manner. This was evident for 1 of 3 sampled residents selected for review. The findings include:  Resident #2 was admitted to the facility on [DATE] for rehabilitation. The resident expired at the facility on [DATE].  On [DATE] the Office of Health Care Quality received a complaint from Resident #2's representative alleging that an authorization form for the release of Resident #2's medical records was submitted to the facility on [DATE]. On [DATE] the complainant alleged that he/she spoke with Staff #1 regarding the medical record request and was told the medical record would be sent. The complainant/resident's representative alleged that after multiple messages were left for Staff #2, on [DATE], Staff #2 informed the complainant/resident's representative that the medical record request would need to be referred to the facility's legal team.  On [DATE] the Nursing Home Administrator advised the surveyor that a request for Resident #2's medical record was made in (MONTH) (YEAR), and the medical records were sent to the resident's representative on [DATE].  **Provide appropriate pressure ulcer care and prevent new ulcers from developing.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\* >  Based on medical record review it was determined the facility staff failed to document an assessment of a pressure sore and failed to promptly initiate the treatment of [REDACTED].#1. This was evident for 1 of 3 sampled residents selected for review.  The findings include:  Resident #1 was readmitted to the facility on [DATE] after a hospitalization .  The resident's medical record was reviewed on (MONTH) 20, (YEAR), (MONTH) 23, (YEAR) and (MONTH) 24, (YEAR).  Review of the Skin Grid Pressure, an assessment tool for pressure sores utilized by the facility, dated 12/31/17, revealed that the resident had a stage 3 sacral pressure sore that measured 1 cm x 0.5 cm x 0.3 cm with pink granulation tissue and  a small amount of exudate that was present on readmission to the facility on [DATE]. However, there was not a documented assessment of the pressure sore on 12/24/17.  Review of the Treatment Administration Record revealed that a treatment to the sacral pressure sore was not initiated until 1/3/18, 9 days after the resident was readmitted to the facility.  **Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\* >  Based on medical record review it was determined the facility staff failed to ensure that Resident #1, who was dependent on a gastrostomy tube for nutrition and hydration, received adequate water flushes to prevent dehydration. This was evident in 1 of 3 sampled residents selected for review.  The findings include:  Resident #3 was admitted to the facility in (MONTH) (YEAR). The resident had a gastrostomy tube for the administration of nutrition and hydration. A gastrostomy tube is a flexible tube, surgically inserted through the abdomen, that delivers nutrition and hydration directly to the stomach.  The resident's medical record was reviewed on (MONTH) 20, (YEAR), (MONTH) 23, (YEAR) and (MONTH) 24, (YEAR).  Medical record review revealed that the resident was readmitted to the facility on [DATE] after a hospitalization . Review of the hospital progress notes, dated 12/22/17, revealed that the resident's tube feeding should be slowly titrated up to a goal rate of 65 ml. per hour.  Medical record review revealed that the resident's admission tube feeding orders were Glucerna 1.5 via gastrostomy tube at 50 ml. per hour x 18 hours which provided 1,350 calories and water flushes of 250 ml. every 6 hours. There was not a physician's orders [REDACTED]. per hour.  Medical record review revealed that on 12/30/17 the Dietitian completed the resident's nutritional assessment. Based on the resident's weight of 156.6 pounds, the Dietitian recommended Glucerna 1.5 65 ml. per hour x 18 hours and water flushes of 220 ml. of water every 4 hours.  A physician's orders [REDACTED].  Review of the Medication Administration Record [REDACTED]. of water every 4 hours.  Medical record review revealed that the resident was readmitted to the facility on [DATE] after a hospitalization .  Medical record review revealed that the resident's weight on 3/7/18 was 148.2 pounds (67 kg.). The resident's admission tube feeding orders were Glucerna 1.2 60 ml. per hour x 11 hours and water flushes of 150 ml. every 6 hours. Based on the resident's weight of 148.2 pounds (67 kg.), the resident's fluid requirement was 2,010 ml. of water per day (30 ml/kg.).  The tube feeding order provided the resident with a total of 1,131 ml. of water per day which was significantly less than the resident's water requirement based on the resident's weight of 148.2 pounds (67 kg.).  Medical record review revealed that on 3/12/18 the resident's weight was 144.8 pounds. The resident had lost 3.4 pounds (2.3% of body weight) over 5 days, which is suggestive of fluid loss. Additionally, laboratory blood work on 3/12/18 revealed that the resident's BUN/creatinine ratio was 41.1. The normal range is 8.0 - 25.0. An elevated BUN/creatinine ratio is suggestive of dehydration.  Medical record review revealed that on 3/12/18 the Dietitian completed the resident's nutritional assessment. Based on the assessment, the Dietitian determined that the resident's tube feeding was not meeting the resident's nutritional or  hydration needs. The resident's tube feeding was increased to Glucerna 1.5 at 65 ml. per hour x 18 hours and water flushes were increased to 75 ml. per hour x 18 hours which provided the resident with a total of 2,238 ml. of water per day.  From 3/7/18 through 3/12 18 the resident had a water deficit of approximately 879 ml. per day.  **Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.** | | | |

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

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **215020** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **07/24/2018** |
| NAME OF PROVIDER OF SUPPLIER  **FORESTVILLE HEALTH & REHABILITATION CENTER** | | | STREET ADDRESS, CITY, STATE, ZIP  **7420 MARLBORO PIKE**  **FORESTVILLE, MD 20747** | |
| 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 0757  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few | (continued... from page 1)  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\* >  Based on medical record review it was determined the facility staff failed to promptly respond to the consultant pharmacist's recommendations related to drug irregularities for Resident #1. This was evident for 1 of 3 sampled residents selected for review.  The findings include:  Resident #1 was readmitted to the facility on [DATE] after a hospitalization .  The resident's medical record was reviewed on (MONTH) 20, (YEAR), (MONTH) 23, (YEAR) and (MONTH) 24, (YEAR). Medical record review revealed that on 1/24/18 the consultant pharmacist reviewed the resident's medication regimen. The following recommendations were made to the physician:  1. This [AGE] year old resident has an order for [REDACTED]. the extended-release product, [MEDICATION NAME] ER ([MEDICATION  NAME] XL). Only the extended-release product has been approved for the treatment of [REDACTED]. The immediate-release [MEDICATION NAME] in elderly for the treatment of [REDACTED].  (1) Given the increased risk to this resident, please discontinue the immediate-release [MEDICATION NAME] 10mg. capsule. (2) As this resident has a [DEVICE], and the extended-release [MEDICATION NAME] ER tablet can NOT be crushed, an alternative calcium channel blocker, such as [MEDICATION NAME], is recommended.  The physician did not address the pharmacist's recommendation until 2/18/18 at which time the physician agreed with the recommendation, however, failed to discontinue the medication. On 2/22/18 the consultant pharmacist documented that the recommendation was resubmitted to the physician.  However, review of the Medication Administration Record [REDACTED]., 3 capsules every 12 hours through 3/2/18, at which time the resident was discharged to the hospital.   1. Resident has an order for [REDACTED]. To avoid confusion re: 'remove per schedule', please clarify order to include exactly when the [MEDICATION NAME] is to be removed.   The physician did not address the pharmacist's recommendation until 2/21/18 at which time the physician agreed with the recommendation.  However, review of the (MONTH) (YEAR) and (MONTH) (YEAR) MAR indicated [REDACTED].M., but was not being removed at bedtime  through 3/2/18, at which time the resident was discharged to the hospital.   1. This [AGE] year old resident has an order for [REDACTED].g. dyskinesias, hallucinations, drowsiness, tremor, and restlessness). The risk for IRREVERSIBLE tardive dyskinesias is significantly increased when used in older individuals.   Please consider discontinuing [MEDICATION NAME]. Alternative therapy, such a proton pump inhibitor - which is actually the preferential treatment for [REDACTED].  The physician did not address the pharmacist's recommendation until 2/21/18 at which time the physician agreed with the recommendation to discontinue the medication.  However, review of the MAR indicated [REDACTED].  **Ensure each resident’s drug regimen must be free from unnecessary drugs.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\* >  Based on medical record review it was determined the facility staff failed to ensure that Resident #1's drug regimen was free from unnecessary medications. This was evident for 1 of 3 sampled resident selected for review.  The findings include:  Based on medical record review it was determined the facility staff failed to promptly respond to the consultant pharmacist's recommendations related to drug irregularities for Resident #1. This was evident for 1 of 3 sampled residents selected for review.  The findings include:  Resident #1 was readmitted to the facility on [DATE] after a hospitalization .  The resident's medical record was reviewed on (MONTH) 20, (YEAR), (MONTH) 23, (YEAR) and (MONTH) 24, (YEAR). Medical record review revealed that on 1/24/18 the consultant pharmacist reviewed the resident's medication regimen. The following recommendations were made to the physician:  1. This [AGE] year old resident has an order for [REDACTED]. the extended-release product, [MEDICATION NAME] ER ([MEDICATION  NAME] XL). Only the extended-release product has been approved for the treatment of [REDACTED]. The immediate-release [MEDICATION NAME] in elderly for the treatment of [REDACTED].  (1) Given the increased risk to this resident, please discontinue the immediate-release [MEDICATION NAME] 10mg. capsule. (2) As this resident has a [DEVICE], and the extended-release [MEDICATION NAME] ER tablet can NOT be crushed, an alternative calcium channel blocker, such as [MEDICATION NAME], is recommended.  The physician did not address the pharmacist's recommendation until 2/18/18 at which time the physician agreed with the recommendation, however, failed to discontinue the medication. On 2/22/18 the consultant pharmacist documented that the recommendation was resubmitted to the physician.  However, review of the Medication Administration Record [REDACTED]., 3 capsules every 12 hours through 3/2/18, at which time the resident was discharged to the hospital.   1. Resident has an order for [REDACTED]. To avoid confusion re: 'remove per schedule', please clarify order to include exactly when the [MEDICATION NAME] is to be removed.   The physician did not address the pharmacist's recommendation until 2/21/18 at which time the physician agreed with the recommendation.  However, review of the (MONTH) (YEAR) and (MONTH) (YEAR) MAR indicated [REDACTED].M., but was not being removed at bedtime  through 3/2/18, at which time the resident was discharged to the hospital.   1. This [AGE] year old resident has an order for [REDACTED].g. dyskinesias, hallucinations, drowsiness, tremor, and restlessness). The risk for IRREVERSIBLE tardive dyskinesias is significantly increased when used in older individuals.   Please consider discontinuing [MEDICATION NAME]. Alternative therapy, such a proton pump inhibitor - which is actually the preferential treatment for [REDACTED].  The physician did not address the pharmacist's recommendation until 2/21/18 at which time the physician agreed with the recommendation to discontinue the medication.  However, review of the MAR indicated [REDACTED]. | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **215020** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **05/03/2018** |
| NAME OF PROVIDER OF SUPPLIER  **FORESTVILLE HEALTH & REHABILITATION CENTER** | | | STREET ADDRESS, CITY, STATE, ZIP  **7420 MARLBORO PIKE**  **FORESTVILLE, MD 20747** | |
| 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 0583  **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 -** Few  F 0688  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few  F 0690  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few | **Keep residents' personal and medical records private and confidential.**  >  Based on medical record review and observation of Resident #1 it was determined the facility staff failed to maintain Resident #1's personal privacy. This was evident for 1 of 4 sampled residents selected for review.  The findings include:  Resident #1 has resided at the facility since (YEAR).  The resident's medical record was reviewed on 4/26/18 and 5/3/18.  Review of the quarterly Minimum Data Set (MDS), an assessment tool, revealed that the resident has severe cognitive impairment and is dependent on staff for personal hygiene and bathing.  On 4/26/18 at 11:40 A.M., the resident was observed in his/her room in bed. The Geriatric Nursing Assistant (GNA) was providing hygienic care to the resident. The resident was completely exposed from the waist up. The curtains were not drawn to protect the resident's privacy, and the resident's 2 roommates were in the room while the resident was lying on the bed exposed from the waist up. The surveyor intervened and at that time, the GNA closed the curtains.  **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 it was determined the facility staff failed to promptly notify the physician and Dietitian of Resident #2's significant weight loss and failed to obtain weekly weights for Resident #2 as ordered by the physician. This was evident for 1 of 4 sampled residents selected for review.  The findings include:  Medical record review revealed that the resident's admission orders [REDACTED]. The resident's weight on 2/28/18 was 167 pounds. The resident was due to be weighed on 3/5/18, 3/12/18, 3/19/18 and 3/26/18.  Medical record review revealed on 3/6/18 that the resident's weight was 159 pounds and on 3/7/18, 160.2 pounds. The resident was not weighed again until 3/19/18. The resident's weight was 130 pounds. There was no documented evidence that the physician or Dietitian was notified of the resident's significant weight loss on 3/19/18. On 3/28/18 the resident's weight  was 108 pounds, 4/2/18 102.4 pounds and 4/3/18 102.4 pounds. Again, there was no documented evidence that the physician or Dietitian was notified of the resident's significant weight loss.  Medical record review revealed that on 4/5/18 the Dietitian documented the following late entry for 3/28/18 in the progress note: Notified of significant weight loss of (59# since admission). Admission weight recorded at 167, last weight 3/7 of  160.2 and 108# recorded on 3/28/18. Reviewed intakes and res (resident) intakes 76-100% most meals. Spoke to resident concerning weight loss. Per resident (he/she) had massive [MEDICAL CONDITION] on admission, stated 'my legs were as big as an elephant', [MEDICAL CONDITION] is now resolved except for some swelling on the left leg which has a brace on it. (Resident) anticipating more weight loss as the [MEDICAL CONDITION] resolves in this leg as well .  **Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\* >  Based on medical record review it was determined the facility staff failed to ensure that Resident #1 received appropriate care to prevent worsening of contractures. This was evident for 1 of 4 sampled residents selected for review. Resident #1 was affected by the deficient practice.  The findings include:  Resident #1 has resided at the facility since (YEAR). The resident has severe cognitive impairment and is dependent on staff for activities of daily living.  The resident's medical record was reviewed on 4/26/18 and 5/3/18.  Review of the resident's care plan revealed that Resident #1 has a left hand splint and resting splint and a right hand carrot splint to prevent further contracture development. Interventions include wearing the splints for 6 hours and removing the splints to check for redness, swelling, increased pain or pressure areas.  Medical record review revealed that on 4/10/17 Resident #1 was discharged from occupational therapy to nursing with a left upper extremity elbow splint. The Occupational Therapist documented that the resident tolerated the splint for 2 hours at the time of discharge, and a right upper extremity splint was pending.  Review of the resident's (MONTH) (YEAR) physician's orders [REDACTED]. There is a physician's orders [REDACTED]. Review of the (MONTH) (YEAR) treatment administration record revealed no documented evidence that splints are applied, however, nursing is documenting that they are assessing the splint site before donning and removal of splint every day and evening shift for skin check.  The facility staff failed to provide care to ensure that occupational therapy recommendations were implemented to prevent further contracture development.  **Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\* >  Based on medical record review, it was determined the facility staff failed to monitor urinary output for a resident with a suprapubic catheter. This was evident for 1 of 4 sampled residents selected for review. Resident #2 was affected by the deficient practice.  The findings include:  Resident #2 has a [DIAGNOSES REDACTED].  The resident's medical record was reviewed on 5/3/18.  Medical record review revealed that Resident #2 had a physician's orders [REDACTED].  Review of the (MONTH) (YEAR) treatment administration record revealed that the facility failed to document Resident #2's | | | |

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

TITLE (X6) DATE

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **215020** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **05/03/2018** |
| NAME OF PROVIDER OF SUPPLIER  **FORESTVILLE HEALTH & REHABILITATION CENTER** | | | STREET ADDRESS, CITY, STATE, ZIP  **7420 MARLBORO PIKE**  **FORESTVILLE, MD 20747** | |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | |
| F 0690  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few F 0692  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few  F 0695  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few | (continued... from page 1)  urinary output as ordered by the physician.  **Provide enough food/fluids to maintain a resident's health.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\* >  Based on medical record review it was determined the facility staff failed to ensure that Resident #3 had a nutritional assessment by the Dietitian. This was evident for 1 of 4 sampled residents selected for review.  The findings include:  Resident #3 was admitted to the facility on [DATE] for rehabilitation after a hospitalization .  On 3/22/18 and 4/12/18, the Office of Health Care Quality received a complaint alleging that the facility failed to accommodate the resident's nutritional preferences, as the resident is a vegetarian and does not consume meat or dairy products.  Medical record review revealed that the resident was discharged to home on 3/30/18. There was no documented evidence that a nutritional assessment was completed during the resident's admission.  On 3/30/18, the Dietitian documented the following late entry in the progress note:  Res (resident) discharged before comprehensive assessment could be completed. Was admitted for orthopedic aftercare. Dx (diagnosis) of obesity. Received a regular diet which was tolerated with intakes of 76-100% most meals, adequate to meet needs . No Nutrition concerns during stay.  **Provide safe and appropriate respiratory care for a resident when needed.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\* >  Based on observation and medical record review it was determined the facility staff failed to consult with the physician and obtain clarification for the administration of oxygen for Resident #1. This was evident for 1 of 4 sampled residents selected for review.  The findings include:  Resident #1 has resided at the facility since (YEAR). The resident has severe cognitive impairment and is dependent on staff for activities of daily living.  The resident's medical record was reviewed on 4/26/18 and 5/3/18.  Medical record review revealed that Resident #1 has a physician's orders [REDACTED].  Observation of the resident on 5/3/18 at 11:00 A.M. and 12:30 P.M. revealed that the resident was receiving oxygen via nasal canula at 3 liters per minute.  The facility staff failed to consult with the physician and clarify the orders for administering oxygen to Resident #1. | | | |

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Previous Versions Obsolete

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **215020** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **03/14/2018** |
| NAME OF PROVIDER OF SUPPLIER  **FORESTVILLE HEALTH & REHABILITATION CENTER** | | | STREET ADDRESS, CITY, STATE, ZIP  **7420 MARLBORO PIKE**  **FORESTVILLE, MD 20747** | |
| 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 0550  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few  F 0583  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Some  F 0657  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few  F 0726  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Some  F 0758  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few | **Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.**  Based on observation the facility staff failed to maintain dignity for Resident #107 while dining in the second-floor dining room, during the lunch period. This was evident for 1 out of 19 Residents observed during meal time.  The findings include:  On (MONTH) 7, (YEAR) while observing the second-floor lunch dining service around 12:30 PM, Staff #3 was observed standing over Resident #107 while assisting the resident to eat.  Standing over a resident while feeding the resident does not promote independence and dignity while dining.  **Keep residents' personal and medical records private and confidential.**  Based on observation and interview, it was determined that facility staff failed to ensure that resident identities were protected in documents that were available to the public. This was evident for 22 of the 50 residents included in the investigation sample, Resident #'s 73, 216, 123, 35, 36, 42, 134, 217, 68, 57, 13, 71, 91, 45, 164, 98, 220, 92, 24, 218,  219 and 221.  The findings include:  On (MONTH) 12, (YEAR), at 12:45 PM the surveyor reviewed the results of previous surveys conducted by the Office of Healthcare Quality. A list of residents, by name,was included in the survey binder for the last annual survey. This finding was verified by interview of the Administrator on (MONTH) 12, (YEAR) at 1:00 PM.  **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 observation and staff interviews the facility staff failed to follow their Care Plan to treat Resident #42's wandering around the unit and in other's rooms. This was evident for 1 out of 50 residents investigated during the survey process.  The findings include:  Throughout the survey process, started at the facility on (MONTH) 7, (YEAR), Resident #42 was seen wandering about the unit and attempting to open closed doors, and just standing around.  Review of the Resident's Care Plan listed as one of its interventions, that nursing will monitor resident at stated intervals, the location where the resident has wandered, interventions used to interact with the resident to redirect the resident. All of this was to be documented on a behavior log.  Writer was unable to locate the behavior log. Nursing documentation did not relate to the specifics. The facility staff failed to follow the Resident's Plan of Care.  **Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.**  Based on medical record review, it was determined the facility staff failed to ensure that subcutaneous (under the skin) injections were administered in a manner consistent with standards of nursing practice. This was evident for 1 resident (#60) of 50 residents selected for review.  The findings include:  On 03/13/2018 a review of Resident #60's Medication Administration Record [REDACTED].  Between (MONTH) 11th and (MONTH) 31st, (YEAR) there were 8 times injections were given in the same area twice in a row and 2 times injections were given in the same area three times in a row.  It is the standard of nursing practice to rotate injection sites to keep skin healthy and prevent problems such as scarring and the hardening of fatty tissues which could interfere with ability of the body to utilize the medication. This standard of practice is reflected in the facility's policies and standard procedures.  These findings were brought to the attention of the Director of Nursing.  The facility staff have a responsibility to ensure that injections are administered in a manner consistent with standards of nursing practice.  **Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*  Based on observation and staff interviews the facility staff failed to follow or correct a physician's order, on a medication for Resident #50. This was evident for 1 out of 50 residents investigated in the survey process. The findings include:  On 3/9/18 around 12:00 PM, while reviewing Resident #50's medications for unnecessary med's, writer noted that the consultant pharmacist, while doing a monthly review of the resident's medication forwarded a note to the resident's physician/Prescribe. The Note read:  Resident is currently receiving immediate-release [MEDICATION NAME] ([MEDICATION NAME]) (an antidepressant) 200 mg via | | | |

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

TITLE (X6) DATE

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **215020** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **03/14/2018** |
| NAME OF PROVIDER OF SUPPLIER  **FORESTVILLE HEALTH & REHABILITATION CENTER** | | | STREET ADDRESS, CITY, STATE, ZIP  **7420 MARLBORO PIKE**  **FORESTVILLE, MD 20747** | |
| 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 0758  **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 0842  **Level of harm -** Potential for minimal harm  **Residents Affected -** Some  F 0880  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few  F 0921  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few | (continued... from page 1)  J-tube once daily. The immediate-release product is formulated (created) for twice daily dosing. The product that has been formulated for once daily dosing is EFFERXOR XR (extended release). However, the extended-release product would not be recommended for administration via J-tube.  Please clarify current order as a divided dosing schedule-[MEDICATION NAME] 100 mg via J-tube twice daily.  The Certified Nurse Practitioner neither agreed nor disagreed with the pharmacist's recommendation, instead checked other on the form and wrote an order (MONTH) 13, (YEAR) for [MEDICATION NAME] 100 mg every morning - GDR (gradual dose reduction-  done in an effect to decrease the amount of the medication the resident needs and/or gradually taper the resident off the medication.  Review of the resident's MAR (medication administration record) shows that the resident was still receiving the 200 mg dose once a day despite the (MONTH) 1 order.  An interview with staff #4, on 3/12/18, indicated that a meeting was held on 2/22/18 where it was determined that they would be no changes to the Resident #50's medication however, the order to change the medication was done on 2/13/18.  Staff failed to respond to or clarify the order for 2/13/18.  **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.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*  Based on observation and verified by facility staff, it was determined the facility staff failed to ensure that medications were labeled with the date opened. This was evident in 1 of 3 medication carts on the 2nd floor and has the potential to affect any resident receiving the medication.  The findings include:  An observation conducted on 03/14/2018 at 9:15 AM on the 2nd floor revealed that cart #1 had 2 opened multiple dose PPD ([MEDICAL CONDITION] skin test) vials that were not labeled with the date opened. According to manufacturer instructions a PPD vial which has been entered should be discarded after 30 days.  This finding was verified by the Director of Nursing.  The facility staff has the responsibility to ensure that medications that require it are labeled.  **Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.**  Based on staff interview and medical records review, it was determined that the facility staff failed to ensure: 1) that medications for Resident #14 were accurately charted in the Medication Administering Record (MAR) and 2) that a Medical Orders for life-sustaining treatment (MOLST) form was filled out correctly for Residents #128 & #144. This was evident for three of fifty residents identified for investigation, Resident #'s 14, 128 and 144.  The findings include:  1) A medical record review conducted on 3/13/2018 revealed that the medications administered for Resident #14, on the evening shift of 3/2/2018, were not documented in the MAR indicated [REDACTED]. A late entry nursing note indicated that  all medications were given. There was no additional information provided in the MAR indicated [REDACTED]. The Director of Nursing was made aware immediately after the finding.  Failure to document all aspects of medication administration in the resident's MAR, had the potential to cause confusion to staff members and could have led to medication errors.  2a) Review of the medical record for Resident #128 on (MONTH) 7, (YEAR) revealed that two MOLST ([NAME]land Orders for Life  Sustaining Treatment) forms were included in the resident's chart. One MOLST form was dated (MONTH) 29, (YEAR) and the most recent was dated (MONTH) 1, (YEAR), indicating that the resident's surrogate decision maker had made changes in decisions concerning acceptable care for the resident. When a change is made in the MOLST form, any previously completed forms must  be voided. The Unit Manager was notified of the finding on (MONTH) 7, (YEAR) at 10:17 AM. The Administrator was notified of the findings on (MONTH) 12, (YEAR) at 1:00 PM.  2b) A MOLST form helps to ensure that a patient's wishes to receive or decline care are honored. During the admissions process, a practitioner must review the MOLST form with the resident or the resident's representative if the resident is deemed incapable of making decisions.  A medical record review conducted 03/09/2018 revealed that on 02/16/2018 Resident #144's Attending Physician deemed him/her as unable to make decisions. That same day Resident #144's Attending Physician marked on the MOLST form that it was reviewed with the patient (who was deemed unable to make decisions).  During an interview conducted 03/09/2018 at 1:00 PM with Resident #144's Attending Physician he/she stated; I made a mistake. It was a mechanical area. The physician reported reviewing the MOLST on the phone with the son who the physician identified as being the POA.  A review of the medical record revealed that it did not contain any advanced directives or paperwork regarding Power of Attorney (POA). On 03/09/2018 at 1:30 PM the Director of Nursing verified that there were no advanced directives or medical POA on file for the resident but that the son had verbalized he was the POA.  The facility staff have a responsibility to ensure that medical records are complete and accurate.  **Provide and implement an infection prevention and control program.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*  Based on observation and interviews, it was determined that the facility staff failed to ensure that resident care items that are unable to be adequately disinfected were not being utilized. This was evident in 2 of 3 medication carts on the 2nd floor and has the potential to affect any resident on which the items were used.  The findings include:   1. An observation conducted on 03/14/2018 at 9:20 AM on the 2nd floor revealed that in cart #3 there was a Panasonic EW3109 blood pressure monitor. The cuff on the monitor was made of a soft, grey, fuzzy material which could not adequately be disinfected between uses.   An observation conducted on 03/14/2018 at 9:25 AM on the 2nd floor revealed that on top of cart #2 there was a Microlife brand blood pressure monitor. The monitor belonged to staff #2 who reported that he/she purchased the monitor at a local drugstore and that it was the same monitor the facility uses. Several areas on the cuff were observed to have soft grey blue fabric which could not adequately be disinfected between uses. When asked how he/she disinfects the cuff nurse #2 stated I take it home and put it in the washer once a week. The same model cuff belonging to the facility was observed in the bottom drawer.  These findings were verified by the Director of Nursing.   1. Observation on 3/14/18 at 8:30 A.M., on the second floor outside of room [ROOM NUMBER], revealed that the blood pressure cuff used to check residents blood pressure was shredded on the ends. Interview of Licensed Practical Nurse (LPN #1)   confirmed that a new blood pressure cuff needs to be purchased as the shredded cuff cannot be sanitized adequately.  Failure to properly sanitize patient equipment, had the potential to spread infection to residents through  cross-contamination. Porous materials can harbor microorganisms such as bacteria, viruses, and fungi. These microorganisms could potentially be transmitted to residents through contact with the equipment.  The facility staff have a responsibility to ensure that patient care items can be adequately disinfected.  **Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **215020** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **03/14/2018** |
| NAME OF PROVIDER OF SUPPLIER  **FORESTVILLE HEALTH & REHABILITATION CENTER** | | | STREET ADDRESS, CITY, STATE, ZIP  **7420 MARLBORO PIKE**  **FORESTVILLE, MD 20747** | |
| 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 0921  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few | (continued... from page 2)  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*  Based on observation and verified while conducting environmental rounds with the Maintenance Director, it was determined that facility staff failed to ensure that repairs were made, as needed, in resident and food service areas.  The findings include:  On (MONTH) 7, (YEAR), at 09:54 AM, during initial kitchen tour, a shelf in the dishwashing area of the kitchen was damaged and rusty. Food service shelving must be smooth and easily cleanable.  On (MONTH) 14, (YEAR), at 10:15 AM, the surveyor and Maintenance Director made the following observations:   1. In room [ROOM NUMBER], a hole was observed in the wall behind the entry door. 2. In room [ROOM NUMBER], flooring was torn and damaged. | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **215020** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **01/05/2017** |
| NAME OF PROVIDER OF SUPPLIER  **FORESTVILLE HEALTH & REHABILITATION CENTER** | | | STREET ADDRESS, CITY, STATE, ZIP  **7420 MARLBORO PIKE**  **FORESTVILLE, MD 20747** | |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | |
| F 0157  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few  F 0309  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few  F 0313  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few  F 0514  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few | **Immediately tell the resident, the resident's doctor and a family member of the resident of situations (injury/decline/room, etc.) that affect the resident.**  Based on medical record review and interview it was determined the facility staff failed to notify family immediately when a resident had a change of condition (Resident #67). This was evident for 1 out of 22 residents selected for review during Stage 2 of the survey process.  The findings include:  During a phone interview with Resident #67's family member on 12/28/2016 at 1:01 PM, he/she stated that he/she was not notified immediately when the Resident had a change of condition after an incident that occurred on 3/20/2016.  Review of the medical record revealed a Concurrent Review that documented the Resident had a change of condition on 3/20/2016 at 3:10 AM and was sent to the hospital. It was also documented that the facility staff did not call to inform the family until 7:00 AM. Three hours and fifty minutes after the incident occurred.  Interview with the Director of Nursing on 01/05/2017 at 9:45 AM confirmed that the facility staff did not immediately notify family at the time of the incident.  **Provide necessary care and services to maintain the highest well being of each resident**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*  Based on medical record review and interview, the facility staff failed to follow physician orders [REDACTED].#91). This was evident for 1 out of 22 residents selected for review during Stage 2 of the survey process.  The findings include:  Review of Resident #91's medical record revealed on 11/19/16 the physician ordered annual screen for mammogram and GI consult for screening/colonscopy. Further review of the medical record revealed the mammogram and GI consult were not completed. After surveyor intervention, the mammogram and GI consult were scheduled on 12/29/16 for (MONTH) (YEAR). Interview with the Director of Nursing on 12/30/16 at 11:21 AM confirmed the surveyor's findings.  **Make sure that residents receive proper treatment and assistive devices to maintain their vision and hearing.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*  Based on medical record review and interview, the facility failed to provide treatment/services to maintain vision (Resident #91). This is evident for 1 out of 22 residents selected for review during Stage 2 of the survey process.  The findings include:  During interview with Resident #91 on 12/28/2016 at 11:42 AM, the Resident stated he/she never received glasses after going to the eye doctor. review of the resident's medical record revealed [REDACTED].? Yes, to be delivered upon approval.  Glasses Required? Yes, encourage full-time use for distance and reading.  Interview the Director of Nursing on 12/30/2016 at 10:15 AM confirmed the facility staff failed to obtain corrective lenses for a resident as ordered by the physician.  **Keep accurate, complete and organized clinical records on each resident that meet professional standards**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*  Based on medical record review and interview, it was determined that the facility staff failed to maintain clinical records in the most complete and accurate form (Resident #149). This was evident for 1 out of 22 residents selected for review in Stage 2 of the survey sample.  The findings include:  Review of Resident #149's medical record revealed on 10/27/2016 the physician ordered the Resident to have a pulse ox every shift. Pulse oximetry is a test used to measure the oxygen level (oxygen saturation) of the blood. It is an easy, painless measure of how well oxygen is being sent to parts of your body furthest from your heart, such as the arms and legs.  Further review of the resident's medical record revealed [REDACTED]. In the 65 days since the pulse ox was ordered, the pulse ox was only recorded 7 days (10/27/16, 10/28/16, 11/1/16, 12/11/16, 12/19/16, 12/20/16 and 12/23/16).  Interview with the Director of Nursing on 12/30/2016 at 10:18 AM confirmed the surveyor's findings. | | | |

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

TITLE (X6) DATE

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **215020** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **10/30/2015** |
| NAME OF PROVIDER OF SUPPLIER  **FORESTVILLE HEALTH & REHABILITATION CENTER** | | | STREET ADDRESS, CITY, STATE, ZIP  **7420 MARLBORO PIKE**  **FORESTVILLE, MD 20747** | |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | |
| F 0253  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few  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 0309  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few | **Provide housekeeping and maintenance services.**  Based on observation and staff interview it was determined that the facility failed to maintain a resident's (Resident#66) medical equipment in a clean, orderly and sanitary manner for 1 of 28 sampled residents in the Stage 2 review.  The findings include:  On 10/26/2015 at 11:30 AM during interview with Resident #66, his/her wheelchair was noted to be covered with debris and spilled food substances.  On 10/28/15 at 8:30 AM the Unit 1 Manager confirmed the wheelchair was covered with debris and food substances. The Unit Manager stated the wheelchair would be cleaned.  Clean equipment is essential to prevent the spread of infection.  **Make sure each resident receives an accurate assessment by a qualified health professional.**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*  Based on medical record review and staff interview it was determined that the facility staff failed to accurately document assessments on the MDS for residents (# 273 and # 87). This was evident for 2 of 28 residents selected for review in the stage 2 survey sample.  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.  Categories of MDS (Minimum Data Set) are: Cognitive patterns, Communication and hearing patterns, Vision patterns, Physical functioning and structural problems which includes the assessment of range of motion, Continence, Psychosocial well-being, Mood and behavior patterns, Activity pursuit patterns, Disease diagnosis, Other health conditions, Oral/nutritional status, Oral/dental status, Skin condition, Medication use and Treatments and procedures. At the end of the MDS assessment the interdisciplinary team develops the plan of care for the resident to obtain the optimal care for the resident.  MDS assessment forms are completed for all residents in certified nursing homes, regardless of source of payment for the individual resident. MDS assessments are required for residents on admission to the nursing facility and then periodically, within specific guidelines and time frames.   1. The facility staff failed to accurately assess and document on the MDS for a resident receiving Respite care.   Medical record review for resident # 273 revealed the facility staff assessed the resident on 7/19/15. At that time the facility staff documented on the MDS- Section O 0100-Special Treatments and Programs-sub section L-Respite that the resident was not a Respite resident.  Respite care is the provision of short-term accommodation in a facility outside the home in which a loved one may be placed. This provides temporary relief to those who are caring for family members, who might otherwise require permanent placement in a facility outside the home; however, the resident was admitted to the facility as a Respite resident and had been  receiving Respite care from the day of admission to the facility.  Interview with the Director of Nursing on 10/29/15 at 10:00 AM confirmed the facility staff failed to accurately document on the MDS the coding of Respite care for a resident.   1. Review of the medical record on 10/27/15, revealed that Resident # 87 had contractures to both hands. Further review of the Physicians ' Order Sheet (POS) revealed that the resident had an order dated 8/26/15 for the Resident to have hand towel role to bilateral hands to prevent fingernails from digging into skin - apply at 10 AM and remove at 10 PM.   Review of Resident ' s # 87 MDS dated [DATE], Section G - Functional Status; item G-0400, code for limitation that interfered with daily functions . was checked 0 - no impairment.  Interview with the Director of Nursing, on 10/28/15 at 12:25 AM, confirmed that the facility staff failed to code the MDS accurately, to reflect the Resident's current status of contractures for both hands.  **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 the facility staff failed to develop a care plan to manage pressure ulcers (Resident # 278). This was evident for 1 of 28 residents selected for review in the stage 2 survey sample.  A comprehensive care plan is used to identify care area concerns that are specific to the resident and are used to improve and maintain a resident's status. A care plan includes a measurable objective and a time frame to evaluate its effectiveness.  The findings include:  Review of Resident # 278's Admission MDS dated [DATE] revealed the facility staff coded the Resident in Section M Pressure Ulcers M0210 Unhealed Pressure Ulcers as 1(yes). Review of Section V CAA (Care Area Assessments) Summary revealed #16 Pressure Ulcers and indicated the facility staff would develop a care plan to address the care area.  Further review of the medical record revealed the facility staff failed to develop and implement a care plan with specific interventions and approaches to manage and heal pressure ulcers.  Interview with the Director of Nursing on 10/28/15 at 11:30 AM confirmed the facility staff failed to develop and implement a care plan to manage and heal pressure ulcers.  **Provide necessary care and services to maintain the highest well being of each resident**  \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*  Based on medical record reivew, observation and interview, it was determined the facility staff failed to maintain accurate communication with Hospice staff for a resident ( # 18) and failed to obtain a medical test for a resident(#114) and failed to apply a heel boot for a resident (# 114). This was evident for 2 of 28 residents selected for review in the stage 2  survey sample. | | | |

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

TITLE (X6) DATE

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **215020** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **10/30/2015** |
| NAME OF PROVIDER OF SUPPLIER  **FORESTVILLE HEALTH & REHABILITATION CENTER** | | | STREET ADDRESS, CITY, STATE, ZIP  **7420 MARLBORO PIKE**  **FORESTVILLE, MD 20747** | |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | |
| F 0309  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few  F 0312  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few  F 0318  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few  F 0356  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Some | (continued... from page 1) The findings include:  1. The facility staff failed to maintain current communications with Hospice staff.  Medical record review for resident # 18 revealed in 2014 the physician ordered: [MEDICATION NAME] 40 milligrams (mgs) by mouth everyday and [MEDICATION NAME] 75 mgs. [MEDICATION NAME] is a medication that lowers the blood pressure and [MEDICATION NAME] is a medication that lowers the blood pressure and heart rate.  On 7/17/15 the resident was admitted to Hospice care. Hospice care is end-of-life care. A team of health care professionals and volunteers provides it. They give medical, psychological, and spiritual support. The goal of the care is to help people who are dying have peace, comfort, and dignity. The caregivers try to control pain and other symptoms so a person can remain as alert and comfortable as possible. Hospice programs also provide services to support a patient's family. On 7/17/15 the Hospice staff ordered: Discontinue routine laboratory specimens and discontinue vitals (temperature, blood pressure, heart rate and respiration).  On 7/23/15 the Hospice staff ordered: recommend SLP (Speech Language Pathology) evaluation as indicated-secondary consult from Hospice. Speech-language pathology is a field of expertise practiced by a clinician known, who specializes in the evaluation and treatment of [REDACTED].  Further record review revealed on 8/20/15 the Consultant Pharmacist's Medication Regimen Review revealed: resident received a recommendation from Hospice to discontinue vitals. However, the resident currently has blood pressure and heart rate hold parameters as part of the [MEDICATION NAME] and [MEDICATION NAME] orders. For resident's comfort, as now Hospice, please  consider discontinuing the blood pressure and heart rate parameters for the medications.  Surveyor review of the residents's medical record during the survey process revealed the facility staff obtained blood pressure and heart rate on the resident every day since admission.  Interview with the Director of Nursing on 10/28/15 at 1:00 PM revealed that the Hospice staff determined the resident's blood pressure and heart rate could continue to be obtained due to the medications; however, that communication and/or order could not be provided for the surveyor.  It was also revealed at that time, the facility staff failed to provide the SLP evaluation as recommended by the Hospice staff.  Interview with the Director of Nursing on 10/29/15 at 12:00 PM confirmed the facility staff failed to maintain accurate communication with Hospice staff in reference to obtaining a SLP evaluation as recommended and clarifying the need for vital signs with the administration of medications.  2 A. The facility staff failed to obtain a medical test as ordered for a resident.  Medical record review for resident # 114 revealed on 8/25/15 the physician ordered: MBS (Modified [MEDICATION NAME] Swallow). A Modified [MEDICATION NAME] Swallow Study, or MBS, is a special x-ray that is taken to check swallowing skills. Further record review revealed the facility staff failed to obtain the MBS as ordered by the physician.  Interview with the Director of Nursing on 10/29/15 at 10:00 AM confirmed the facility staff failed to obtain the MBS as ordered by the physician.  2 B The facility staff failed to apply a heel boot as ordered by the physician.  Medical record review for resident # 114 revealed on 9/18/15 the physician ordered: left heel boot on at all times for pressure relief. Surveyor observation of the resident on 10/28/15 at 11:50 AM revealed the resident out of bed in the wheelchair; however, the facility staff failed to apply the heel boot as ordered.  Interview with the Director of Nursing on 10/29/15 at 10:00 AM confirmed the facility staff failed to apply a heel boot as ordered by the physician.  ·  **Assist those residents who need total help with eating/drinking, grooming and personal and oral hygiene.**  Based on medical record review and interview, it was determined that the facility staff failed to document showers were provided to residents (# 114 and # 120) as ordered. This was evident for 2 of 28 residents selected for review in the stage 2 sample.  The findings include:   1. The facility staff failed to provide showers to a resident 2 times a week as ordered.   Medical record review for resident # 114 revealed on 8/20/15 the physician ordered: Shower twice weekly (Mon/Thurs 7 A-3 P shift). Review of the task flow sheet (a medical record form the facility staff documented the care provided to the  resident) revealed the facility staff documented showers on 10/5/15, 10/12/15, 10/19/15 and 10/26/15- all Mondays; however, there is no evidence the resident was provided showers on Thursdays as ordered.   1. The facility staff failed to provide showers to a resident.   Medical record review of resident # 120 revealed on 9/29/15 the physician ordered: Shower on Wednesdays and Saturdays on day shift (7 A-3 P shift). Review of the task flow sheet revealed the facility staff documented showers were provided to the  resident on 10/7/15, 10/14/15, 10/21/15 and 10/28/15- all Wednesdays; however, there is no evidence the facility staff provided showers to the resident on Saturdays as ordered by the physician.  Interview with the Director of Nursing 10/29/15 at 10:00 AM confirmed the facility staff failed to provide showers 2 times a week to residents.  **Make sure that residents with reduced range of motion get propertreatment and services to increase range of motion.**  Based on medical record review and staff interview, it was determined the facility staff failed to provide services to prevent possible self injury, and decrease in range of motion for a Resident (# 75). This was evident for 1 of 28 residents selected for review in the stage 2 survey sample.  The findings include:  Review of the medical record on 10/27/15, revealed that Resident # 87 had contractures to both hands. Further review of the Physicians' Order Sheet (POS) revealed that the resident had an order dated 8/26/15 for the Resident to have hand towel role to bilateral hands to prevent fingernails from digging into skin - apply at 10 AM and remove at 10 PM.  Observation of Resident # 87 on 10/27/15 at 10:30 AM, and later at 1:30 PM, revealed that the resident was not wearing the ordered hand towel role. Another observation of Resident # 87 on 10/28/15 at 11:30 AM revealed that the resident was not wearing the ordered hand towel role.  Interview with the Director of Nursing, on 10/28/15 at 12:25 AM, confirmed that the facility staff failed to place the hand towel roles in the Resident ' s hand, to possibly decrease further decline in range of motion, and avoid possible self injury the Resident  **Post nurse staffing information/data on a daily basis.**  Based on observation during the initial tour and subsequent daily facility tours during the Annual Survey, it was determined the facility failed to post scheduled staffing assignments in a prominent place readily accessible to residents and  visitors on both of the Facility Nursing Units. The findings include:  On 10/26/15 during the initial tour at 8:40 AM it was noted the nursing staffing assignments were posted on wall within the nurses station and not readily visible by residents and visitors. | | | |

FORM CMS-2567(02-99)

Previous Versions Obsolete

Event ID: YL1O11 Facility ID: 215020 If continuation sheet Page 2 of 3

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| --- | --- | --- | --- | --- |
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER  / CLIA IDENNTIFICATION NUMBER  **215020** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING 2. WING | | (X3) DATE SURVEY COMPLETED  **10/30/2015** |
| NAME OF PROVIDER OF SUPPLIER  **FORESTVILLE HEALTH & REHABILITATION CENTER** | | | STREET ADDRESS, CITY, STATE, ZIP  **7420 MARLBORO PIKE**  **FORESTVILLE, MD 20747** | |
| 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 0356  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Some F 0514  **Level of harm -** Minimal harm or potential for actual harm  **Residents Affected -** Few | (continued... from page 2)  This finding was confirmed by the Administrator on 10/28/15 at 11:20 AM.  Failure to display the nursing assignment information did not allow residents or visitors easy access to names of daily caregivers or staffing ratios.  **Keep accurate, complete and organized clinical records on each resident that meet professional standards**  2. The facility failed to accurately document Resident #50's medical condition and physician's orders.  Resident #50 is unable to walk even with assistance due to paralysis from the cervical area or neck down and amputation of one leg. The facility had signed off as completed from (MONTH) 1 through (MONTH) 28 in the Geriatric Nursing Assistant's (GNA) Daily Tasks section of the medical record that Resident #50 is walked three times a day on every nursing shift in the room and the corridor.  Resident #50 had physician orders to to wear a finger extension splint to the right hand for 6 hours a day, 6 days a week.  Also, Resident # 50 was to perform upper body exercise: Assisted Range of Motion with 2.5 lb weight 10 x 3 sets in all  planes both arms 6 days a week. On the GNA's Daily Task sheet and the Nurses Treatment Administration Record the two orders were signed off as completed for 7 days a week from (MONTH) 1 through (MONTH) 28, (YEAR), not 6 days as ordered.  On 10/29/15 at 8:30 AM the Director of Nursing confirmed the inaccurate charting in Resident #50's medical record. Based on medical record review and interview, it was determined that the facility staff failed to maintain clinical records in the most complete and accurate form (Resident #284 and Resident #50). This was evident for 2 out of 28 residents selected for review in Stage 2 of the survey sample.  The findings include:  1. Review of Resident #284's medical record revealed the Resident's spouse consented to an influenza vaccination for the Resident on 10/9/2015 on the facility's Influenza Immunization Informed Consent form. Further review of the medical record on 10/29/2015 revealed the Resident was coded in the electronic medical record as consent refused for influenza immunization.  Interview with the Director of Nursing on 10/29/2015 at 10:50 AM confirmed the surveyor's findings. | | | |

FORM CMS-2567(02-99)

Previous Versions Obsolete

Event ID: YL1O11 Facility ID: 215020 If continuation sheet Page 3 of 3

May 24, 2019

Health Facilities Survey Coordinator Long Term Care

Office of Health Care Quality Spr ing Grove Center

Bland Bryant Building 55 Wade Avenue

Cato nsv ille, MD 21228-4663

Re: Communicare Health Services-Forestville Health and Rehabilitation Center Prov ider#: 215020

Survey Date: April 10-16, 2019 Dear Mrs. Jacqueline Cooper:

Enclosed please find our completed plan of correction dated May 24, 2019 responding to the

complaint survey conducted at our facility on April 10-16, 2019.

Our plan of correction should be considered to serve as our allegations of compliance to cited deficiencies: F-623, F-684, and F- 686.

CommuniCare Health Ser vices- Forestville Health and Rehabilitat ion Center takes the cited deficienciesvery seriously and is comm itt ed to implementing the plan of correction as expeditious ly as possible. Please be assured that Commun iCare Health Services- Forestville Health and Rehabilitation Center is undertaking measures to ensure compliance as of May 31, 2019.

Please contact me with any questions or concerns you may have. Thank you in advance for your cooperation and assistance in this matt er.

Sincerely,

CommuniCare Health Services- Forestville Health and Rehabilitation Center

Sytina Smith, LNHA RN, Senior Executive Director Enclosure

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**Department of Health**

*Larry Hoga11, Gol'ernor* · *Boyd* ***K.*** *Rutherford , Lt. Governor* · *Roher! R. Neall, Secreta1y*

**Office of HealthCare Quality** 7120 Samuel Morse Drive,2nd Floor Columbia, MD21046-3422

410-402-8201

May 10, 2019

Ms. Sytina Smith, Administrator Forestville Health & Rehabilitation Center 7420 Marlboro Pike

Forestville, MD 20747

###### PROVIDER# 215020

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

Dear Ms. Smith:

On April 10, 2019 through April 16, 2019, a complaint 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 thepurpose of State Iicensure. 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. Failw·e 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 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;

*20 I* ***W*** *Preston Street- Baltimore, MD 2120 J* · *health.ma,yla11d.gov* · *Toll Free: 1-877-463-3464* · *T'I'Y- 1-800-735-2258*

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 p]ace and;

Specific date when the corrective action will be completed.

References to a resident(s) by Resident# only. 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 substantialcompliance by May 31, 2019. Informal dispute resolution for the cited deficiencies wiU not delay the imposition of the enforcement actions recommended on this date. A change in the seriousness of the noncompliance may resu1t 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 (Le.July 16, 2019) identifying non-compliance,we must deny payments for new admissions. (§488.417(a)) Also, if thedenial 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 dayof the survey. (§483.151)

If your facility bas failed to achieve substantial compliance by October 16, 2019, your Medicare provider agreement will be tenninated.

ID. ALLEGATION OFCOMPLIANCE

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, 7120 Samuel Morse Drive, Columbia, MD 21046-3422 with your written credible a11egation of compliance **(i.e. attached lists of attendance at provided training and/or revised statements of policies/proceduresand/or stafflng 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 April 16, 2019 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, 7120 Samuel Morse Drive, Columbia, MD 21046-3422, 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 counterpart in State regulations. These deficiencies are cited on the encJosed 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 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.

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li e al th Facilities Survey Coordinator Long Term Care Unit

Office of Health Care Quality

Enclosures: CMS2567

State Form

cc: Stevanne Ellis Jane Sacco File II

DEPARTMENT OFHEALTH AND HUMAN SERVICES

CENTERS FOR MEDlr.AQE} MEDIC:AID FRVlr.r=s

PRINTED: 05/10/2019 FORM APPROVED

MR 1\1/") nO"ll:l.n"lq1

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| STATEMENT OF DEFICIENCIES ANDPLAN OFCORRECTION | | (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATIONNUMBER:  **215020** B | (X2) MULTIPLE CONSTRUCTION  A BUILDING" \_  .WING | | | (X3) DATE SURVEY COMPLETED  C  **04/16/2019** | |
| NAME OF PROVIDER OR SUPPLIER  **FORESTVILLE HEALTH** & **REHABILITATION CENTER** | | | | STREET ADDRESS, CITY, STATE, ZIP CODE  7420 MARLBORO PIKE  **FORESTVILLE, MD 20747** | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCYMUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | 10  PREFIX TAG | | PROVIDER'S PLAN OF CORRECTION (EACHCORRECTIVEACTIONSHOULD BE CROSS-REFERENCEDTO THE APPROPRIATE DEFICIENCY) | | (XS) COMPLETION DATE |
| F 000 | INITIAL COMMENTS | | F 000 | | Our plan of correction should be considered  •o serve as our allegations of compliance to he cited deficiencies. This plan of correction Is being flied as a matter of compliance, but should not be constructed ias an admission as to the validity of any of the cited deficiencies.  Resident #3 no longer resides at the facility.  Others have the potential to be affected by this deficient practice.  The Social Services and nursing department verbally notified the residents' representative of the transfer via Emergency Petition and a copy of the bed hold policy was sent with the resident upon transfer. | |  |
|  | On April 10, 2019 through April 12, 2019 and | |  | |  |
|  | April 15, 2019 through April 16, 2019, a complaint  investigation survey was conducted by the Office of Health Care Quality to investigate complaint numbers MD00129439, MD00130909, **MO00131333, MO00131834, MO00133521, MO00134279, MO00135780, MD00135848,**  **MO00136112, MD00136513, MO00137747 and** | |  | |  |
|  | MD00138496. The facility is licensed for 162  beds with an occupancy of 152 beds at the initiation of the survey. Survey activities consisted of a review of thirteen residents' medical records, interviews with residents and | |  | |  |
|  | staff and observation of resident care and staff  practices. | |  | |  |
|  | It was detennined that there were deficiencies identified as a result of this investigation under the | |  | |  |
| F 623 SS=D | requirements of 42 CFR Part 483, Subpart B,  Requirements for Long Term Care Facilities. Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-{6)(8) | | F 623 | | 5/31/19 |
|  | §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- | |  | |  |
|  | (i) Notify the resident and the resident's  representative(s)of the transfer or discharge and the reasons for the move In writing and in a | |  | |  |
|  | language and manner they understand. The facility  must send a copy of the notice to a representative of the Office of the State  Long-Term Care Ombudsman.  (ii) Record the reasons for the transfer **or** | |  | |  |
|  | discharge in the resident's medi<',al record in  accordance with paragraph (c)(2) of this section; | |  | |  |

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

Sytina Smith, LNHA RN Senior Executive Director

TITLE (X6) DATE

### May 24, 2019

Any deficiency statement ending wilh an asterisk (•) denotes a deficiency which theinslilution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to thepatients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90days following the dateof 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 availableto the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) PreviousVersions Obsolete Event ID:YK0911 Facility 10:16017 If continuation sheet Page 1 of14

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 05/10/2019 FORM APPROVED

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| CENTERS FOR MEDICARE & MEDICAID SERVICES | | | | | | )MB NO 0938-0391 | |
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:  **215020** 8 | (X2) MULTIPLE CONSTRUCTION  A BUILDING. \_  .WING | | | (X3) DATE SURVEY COMPLETED  C  **04/16/2019** | |
| NAME OF PROVIDEROR SUPPLIER  **FORESTVILLE HEALTH** & **REHABILITATION CENTER** | | | | STREET ADDRESS, CliY,STATE, ZIP CODE  **7420 MARLBORO PIKE**  **FORESTVILLE, MD 20747** | | | |
| (X4) 10 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 (EACHCORRECTIVEACTION SHOULDBE CROSs-REFERENCEOTO THE APPROPRIATE DEFICIENCY) | | (XS} COMPLETIO NDATE |
| F 623 | Continued From page 1 and  (iii} Include In the notice the items described in paragraph (c}(S} of this section.  §483.15(c)(4)Timing of the notice.  {i) Except as specified in paragraphs (c}(4)(ii) and  {c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.   1. Notice must be made as soon as practicable before transfer or discharge when-    1. The safety of individuals in the facility would be endangered under paragraph (c}{1}(i)(C) of this section;    2. The health of individuals in the facility would be endangered, under paragraph (c)(1)(I)(D) of this section;    3. The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1}(l)(B) of this section;    4. An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1**)(i)(A)** of this section; or    5. A resident has not resided in the facility for30 days.   §483.1S(c)(S) Contents of the notice. The written notice specified In paragraph (c)(3) of this section must include the following:  (i} The reason for transfer or discharge;   1. The effective date of transfer or discharge; 2. The location to which the resident is transferred or discharged; 3. **A** statement of the res ident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how | | F 623 | | The Office of the Ombudsman Office  !Was called by Social Services and notified verbally of the transfer via Emergency Petition and the Ombudsman Nisited the facility on 9/12/19 to obtain any updates on residents #3 condition; signature of visit noted on the visitor log.  !The Executive Director will lnservice the Social Services Dlrector/deslgnee on the dmlsslon, Discharge, Transfer policy and procedure reiterating providing a written copy of the notice to the residents representative and Ombudsman Office.  The Social Services Director/designee will send a written copy of the written transfer/discharge notice to the residents representative and Ombudsman Office via  regular mail and place a copy of the notice in the medical record.  The Social Services Director/designee  !Will maintain a tracking log of the notices mailed to the residents representative and Ombudsman Office.  The QA Director will complete a monthly audit reviewing the tracking log and transfer/ discharge report in PCC to ensure the process is occurring.  The QA Director will monitor compliance  monthly X 3 months and report findings to the QA Committee. | | 5/31/19 |

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: YKO911 Facility 10:16017 If continuation sheet Page 11 of 14

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPUER/CUA IDENTIFICATIONNUMBER:  **215020** | (X2) MULTIPLE CONSTRUCTION   1. BUI LD IN G \_ \_ \_ \_ 2. WING | | | (X3) DATE SURVEY COMPLETED  C  **04/16/2019** | |
| NAME OF PROVIDER OR SUPPLIER  **FORESTVIUE HEALTH** & **REHABILITATION CENTER** | | | | STREET ADDRESS, CIT,Y STATE,ZIP CODE  **7420 MARLBORO** PIKE  **FORESTVILLE, MD 20747** | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTFI YING INFORMATION) | | ID PREFIX TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTIONSHOULD BE  CROSS-REFERENCED TO THEAPPROPRIATE DEFICIENCY) | | (XS) COMPLETIO NOATE |
| F 623 | Continued From page 2  to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;   1. The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; 2. For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephonenumber of the agency responsible for the protection and advocacy of individuals with developmental disabilities established underPart C of the Developmental Disabilities Assistanceand Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and 3. For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection andAdvocacy for Mentally Ill Individuals Act.   §483.15(c)(6) Changes to the notice.  If the Information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated Information becomes available.  §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long­ Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate | | F623 | |  | |  |

FORM CMS-2567(02-99) Previous Versions Obsolete EventID: YKO911 Facility 10:16017 If continuation sheet Page11 of 14

CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM CMS-2567(02-99) Previous Versions Obsolete Event 10: YK0911 Facility ID:16017 If continuation sheet Page11 of **14**

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| STATEM ENT OF DEFICIENCIES ANO PLAN OFCORRECTION | | (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATIONNUMBER:  **215020** | (X2) MULTIPLE CONSTRUCTION  **A.** BUILDING \_  B.WING | | | (X3) DATE SURVEY COMPLETED  C  **04/16/2019** | |
| NAME OF PROVIDER OR SUPPLIER  **FORESTVILLE HEALTH** & **REHABILITATION CENTER** | | | | STREET ADDRESS, CITY, STATE, ZIP CODE  **7420 MARLBORO PIKE**  **FORESTVILLE, MD 20747** | | | |
| (X4)ID PREFIX TAG | SUMMARY STATEMENT OFDEFICIENCIES (EACH DEFICIENCYMUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | 10  PREFIX TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (XS) COMPLETION DATE |
| F 623 | Continued From page 3  relocation of the residents, as required at§ 483.70(1).  This REQUIREMENT is not met as evidenced by: Based on medical record review and interview of facility staff it was determined the facility staff failed to ensure that Resident #3's representative was notified of a hospital transfer and the reason for the transfer in writing, and failed to provide a copy of the notice to the representative of the Office of the State Long-Term Care Ombudsman. This was evident for 1 of 13 residents reviewed. Resident #3 was affected by the deficient practice.  The findings include:  Medical record review on 4/10/19 through 4/12/19 and 4/15/19 through 4/16/19 revealed that Resident #3 has resided at the facility since 2008. The resident has a diagnosis of a psychotic disorder with delusions.  Medical record review revealed that on­  Resident #3 was transferred to the hospital on an emergency petition due to spreading feces around his/her room, breaking a piece of furniture and taking the screen out of the window of his/her room and trying to get out of the window.  Further review of the medical record and interview of the Nursing Home Administrator on 4/16/19 at 2:42 p.m. revealed that the facility staff failed to notify the resident's representative of the hospital transfer in and reason for the transfer in writing and failed to provide a copy of the notice to the representative of the Office of the State Long-Term Care Ombudsman. | | F623 | |  | |  |

DEPARTMENT OFHEALTH ANDHUMAN SERVICES

CENTERS FOR MEDICARE& MEDICAID SERVICES

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| STATEMENT OF DEFICIENCIES ANDPLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:  **215020** | (X2) MULTIPLE CONSTRUCTION  A BUILDING\_ \_ \_ \_ \_ \_ \_ \_  B.WIN\_G \_ \_ \_ \_ \_ \_ \_ \_ \_ | | | (X3) DATE SURVEY COMPLETED  C  **04/16/2019** | |
| **NAME** OF PROVIDER OR SUPPLIER  **FORESTVILLE HEALTH** & **REHABILITATION CENTER** | | | | STREET ADDRESS, CITY, STATE, ZIPCODE  **7420 MARLBORO PIKE**  **FORESTVILLE, MD 20747** | | | |
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| F 684 SS=E | Quality of Care  **CFR(s): 483.25**  § 483.25 Quality of care  Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residentsreceive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents'choices.  This REQUIREMENT is not met as evidenced by:  Based on medical record review, interview of facility staff and observation It was detennined the facility staff failed to initiate and implement interventions to monitor a resident with suspected heart failure and respiratory failure (Resident #9); and failed to provide appropriate care to residents with urinary catheters {Resident #6, Resident #11 and Resident**#13).** This was evident for 4 of 13 sampled residents reviewed.  The findings include:  1) Medical record review 4/10/19 through 4/12/19 and 4/15/19 through 4/16/19 revealed that Resident #9 had a diagnosis of chronic respiratory failure and heart failure.  Medical record review revealed that on 3/8/19 at 9:41 a.m. the nurse documented that Resident #9 was observed with shortness of breath and lethargy. The resident's pulse rate was 92 and respiratory rate was 24 (a normal respiratory rate Is 12 to 20  breaths per minute). The nurse practitioner was notified at 9:50 a.m. | | F 684 | | Resident #9 no longer resides at the facility.  Others have the potential to be affected by this deficient practice.  Staff #2 was counseled for not documenting the respiratory or cardiac assessment whlct Includes monitoring the resident's vital signs, oxygen saturation, or intake  and output. She was also counseled for not documenting the administration  of Lasix, prednisone, or nebulizer treatment  The Unit Manager will complete 100% audit on the current residents MAR/TAR records to ensure proper documentation of the administration of prescribed medications.  The Staff Development Coordinator will lnservice the licensed staff on respiratory and cardiac assessments which includes 1 monitoring the resident's vital signs, oxygen saturation, or intake and output.  The Staff Development Coordinator will inservlced the licensed staff onmedication administration policy and procedure reiterating properly documenting the administration of medications on the **MAR/TAR.**  The Unit Manager(s) will audit a random | | 5/31/19 |

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|  |  |  |  | of 40 MARfTAR monthly, for compliance  X 3 months and report findings to QA  Committee. |  |

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CENTERS FOR MEDICARE & MEDICAID SERVICES

0MB NO. 0938 0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATIONNUMBER:  **215020** | (X2)MULTIPL E CONSTRUCTION  A.BU I LD I N\_G. \_ \_ \_ \_ \_ \_ \_  B WING \_ | | | (X3)DATE SURVEY COMPLETED  C  **04/16/2019** | |
| NAME OF PROVIDER OR SUPPLIER  **FORESTVILLE HEALTH** & **REHABILITATION CENTER** | | | | STREET ADD RESS , CIT,Y STATE, ZIP CODE  **7420 MARLBORO PIKE**  **FORESTVILLE, MD 20747** | | | |
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|  |  | |  | | Resident #6 received a leg strap and Foley catheter was secured properly.  Resident #11 and #13 Foley catheter arders were clarified to include recording urinary output after surveyor intervention .  Others have the potential to be affected by this deficient practice.  Unit Manager(s) completed 100% audit  on residents with Foley catheters to ensure leg straps are utilized in securing the catheter in place properly.  Unit Manager(s) completed a 100% audit Ion residents with Foley catheters to ensure orders and TAR reflect recordings for urinary output.  Staff Development Coordinator will inserviced the licensed staff on documenting urinary output each shift in accordance to physicians order.  Staff Development Coordinator will inserviced the GNA's on obtaining urinary  !output each shift and reporting totals to the charge nurses for recording.  The Unit Managers will review orders at the | | 5/31/19 |
| F 684 | Continued From page 5 | | F 684l | |  |
|  | Medical record review revealed that **onllllthe** resid ent was seen and examined by the nurse practitioner for follow-up management of heart failure, morbid obesity and chronic respiratory failure with hypoxia. The nurse practitioner documented that the resident was assessed with heart failure related to shortness of breath, increased edema to the right hand and bilateral lower extremity edema. The nurse practitioner documented in the plan to continue oxygen and monitor oxygen saturations. The nurse practitioner  ordered a chest x-ray, Laslx, a diuretic medication, | | l | |  |
|  | 20 mg. Intramuscularly dailyx 4 days, Prednlsone 40 mg. by mouth daily x 5 days, nebulizer treatments every 4 hours, an indwellingurinary catheter to maintain accurate input and output, and a stat (right away) complete blood count and comprehensive metabolic panel. The nurse practitioner further documented that the contingent plan would be to send the resident to the hospital for further evaluation if no improvement occurred. | | I  ! | |  |
|  | Medical record review revealed that there is no further documentation of a respiratory or cardiac assessment of the resident by nursing staff after  - at 9:41 a.m. including monitoring of the | |  | |  |
|  | resident's vital signs, oxygen saturation or intake an output. Additionally, nursing staff failed to document  the administration of Lasb<, Prednisone or nebulizer | | d | |  |
|  | treatments 01 | |  | |  |
|  | Staff #2, the nurse that cared for the resident on  - on the 7:00 a.m. to 3:00 p.m. shift was interviewedon 4/11/19 at 4:15 p.m. It was determined that the nurse had failed to document | |  | |  |
|  | administration of medications, documentation of assessment of the resident's condition and documentation of input and output for the | |  | |  |



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aily clinical meeting and make necessary 5/31/19 corrections/clarifications to ensure output is

being recorded on the TAR as per physician orders.

Unit Manager{s)/deslgnee will complete a daily 5x/week random round on residents

ith Foley catheter to ensure leg straps are placed.

he Unit Manager{s) will audit monthly the AR's to ensure outputs are being

recorded each shift if ordered

he QA Director will monitor compliance monthly *X* 3 months and report findings o the QA Committee.

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CEN TERS FOR MEDICARE MEDICAID SERVICES 0MB NO 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OFCORRECTION | | (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:  **215020** | (X2) MULTIPLE CONSTRUCTION  A BUILDING \_ \_ \_ \_\_ \_ \_ \_  8. WING \_ \_\_\_ \_ \_ \_\_ | | | (X3) DATE SURVEY COMPLETED  C  **04/16/2019** | |
| NAME OF PROVIDER OR SUPPLIER  **FORESTVILLE HEALTH** & **REHABILITATION CENTER** | | | | STREET ADDRESS. CITY, STATE, ZIPCODE  **7420 MARLBORO PIKE**  **FORESTVILLE, MD 20747** | | | |
| (XA) 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) COMPLETION DATE |
| F 684 | Continued From page 6  resident When Staff #2 was questioned about the reason for failing to document assessment, medication administration, or ongoing monitoring of the resident's condition, Staff #2 stated: "I had orders and I was trying to catch up. I wasn't given an order to monitor."  Interview of the nurse practitioner, Staff #3, on 4/12/19 at 10:40 a.m. revealed that on the morning  of - she was called by nursing who advised her that the family was concerned about the  resident's condition and felt the resident should go to the hospital. The nurse practitioner stated that prior to coming to the facility, she ordered a chest x­ ray. The nurse practitioner stated that the resident was clinically stable when she examined the resident She stated that the resident had a lot of fluid build up in the lower extremities. The nurse practitioner stated that she discussed the plan of care with the resident and the resident's family member. The nurse practitioner stated that all orders were in place for x-ray, laboratory work and medications and were discussed with the nurse.  The nurse practitioner stated that Lasix was given at the bedside and an indwelling urinary catheter was ordered to monitor the resident's intake and output. The nurse practitioner stated that the resident's intake and output and vital signs should have been monitored every shift and with any change in condition.  Medical record review revealed that the next documented assessment of the resident was on  The nurse, Staff #4, documented that at 10:55 a.m. the physician was notified that the resident was having labored breathing. The  resident's blood pressure was low, 71/44, the pulse rate was high, IOI beats per minute and | | F684 | |  | |  |

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CENTERS FOR MEDICARE & MEDICAIDSERVICES 0MB NO 0938-0391

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CENTERS FOR MEDICARE MEDICAIDSERVICES

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| STATEMENT OFDEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATIONNUMBER:  **215020** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING \_ 2. WING. | | | (X3) DATE SURVEY COMPLETED  C  **04/16/2019** | |
| NAME OFPROVIDER OR SUPPLIER  **FORESTVILLE HEALTH** & **REHABILITATION CENTER** | | | | STREET ADDRESS, CITY, STATE, ZIP CODE  **7420 MARLBORO PIKE**  **FORESTVILLE, MD 20747** | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORYOR LSC IDENTIFYINGINFORMATION) | | ID PREFIX TAG | | PROVIDER'S PLANOF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION PATE |
| F 684 | Continued From page 7  the respiratory rate was high, 24 breaths per minute. Staff #3 documented that the resident's breath sounds were diminished bilaterally. The resident was subsequently sen emergency department via 911 o,\_ at 11:15 a.m.  Review of the hospital medical record, which was provided to the surveyor on4/18/19, revealed that upon arrival at the hospital emergency department, the resident reported worsening shortness of breath for 3 days. The resident was intubatedin the emergency department to assist with breathing. At 2:25 p.m. the resident went into cardiac arrest and was subsequently pronounced dead at 3:01 p.m. in the emergency department. The final diagnosis **was** acute respiratory failure with hypoxia, acute pulmonary edema and cardiogenic shock.  2) Medical record review on 4/15/19 and 4/16/19 revealed that Resident #6 has resided at the facility  since**llllllllot**2018. The resident has a  diagnosis of recurrent urinary tract infections likely  related to obstructive uropathy.  Review of Resident #6's physician's orders revealed the resident has an order for an indwelling urinary catheter to continuous drain for obstructive uropathy, catheter care every shift and as needed, secure straps if applicable and documentation of urinary output every shift.  Review of Resident #6's January 2019, February 2019, March 2019 and Aprll 2019 treatment administration records revealed that the facility staff failed to document the residents urinary | | F684 | |  | |  |

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| STATEMENT OF DEFICIENCIES AND PLANOF CORRECTION | | ()(1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:  **.**  **215020** | (X2) MULTIPLE CONSTRUCTION  A BUILDING \_ \_ \_ \_ \_\_ \_  **B** WIN\_G\_ \_ \_ \_ \_ \_ \_ | | | (X3) DATE SURVEY COMPLETED  C  **04/16/2019** | |
| NAME OF PROVIDER OR SUPPLIER  **FORESTVILLE HEALTH** & **REHABILITATION CENTER** | | | | STREET ADDRESS, CITY. STATE, ZIP CODE  **7420 MARLBORO PIKE**  **FORESTVILLE, MD 20747** | | | |
| (X4) 10 PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BYFULL REGULATORY OR lSC IDENTIFYING INFORMATION) | | ID PRE.FIX TAG | | PROVIDER'S**PLAN** OF CORRECTION (EACH CORRECTNE ACTIONSHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (XS)  COMPLETIO NOATE |
| F 684 | Cont inued From page 8  output every shift as ordered by the physician.  The Unit Manager, Staff #4, was interviewed on 4/16/19 at 4:25 p.m. Staff #4 stated that staff should be recording urinary output for any resident with an indwelling urinary catheter. Staff #4 further stated that the staff were documenting their initials,  but not documenting the amount of urinary output for Resident #6.  Observation of Resident #6 on 4/16/19 at approximately 5:00 p.m. revealed that the resident's indwelling urinary catheter was not secured with a catheter stabilization device.  A catheter stabilization device provides comfortable, secure and hygienic placement of the catheter away from areas of the body that could lead to bacteria contaminating the surface of the catheter. A stabilization device further prevents the catheter from becoming misplaced which can lead to trauma and obstruction of urinary flow.  3) Medical record review on 4/16/19 revealed that Resident #11 has a suprapubic urinary catheter care every shift, secure straps if applicable and documentation of urinary output every shift.  Review of Resident **#11**'s April 2019 treatment administration record revealed that the facility staff failed to document the resident's urinary output every shift as ordered by the physician.  After surveyor intervention on 4/16/19, the facility | | F684 | |  | |  |

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| STATEMENT OF DEFICIENCIES AND PLAN OFCORRECTION | | (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:  **215020** | (X2)MULTIPLECONSTRUCIOTN  A.BUILDING\_ \_ \_ \_ \_ \_ \_  B. WI \_ \_ | | | (X3) DATE SURVEY COMPLETED  C  **04/16/2019** | |
| NAME OF PROVIDER OR SUPPLIER  **FORESTVILLE HEALTH** & **REHABILITATION CENTER** | | | | STREET ADDRESS, CITY, STATE, ZIPCODE  **7420 MARLBORO PIKE**  **FORESTVILLE, MD 20747** | | | |
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| F 684  F 686 SS=D | Continued From page 9  staff ensured there was an entry on the treatment administration record to record the resident's urinary output every shift.  4} Medical record review on 4/16/19 revealed that Resident #13 has a suprapubic urinary catheter. The resident has a physician'sorderfor catheter care, secure straps to leg and documentation of urinary output every shift.  Review of Resident#13's April 2019 treatment administrationrecord revealed that the facility staff failed to document the resident's urinary output every shift as ordered by the physician.  After surveyor intervention on 4/16/19, the facility staff ensured there was an entry on the treatment administration record to record the resident's urinary output every shift.  Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(I)(ii)  §483.25(b) Skin Integrity  §483.25(b)(1) Pressure ulcers.  Based on the comprehensive assessment of a resident, the facility must ensure that-  (i} A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual'sclinical condition demonstrates that they were unavoidable; and (ii} A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.  This REQUIREMENT is not met as evidenced | | F684  F686 | | .  Resident #1 no longer resides at the  facility.  Resident #7 current orders were reviewed and existing wounds are properly k!ocumented on skin grid(s) with treatment brders.  !Others have the potential to be affected  **by** this deficient practice.  !Staff #2 was counseled and will be  nservlced on MD notification  of any change In condition per facility jpolicy/procedure.  IWound Manager and Unit Managers/ | | 5/31/19 |

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: YK0911 Facmty 10:16017 If contni uationsheet Page 11 of 14



esignee will complete 100% audit of urrent residents with wounds to ensure ach is appropriately assessed with

·reatment order amt documented.

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| STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION | | {Xl) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:  **215020** | {X2) MULTIPLE CONSTRUCTION  **A** BUILDING \_ \_ \_ \_  8. WIN§ \_ \_ \_ \_ \_ \_ \_ | | | {X3) DATE SURVEY COMPLETED  C  **04/16/2019** | |
| NAME OF PROVIDER OR SUPPLIER  **FORESTVILLE HEALTH** & **REHABILITATION CENTER** | | | | STREET ADDRESS, CITY, STATE, ZIP CODE  **7420 MARLBORO PIKE**  **FORESTVILLE, MD 20747** | | | |
| **(X4)** ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | 10  PREFIX TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRI.ATE DEFICIENCY) | | (XS) COMPLETION DATE |
| F 686 | Continued From page 10 by:  Based on medical record review it was determined the facility staff failed to appropriately assess and treat pressure ulcers. This was evident for 2 of 13 residents reviewed. Resident #1 and Resident #7 were affected by the deficient practice.  The findings include:  Medical record review on 4/10/19 through 4/12/19 and 4/15/19 through 4/16/19 revealed that Resident #1 was admitted to the facility o  Medical record review revealed that on- the nurse completed the Admission Observation TooL Review of the Admission Observation Tool revealed that the nurse documented that the resident had 2 skin areas of concern which were identified as the left buttock and the sacrum.  Medical record review revealed that on- the nurse documented the following entry in the skilled documentation:" ... WOUND OBSERVATION: Existing Wound. Sacrum - length 2 cm, width 7cm, left inner buttocks wound L (length] 3 cm. width 3 cm Other (specify) - . [Wlwound on sa[c]rum was not with bright red moderate bleeding. Left inner buttock wound noted with slough on the surrounding area of the wound and redness on the base ... ".  Medical record review revealed that on 7/17/18 the nurse completed a skin grid for a community acquired pressure ulcer of the sacrum. The nurse documented that the resident's sacral | | F 686 | | 3taff Development Coordinator will nservice the licensed Nurses on  )roperly assessing new admissions,  ·a-admissions, and with any report of a  ,ew wound to ensure accurate type and/or  ;taging and treatments;  ncluding timely completion of skin grid(s) to  ·eflect the assessment; as well as MD  ,otiflcation of any new wound identified.  Staff Development Coordinator will inservicE he Unit Manager(s) and Wound  \ifanager/designee will be inserviced on completing a post assessment on new  :1dmissions , re-admission, and with report o1 a new wound to ensure accurate type and/o  ;taging and treatment to verify initial  :1ssessment; as well as MD notification  ·or any new wound identified.  fhe Wound Manager/designee will monitor  :he initial skin grid(s) for completion and ncludes the accurate description of the Nound and treatment; as well as complete "l Neekly skin grids to ensure ongoing  :1ssessment of the wounds.  fhe QA Director/designee will complete 10  :1udits weekly of residents with wounds to  :3nsure compliance X 3 months  and report finding to QA Committee. | | 5/31/19 |

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| STATEMENT OF DEFICIENCIES ANDPLAN OF CORRECTION | | (X1) PROVIDER/SUPPLEIR/CUA IDENTIFICATION NUMBER:  **215020** | (X2) MULTIPLE CONSTRUCTION  A. BUILDING \_ \_ \_ \_ \_ \_ \_  8. WI \_ \_ \_ \_ \_ \_ | | | (X3) DATE SURVEY COMPLETED  C  **04/16/2019** | |
| NAMEOF PROVIDER OR SUPPLIER  **FORESlVILLE HEALTH** & **REHABILITATION CENTER** | | | | STREET ADDRESS, CITY, STATE,ZIPCODE  **7420 MARLBORO PIKE**  **FORESlVILLE, MD 20747** | | | |
| (X4)1D PREFIX TAG | SUMMARY STATEMENT OF DEFICEI NCIES (EACH DEFICIENCY MUST BE PRECEDED BYFULL REGULATORY OR LSC IDENTIFYINGINFORMATION) | | ID PREFIX TAG | | PROVIDER'SPLAN OF CORRECTION (EACHCORRECTIVE ACTIONSHOULDBE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (XS) COMPLETIO NDATE |
| F 686 | Continued From page 11  pressure ulcer measured 4 cm x 7 cm x 0.1 cm and was a stage 2 pressure ulcer. Granulation tissue was present, the wound bed was pink and there was a scant amount of exudate. There is no documentation of assessment of the left inner buttock wound identified on  Medical record review revealed that on 7/24/18 the nurse completed a skin grid for a community acquired pressure ulcer of the sacrum. The nurse documented that the resident's sacral pressure ulcer measured 4 cm x 7 cm x 0.1 cm and was a stage 2 pressure ulcer. Granulation tissue was present , the wound bed was pink and there was a scant amount of exudate. There is no documentation of assessment of the left inner buttock wound identified o-n  Medical record review revealed that on 7/27/18 the nurse completed a skin grid for a house acquired pressure ulcer of the left buttock. The nurse documented that the left buttock pressure ulcer was **a** new area reported. The left buttock pressure ulcer measured 3 cm x 2.5 cm x unable to detem1ine and was a stage 3 pressure ulcer. Granulation tissue and slough (devitalized tissue) were present. The wound bed was pink and yellow and there was a small amount of exudate.  Interview of the wound care nurse on 4/15/19 at 3:04 p.m., Staff #1, revealed that she recalled that the resident's left buttock wound was like scar tissue and was not an open area on 7/17/19.  However, Staff #1 failed to document an assessment of the left buttock area, even though it w m ented as a skinconcern by the nurse on- Further interview of Staff#1 revealed that a nurse contacted Staff #1 on 7/27/19 and  reported that the resident's left | | F686 | |  | |  |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:  **215020** | (X2) MULTIPLECONSTRUCTION  A.BUILDIN\_G \_ \_ \_ \_ \_ \_ \_  **B** Wlll(G \_ | | | (X3) DATE SURVEY COMPLETED  C  **04/16/2019** | |
| NAME OF PROVIDER OR SUPPLIER  **FORESTVILLE HEALTH** & **REHABILITATION CENTER** | | | | STREET ADDRESS, CITY, STATE, ZIP CODE  **7420 MARLBORO PIKE**  **FORESTVILLE, MD 20747** | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY ORLSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTNE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (XS) COMPLETIO NOATE |
| F 686 | Continued From page 12  buttock wound was an open area.  Although the resident's left buttock was an area of concern on- there is no documentation of assessment or interventions to treat the area of concern.  2) Medical record review on 4/10/19 through 4/12/19 and 4/15/19 through 4/16/19 revealed that Resident #7 had resided at the facility since 2012.  Medical record review revealed that on 1/4/19 the nurse, Staff #2, documented on the skin grid that the geriatric nursing assistant notified the nurse that the resident had a left buttock skin tear. The nurse, Staff #2 documented that the left buttock skin tear measured 5 cm. x 3 cm. x 0.1 cm., was red, moist grainy, optimal granulation and no exudate was present. The nurse, Staff #2, further documented that she dressed the skin tear with gauze and wound honey and covered the resident up.  Medical record review revealed that there is no documented evidence that the nurse, Staff#2, notified the physician of the resident's left buttock skin tear or obtained a treatment order for the resident's left buttock skin tear. Between 1/4/19 through 1/11/19, 1 week, there is no documentation of assessment and/or treatment to the resident's left buttock skin tear.  Medical record review revealed that on 1/11/19, the nurse documented in the Concurrent Review that the resident was assessed with a left buttock pressure ulcer that measured 12 cm. x 8 cm. | | F686 | |  | |  |

FORM CMS-2567(02-99)Previous Versions Obsolete Event ID: YK0911 Facility 10:16017 If continuation sheet Page 11 of 14

CENTERS FOR MEDICARE & MEDICAID SERVICES

0MB NO 0938--0391

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: YKO911 Facility ID:16017 If continuationsheet Page 11 of 14

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| STATEMENT OFDEFICIENCIES ANDPLANOF CORRECTION | | (X1)PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:  **215020** | (X2) MULTIPLE CONSTRUCTION  A.BUILDING\_. \_ \_ \_ \_ \_ \_ \_  B.WIN§ \_ | | | (X3)DATE SURVEY COMPLETED  C  **04/16./2019** | |
| NAME OF PROVIDER OR SUPPLIER  **FORESTVILLE HEALTH** & **REHABILITATION CENTER** | | | | STREET ADDRESS, CITY, STATE, ZIP CODE  **7420 MARLBORO PIKE**  **FORESTVILLE, MD 20747** | | | |
| (X4) 1D PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | 10  PREFIX TAG | | PROVIDER'S PLAN OF CORRECTION (EACHCORREC TIVEACTIONSHOULDBE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (XS) COMPI.ETION DATE |
| F 686 | Continued From page 13  which was black (necrotic) with a small amount of serous drainage. The physician was notified and ordered a treatment to the left buttock pressure ulce1 which was initiated on 1/12/19.  Interview of the wound care nurse, Staff #1, on 4/15/19 at 3:04 p.m. revealed that she was not in the facility the week of 1/4/19. Staff #1 confirmed that on 1/4/19 there is no documented evidence of assessment of the wound, no evidence thatthe physician was notified or that a treatment order had been given and/or transcribed 1/4/19 through 1/11/19. | | F686 | |  | |  |

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FORM CMS-2567(02·99) Previous Versions Obsolete Event 10: YKO911 Facility ID:16017 If continuation sheet Page 11 of 14

CENTERS FOR MEDICARE & MEDICAJDSERVICES

0MB NO 0938-0391

FORM CMS-2567(02-99)Previous Versions Obsolete Event ID: YK0911 Facility 10:16017 If continuation sheet Page 11 of 14

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| --- | --- | --- | --- | --- | --- | --- |
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1 ) PROVIDER/SUPPLIER/CUA IDENTIFICATIONNUMBER:  **215020** | (X2) MULTlPLE CONSTRUCTION  A. BUI LD I NG:\_ \_ \_\_ \_\_ \_\_  8 .WI NG \_ \_ \_ \_ \_ \_ \_ \_ | | (X3) DATE SURVEY COMPLETED  C  **04/16/2019** | |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE  **FORESTVILLE HEALTH &REHABILITATIONCE 7420 MARLBORO PIKE**  **FORESTVILLE, MO 20747** | | | | | | |
| ( X4) ID PREFIX TAG | SUMMARY STATEMENT OFDEFICIENCIES (EACH DEFICIENCYMUST BE PRECEDED BY FULL REGULATORYOR LSC IDENTIFYINGINFORMATION) | | ID PREFIX TAG | PROVIDER 'S PLAN OFCORRECTION (EACH CORRECTIVEACTION SHOULD BE  CROSS-REFERENCEDTO THE APPROPRIATE DEFICIENCY) | | (XS) COMPLET E 0ATE |
| S ooc | Initial comments | | S 000 |  | |  |
|  | On April 10, 2019 through April 12, 2019 and April  15, 2019 through April 16, 2019, a complaint investigation survey was conducted by the Office of | |  |  | |  |
|  | Health Care Quality to investigate complaint numbers MD00129439, MD00130909, MD00131333, MD00131834, MD00133521, MD00134279, MD00135780, MD00135848, MD00136112, MD00136513, MD00137747 and  MD00138496 . The facility is licensed for 162 | |  |  | |  |
|  | beds with an occupancy of 152 beds at the initiation of the survey. Survey activities consisted of a review of thirteen residents' medical records, interviews with residents and staff and observation of resident care and staff | |  |  | |  |
|  | practices. | |  |  | |  |
|  | It was determined that there were deficiencies identified as a result of this investigation under the | |  |  | |  |
|  | requirements of 42 CFR Part 483, Subpart 8,  Requirements for Long Term Care Facilities. | |  |  | |  |
| s 32( | 10.07.02.08 E Admission and Discharge | | S 320 |  | |  |
|  | .08 Admission and Discharge | |  |  | | 5/31/19 |
|  | E. Notification of Responsible Persons When Patient Moves. The administrator or the administrator's designee shall notify the private or public agency or relative responsible for the patient | |  | SEE F- TAG 623 | |  |
|  | when the patient is transferred from the facility for any reason or at time of death. The attending physician shall also be notified. | |  |  | |  |
|  | This Regulation Is not met as evidenced by: Refer to CMS 2567  F 623 | |  |  | |  |

OHCQ

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLEI R REPRESENTATIVE'S SIGNATURE

### Sytina Smith, LNHA RN Senior Executive Director

TITLE (X6) DATE

### May 24, 2019



STATE FORM YK0911 Ifcontinuationsheet 1 of3

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| STATEMENTOF DEFICIENCIES ANO PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLI ER/CUA IDENTIFICATION NUMBER:  **215020** | (X2)MULTIPLECONSTRUCTION  A BUILDIN\_G.·. \_ \_ \_ \_ \_ \_ \_ \_  l.!iN\_G \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ | | (X3)DATE SUR VEY COMPLETED  **C**  **04/16/2019** | |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY, STATE, ZIP CODE  **FORESTVILLE HEALTH &REHABILITATIONCE 7420 MARLBORO PIKE**  **FORESTVILLE, MD 20747** | | | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EAa-f DEFICIENCYMUST BEPRECEDED BY FULLREGULATORY OR L SC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH COR RECTNE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (XS) COMPLET E OATE |
| S 506 | 10 .07.02 .12 0 Nsg Svcs;Care 24 Hrs per Day  .12 Nursing Services.  0 . Nursing Care--24 Hours a Day. There shall be sufficient licensed and supportive nursing service personnel on duty 24 hours a day to provide appropriate bedside care to assure that each patient:   1. Receives treatments, medications, and diet as prescribed; 2. Receives rehabilitative nursing care as   needed;   1. Receives proper care to prevent decubitus ulcers and deformities; 2. Is kept comfortable, clean, and well-groomed; 3. Is protected from accident, injury, and infection; 4. Is encouraged, assisted, and trained in self-care and group activities.   This Regulation is not met as evidenced by: Refer to CMS 2567  F 684; F 686  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. | | S 506 |  | |  |
|  |  | SEE F-TAG 684 & 686 | | 5/31/19 |
| Ss10 | S 510 | SEE F-TAG 686 | | 5/31/19 |

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STATE FORM YK0911 If continuation sheet 2 of 3

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER;  **215020** | (X2) MULTIPLE CONSTRUCTION  A BUILOIN\_.G\_: \_ \_ \_ \_ \_ \_ \_  .B WIii!!,, \_ | | (X3) DATE SURVEY COMPLETED  C  **04/16/2019** | |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIPCOOE  **FORESTVILLE HEALTH &REHABILITATIONCE 7420 MARLBORO PIKE**  **FORESTVILLE, MD 20747** | | | | | | |
| **(X4)** ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | IO PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACHCORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY} | | (X5) COMPLETE DATE |
| S510 | Continued From page 2 | | S510 |  | |  |
|  | This Regulation is not met as evidenced by: Refer to CMS 2567 | |  |  | |  |
|  | F686 | |  |  | |  |
| S512 | 10.07.02.12 R Nsg Svcs; Charge Nurse Daily Rounds | | S 512 | SEE F-TAG 623,684, & 686 | | '5/31/19 |
|  | .12 Nursing Services. | |  |  | |  |
|  | 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 not met as evidenced by: Refer to CMS 2567  F 623; F 684; F 686 | |  |  | |  |

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STATE FORM YK0911 If continuation sheet 3 of3

**MARYLAND**

**Department of Health**

*Lany Hogan, Govemor* · *Boyd K. Ruthe,ford, Lt. Governor* · *Robert R. Neall, Secretary*

August **14,** 2018

**Office of Health Care Quality**

##### 55 Wade Ave. - Bland Bryant Building

Catonsville, MD 21228

410-402-8201

##### Ms. Sytina Smith, Administrator Forestville Health & Rehabilitation Center 7420 Marlboro Pike

Forestville, MD 20747

**PROVIDER# 215020**

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

##### Dear Ms. Smith:

On July 20, 2018 , July 23, 2018 and July 24, 2018, a complaint survey was conducted at your facility by the Office of Health Care Quality to detennine 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 IO days at1er the facility receives its Fom1 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•a fter the due date 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;

*201 W Preston Street · Baltimore, MD 21201* · *hea/tlu nw y fand. gov* · *T o ll Free: 1-877-463-3464*· *1TY: 1-800-735-2258*

##### August 14, 20I8 Page2

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. 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 p blic.

1. IMPOSITION OF REMEDIES

The following remedies will be recommended for imposition by the Center for Medicare and Medicaid Services (CMS) Regional Otlice if your facility has failed to achieve substantial compliance by September 7, 2018. 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.October 24, 2018) identifying non-compliance, we must deny payments for new admissions. (§488.4 I 7(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 January 24, 2019, your Medicare provider agreement will be terminated.

**Ill.** ALLEGATION OF COMPLIANCE

If you believe that the deficiencies identified in the CMS fom1 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 2I228 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.

August 14, 2018

Page 3

u: upon the subsequent revisit, your facility has not achieved substantial compliance, we may impose remedies previously mentioned in this letter beginning July 24, 2018 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 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 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 IO 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 license.

If you have any questions concerning the instructions contained in this letter, please contact me at 410-402-820 I or fax 410-402-8234.

,

##### ·ncere yl

J c neCooper

ealth Facilities Survey Coordinator Long Tem1 Care Unit

Office of Health Care Quality

Enclosures: CMS 2567

State Fonn

cc: Stevanne Ellis

Jane Sacco File II

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| STATEMENTOFDEFICIENCIES AND PLAN OF CORRECTION | | | (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:  **215020** | | (X2) MULTIPLE CONSTRUTCION  A BUILDING  B. WING | | | | B NO 0938-0391  (X3) DATE SURVEY COMPLETED | |
| C  **07/24/2018** | |
|  | | |  |
| NAME OF PROVIDEROR SUPPLIER  **FORES TVILLE HEALTH** & **REHABILITATION CENTER** | | | | | | | STREET ADDRESS. CITY, STATE, ZIP CODE  **7420 MARLBORO PIKE**  **FORESTVILLE, MD 20747** | | | |
| (X4) ID I PREFIX I TAG I  I | | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSCIDENTIFYINGINFORMATION) | | I | I | ID PREFIX  TAG | | P ROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTIONSHOULD BE  CROSS-REFERENEDC TO THE APPROPRIATE DEFICIENCY) | | i X5) COMPLETION DATE |
| F 000 | INITIAL COMMENTS  On July 20, 2018, July 23, 2018 and July 24, | | | | F 000  F 573 | | |  | |  |
| I2018 a complaint investigaiot n survey was conducted by the Office of Health Care Quality to  investigatecomplaint numbers MD00124299 and MD00126285. Additional information was providedby°the facility on 8/10/18. The facility is licensed for 162 comprehenisve care facility (CCF) beds with an occupancy of 154 CCF beds at the initiationof the survey. Survey activities consisted of a review of three (3) residents' medical records, interviewswith residentsand staff and observationof resident care and staff practices.  I  I  It was determined that there were deficiencies  identified as a result of this investigation under the requirements of 42 CFR Part 483, Subpart B, Requirementsfor Long Term Care Facilities.  F 573 Right to Access/Purchase Copies of Records  SS =B CFR(s): 483.10(g)(2)(i)(ii)(3)  §483.10(g)(2) The resident has the right to access personal and medical records pertaining to him or hersel.f  i(i) The facility must provide the residentwith  1 access to personal and medical records  I pert aining to him or herself, upon an oral or  1 wr i tt en reques,t in the form and format requested by the individual, if it is readily producible in such form and format (including in an electronicform  or format when such records are maintained electronically), or, if not, in a readable hard copy form or such other form and format as agreed to by the facility and the individua,l within 24 hours (excluding weekends and holidays): and  1 (ii) The facility must allow the resident to obtain a  i | | | | |

LABORATORY DIRECTOR'SOR PROVIDER/SUPPLIER REPRESENTATI'VSESIGNATURE TITLE (X6) 0 ATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution *may* be exc used 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 deficienciesare cited, an approved plan of correction is requisite to continued program participation.

FORMCMS-2567(0-929)PreviousVersionsObsolete Event IO:OSQ411 Facility 10 : 16017 If continuation sheet Page 1 of 16

0MB NO 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | | (X1) | PROVIDER/SUPPLIER/CUA IDENTIFICATIO NUMBER:  **215020** | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  BWING | | | | (X3) DATE SURVEY COMPLETED  C  **07/2412018** | |
| NAME OFPROVIDER OR SUPPLIER  **FORESTVILLE HEALTH** & **REHABILITATION CENTER** | | | | | | | STREET ADDRESS, CITY, STATE. ZIP CODE  **7420 MARLBORO PIKE**  **FORESTVILLE, MD 20747** | | | |
| (X4)ID PREFIX  TAG |  | SUMMARY STATEMENT OFDEFICIENCIES (EACH DEFICIENCY MUSTBEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | ID PREFIX TAG | | | PROVIDER'S PLAN OF CORRECTION (EACHCORRECTIVE ACTION SHOULDBE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | ( XS) COMPLETION DATE |
| F 573 | | Continued From page 1 | | I*I* | | F 573 | |  | |  |
| copy of the records or any portions thereof  (including in an electronic form or format when such records are maintained electronically) upon request and 2 working days advance notice to the | | |  | | |
| Ifacility. The facility may imposea reasonable, cost-based fee on the provisionof copies,  Iprovided that the fee includes only the cost of:   1. Labor for copying the records requested by   the individual, whether in paper or electronic form;   1. Suppiles for creating the paper copy or electronic media if the individual requests that the electroniccopy be provided on portable media; and 2. Postage, when the individualhas requested the copy be mailed.   §483.10(g)(3) With the exception of information describedin paragraphs (g)(2) and (g)(11) of this section, the facility must ensure that information is provided to each resident in a form and manner the resident can access and understand, including in an alternaitve format or in a language that the residentcan understand. Summaries that translate information described in paragraph (g)  (2) of this section may be made available to the  patient at their request and expense in accordance with applicable law.  This REQUIREMENT is not met as evidenced by:  Based on interview of facility staff it was  i1 determined the facility failed to provide Resident | | | | |
|  | | #2's representative with a copy of the resident's  medical record in a timely manner. This was evidentfor 1 of 3 sampled residents selected for review.  The findings include: | | |

FORM CMS-2567(02-99) PreviousVersions Obsolete Event 10: OSO411 Facility ID: 16017 If cont inuation shee t Page 2 of 16

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED : 08114/2018 FORM APPROVED 0MB NO 0938-0391

STATEMNET OF DEFICIENCIES

(Xl) PROVIDER/SUPPLIER/CUA

(X2) MULTIPLE CONSTRUCTION

( X3) DATE SURVEY

AND PLAN OF CORRECTION

IDENTIFICATION NUMBER:

A BUILDING \_ \_ \_ \_ \_ \_ \_ \_

COMPLETED

C

**215020**

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

\_ \_ \_

**07/24/2018**

NAME OF PROVIDER OR SUPPLIER

**FORESTVILLE HEALTH** & **REHABILITATION CENTER**

STREETADDRESS, CITY, STATE, ZIP CODE

**7420 MARLBORO** PIKE

FORESTVIL LE, **MD 20747**

(X4) 10 j

PREFIX • TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCYMUST BE PRECEDED BY FULL REGULATORYOR LSC IDENTIFYING INFORMATION)

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TAG

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

CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

( XS)

COMPl ETION

DATE

F 573 Continued From page 2 I

# 2 was admitted to the facility on

for rehabilitation. The residentexpired

F 573

- at the facility on-

1 On 5/10/18 the Office of Health Care Quality

1 receiveda complaint from Resident #2's I representativealleging that an authorization form for the release of Resident#2's medical records was submitted to the facility on 11/1/18. On 2/28/18the complainant alleged that he/she

spoke with Staff #1 regarding the medical record requestand was told the medical record would be sent. The complainanVresi dent'srepresentative alleged that after multiple messages were left for Staff #2, on 5/2/18, Staff #2 informed the complainanVres ident's representative that the

1 medicalrecordrequest would need to be referred

l to the facility's legal team.

On 8/10/18 the Nursing Home Administrator advised the surveyor that a request for Resident #2's medical record was made in May 2018, and the medical records were sent to the resident's representaitve on 7/23/18.

F 686 TreatmenVSvcs to PrevenUHeal Pressure Ulcer SS=D CFR(s): 483.25(b)(1)(i)(ii)

1 §483.25(b) Skin Integrity

§483.25(b)(1) Pressure ulcers.

'I Based on the comprehenisve assessment of a resident,the facility must ensure that-

I (i) A resident receives care, consistent with

professional standards of practice, to prevent

pressureulcers and does not develop pressure ulcers unless the individual's clinical condition demonstraets that they were unavoidable; and

(ii) A resident with pressure ulcers receives

F 686

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FORM CMS-2567(02-99) Previous Versions Obsolete Event ID.OS0411 Facili ty ID: 16017 If con tinuation sheet Page 3 of 16

STATEMENTOF DEFICIENCIES

**(XI)** PROVIDER/SUPPLIER/CUA

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY

AND PLAN OF CORRECTION

IDENTIFICATION NUMBER:

**215020**

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B. WING

\_ \_ \_ \_ \_

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**07/24/2018**

NAME OF PROVIDER OR SUPPLIER

**FORESTVILLE HEALTH** & **REHABILITATION CENTER**

STREETADDRES,SCITY, STATE, ZIP CODE

**7420 MARLBORO PIKE**

**FORESTVILLE, MD 20747**

(X4) ID PREFIX TAG

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

ID PREFIX TAG

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVEACTION SHOULD BE

CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY}

( XS) COMPLETION

DATE

F 686 Continued From page 3

necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infectionand prevent new ulcers from developing.

This REQUIREMENT is not met as evidenced

**by:**

Based on medical record review it was determined the facility staff failed to document an

Iassessment of a pressure sore and failed to

, promptly initiate the treatment of a pressuresore

for Resident #1. This was evident for 1 of 3 sampled residents selected for review.

F 686

i'

I The findings include:

Resident#1 was readmitted to the facility on after a hospitalization.

The resident's medical record was reviewed on July 20, 2018, July 23, 2018 and July 24, 2018.

Review of the "Skin Grid Pressure,"an assessment tool for pressure sores utilized by the 1 facility, dated 12/31'17, revealed that the resident had a stage 3 sacral pressure sore that

measured 1 cm x 0.5 cm x 0.3 cm with pink granulaUo n tissue and a small amount of exudate that was present on readmission to the facility on

-- However, there was not a documented assessment of the pressure sore on 12/24/17.

I

, Review of the Treatment Administration Record I

revealed that a treatment to the sacral pressure

I sore was not initiated until - 9 days after the resident was readmitted to the facility.

FORM CMS-2567(0,2 99) Previou s Versions Obsolete Evenl ID. OSQ411 Facility 10 : 1601 7 If continuation sheet Page 4 of 16

|  |  |  |  |  |  |  |  |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:  **215020** | (X2)MULTIPLECONSTRUCTION  A BUI L DI NG\_ \_ \_ \_ \_ \_ \_ \_  B. WING \_ \_ \_ \_ \_ | | | (X3) DATE SURVEY COMPLETED  C  **07/24/2018** | |
| NAME OF PROVIDER OR SUPPLIER  **FORESTVILLE HEALTH** & **REHABILITATIONCENTER** | | | | STREET ADDRESS, CITY, STATE, ZIP CODE  **7420 MARLBORO PIKE**  **FORESTVILLE, MD 20747** | | | |
| **(X4)** ID I SUMMARY STATEMENT OF DEFICIENCIES PREFIXI (EACHDEFICIENCY MUST BE PRECEDED BY FULL T AG REGULATORY OR LSC IDENTIFYING INFORMATION) | | | ID PREFIX TAG | | PROVIDER'S PLAN OF CORRECTION (EACHCORRECTIVEACTION SHOULD BE CROSS-REFERECNEDTO THE APPROPRIATE DEFICIENCY) | | ( XS)  CO MP LETION DATE |
| F 693 Continued From page 4  F 693 Tube Feeding Mgmt/Restore Eating Skills  SS=D CFR(s): 483.25(9)(4)(5)  §483.25(9)(4)-(5) Enteral Nutrition  (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-  §483.25(9)(4) A residentwho has been able to eat enough aloneor with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the  Iresident; and  I  I §483.25(g)(5) A resident who is fed by enteral  I means receivesthe appropirate treatment and  : services to restore, if possible, oral eating skills  I and to prevent complications of enteral feeding  including but not limited to aspiraiton pneumonia, diarrhea, vomiting, dehydratio,nmetabolic abnormalies,and nasal-pharyngeal ulcers.  This REQUIREMENT is not met as evidenced by:  Based on medical recordreviewit was determined the facility staff failed to ensure that Resident #1, who was dependent on a gastrostomy tube for nutrition and hydration,   * i receivedadequate water flushes to prevent dehydration. This was evident in 1 of 3 sampled | | | F 693  F 693 | |  | |  |
|  | residents selected for review.  The findings include:  Resident #3 was admitted to the facility in | |
|  | | |

FORMCMS-2567(02-99) PreviousVersionsObsolete EventID. OS0 411 Facility ID: 16017 If continuation sheet Page 5 of 16

CENTERS FOR MEDICARE & MEDICAIDSERVICES

FORM APPROVED

0MB NO 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATIONNUMBER:  **215020** | (X2) MULTIPLE CONSTRUCTION   1. BU LI DI NG \_ \_ \_ \_ \_ \_ 2. WING | | | (X3) DATE SURVEY COMPLETED  C  **07/24/2018** | |
| NAME OF PROVIDER OR SUPPLIER  FORESTVILLE HEALTH & REHABILITATION CENTER  I | | | | STREET ADDRESS, CITY, STATE, ZIP CODE  **7420 MARLBORO PIKE**  **FORESTVILLE, MO 20747** | | | |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX Ii (EACH DEFICIENCY MUST BE PRECEDED BY FULL  TAG REGULATORY OR LSC IDENTFI YINGINFORMATION)  ! | | | ID PREFIX TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCEDTO THE APPROPRIATE DEFICIENCY) | | **(XS)**  COM PLE TION  DATE |
| F 693  -  I | Continued From page 5  2017. The resident had a gastrostomy tube for the administration of nutrition and hydration. A gastrostomy tube is a flexible tube. surgically inserted through the abdomen, that delivers nutrition and hydration directly to the stomach.  The resident's medical record was reviewed on July 20, 2018, July 23, 2018 and July 24, 2018.  Medical record review revealedthat the resident was readmittedto the facilityon - after a hospitalizatio.n Review of the hospital progress notes, dated revealed that the  resident's tube feeding should be slowly titrated up to a goal rate of 65 ml. per hour. | | F 693 | |  | |  |
| I  1  Medical record review revealed that the resident's  1 admission tube feeding orders were Glucerna 1.5 via gastrostomy tube at 50 ml. per hour x 18 hours which provided 1,350 calories and water flushes of 250 ml. every 6 hours. There was not a physician's order to titrate the resident's tube feeding up to a goal rate of 65 ml. per hour.  Medical record review revealed that on 12/30/17 the Dietitian completed the resident's nutritional assessment. Based on the resident'sweight of  ; 156.6 pounds, the Dietitiari recommended  I Glucerna 1.5 65 ml. per hour x 18 hours and  I water flushes of 220 ml. of water every 4 hours.  I | | |
|  | A physician's order was not obtained to increase the resident's tube feeding and water flushes until 1/3/18. | |

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CENTERS FOR MEDICARE & MEDICAID SERVICES

0 MB NO 0938-039 1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATIONNUMBER:

**215020**

(X2) MULTIPLE CONSTRUCTION

A BUI L DI NG \_

B. WIN\_G \_ \_ \_ \_ \_ \_ \_ \_

( X3) DATE SURVEY COMPLETED

C

**07/24/2018**

NAME OF PROVIDER OR SUPPLIER

**FORESTVILLE HEALTH** & **REHABILITATION CENTER**

I

STREETADDRESS. CITY, STATE. ZIP CODE

**7420 MARLBORO PIKE**

**FORESTVILLE, MD 20747**

**(X 4 )** ID PREFIX

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SUMMARY STATEMENT OF DEFICEI NCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORYOR LSC IDENTIFYINGINFORMATION)

ID PREFIX TAG

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

CROS,S REFERENCEO TO THE APPROPRIATE DEFICIENCY)

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COMPLETION

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DATE

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F 693 Continued From page 6 F 693

Review of the m edication administration record

•, revea l ed that the facility staff failed to establish a time schedule for administering 220 ml. of water every 4 hours.

I

Medical record review revealed that the resident was readm itted to the facility on fter a I I

hospitalization.

Medical record review revealed that the resident'sI weight on- was 148.2 pounds (67 kg.). The resident's admission tube feeding orders were

Glucerna 1.2 60 ml. per hour x 11 hours and water flushes of 150 ml. every 6 hours. Based on

, the resident' s weight of 148.2 pounds (67 kg.), I

: the resident's fluid requirement was 2,010 ml. of

I water per day (30 ml/kg.). The tube feeding order provided the resident with a total of 1,131 ml. of water per day which was significantly less than

II

the resident's water requirement based on the re sident's weight of 148.2 pounds (67 kg.).

Medical record review revealed that on- I

the resident's weight was 144.8 pounds. The I resident had lost 3.4 pounds (2.3% of body

I we i g h t) ov er 5 days , w hic h i s sugge s tive o f fluid

1 loss. Additionally, laboratory blood work on

1 3/12/18 r evealed that the resident's ,

, BUN/creatinine ratio was 41.1. The normal range is 8.0 - 25.0. An elevated BUN/creatinine ratio is suggestive of dehydration.

Medical record review revealed that on 3/12/18 the Dietitian completed the resident's nutritional

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

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| STATEMENTOFDEFICIENICES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBE·R  **215020** | (X2) MULTIPLE CONSTRUCTION  A. BUILDING \_ \_ \_ \_ \_ \_ \_ \_  .B WING \_ \_ \_ \_ \_ | | | (X3)DATE SURVEY COMPLETED  C  **07/24/2018** | |
| NAME OFPROVIDER OR SUPPLEI R  **FORESTVILLE HEALTH** & **REHABILITATION CENTER** | | | | STREET ADDRESS. CITY. STATE. ZIP CODE  **7420 MARLBORO PIKE**  **FORESTVILLE, MD 20747** | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENTOFDEFICIENCIES (EACH DEFICIENCYMUST BEPRECEDEDBY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | | PROVIDER"SPLAN OF CORRECTION (EACHCORRECTIVE ACTION SHOULDBE  CROSS-REFERENCED TO THE APPROPRIATE DEFICEI NCY) | | (XS) COMPLETION DATE |
| I  F 693 Continued From page 7  assessment. Based on the assessment, the Dietitian determined that the resident's tube feeding was not meeting the resident's nutritional or hydration needs. The resident's tube feeding was increased to Glucerna 1.5 at 65 ml. per hour x 18 hours and water flushes were increased to 75 ml. per hour x 18 hours which provided the resident with a total of 2,238 ml. of water per day.  From 3/7/18 through 3/12 18 the resident had a water deficit of approximately 879 ml. per day.  F 756 Drug Regimen Review, Report Irregular, Act On SS=D CFR(s): 483.45(c)(1)(2)(4)(5)  §483.45(c) Drug Regimen Review.  §483.45(c)(1) The drug regimen of each resid nt must be reviewed at least once a month·by a licensed pharmacist.  §483.45(c)(2) This review must include a review of the resident's medical chart.  i § 483.45(c)(4) The pharmacist must report any | | | F 693  F 756 | |  | |  |
| irregularities to the attending physician and the  facility's medical director and director of nursing, and these reports must be acted upon. ,  (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph  (d) of this section for an unnecessary drug.  (ii) Any irregularities noted by the pharmacist during this review must be documented on a  I separate, written report that is sent to the  I: attending physician and the facility's medical director and director of nursing and lists, at a | | |  | |
|  | minimum, the resident's name, the relevant drug,  and the irregularity the pharmacist identified.  (iii) The attending physician must document in the resident's medical record that the identified | |

**FORM CMS-2567(02-99) Previous** Versions Obsolete Event ID.OSQ411 Facility 10 16017 If continuation sheet Page 8 of 16

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATIONNUMBER:

**215020**

(X2) MULTIPLE CONSTRUCTION

A BUILDING \_ \_ \_ \_ \_ \_ \_ \_

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(X3) DATE SURVEY COMPLE"!"ED

C

**07/24/2018**

NAME OF PROVIDER OR SUPPLIER

**FORESTVILLE HEALTH** & **REHABILITATIONCENTER**

STREETADORES$. CITY. STATE, ZIPCODE

**7420 MARLBORO PIKE FORESTV ILL E, MD 20747**

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

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

CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY}

( X5 )

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DATE

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F 756 1 Conti nued From page 8 I

* irregularity has been reviewed and what, if any,
* action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly I drug regimen review that include, but are not

I

1 limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that

1 requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced

by:

Based on medical record review it was determined the facility staff failed to promptly respond to the consultant pharmacist's

recommendations related to drug irregularities for Resident #1. This was evident for 1 of 3 sampled residents selected for revi.?w.

!The findings include:

1 Resident #1 was readmitted to the facility on

J fter a hospitalization.

The resident's medical record was reviewed on

1 July 20, 2018, July 23, 2018 and July 24, 2018.

IMedical ,ecord review revealed that on 1/24/18 I

the consultant pharmacist reviewed the resident's

medication regimen. The following

recommendations were made to the physician:

F 756

1 1. "Th.is ear old resident has an order for

I NIFED I P IN E 30mg every 12 hours for HTN

FORMCM-S2567(02-9) 9PreviousVersions ObsoeIIe Event I0 :0 S04t 1 FacilityID: 16017 If continuation sheet Page 9 of 16

CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED

0MB NO 0938-0391

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| STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION | | (Xl ) PROVIOER/SUPPLIER/CLIA IDENTIFICATIONNUMBE:R  **215020** | (X2)MULTIPLE CONSTRUTCION  A. BUILDIN\_G \_ \_ \_ \_ \_ \_ \_  8. WING \_ \_ \_ \_ \_ \_ \_ | | | (X3) DATE SURVEY COMPLETED  C  **07/24/2018** | |
| NAME OFPROVIDER OR SUPPLIER  **FORESTVILLE HEALTH** & **REHABILITATION CENTER** | | | | STREET ADDRESS. CITY, STATE. ZIP CODE  7420 MARLBORO PIKE  FORESTVILLE, MD 20747 | | | |
| **(X4)** ID PREFIX TAG | SUMMARY STATEMENT OFDEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORYOR LSC IDENTIFYINGINFORMATION) | | ID PREFIX TAG | | PROVIDER'S PLAN OF CORRECTION (EACHCORRECTIVE ACTIONSHOULD BE  CROSS-REFERENCETDO THE APPROPRIATE DEFICIENC)Y | | (X5J COMPLETIO N DATE |
| F 756 | Continued From page 9  (hypertension, e] ntered as - NIFEdipine Capsule 10 MG - Give 3 capsule via GTube every 12 hours for high blood pressure. NIFEDIPINE is available as both the immediate-release 'NIFEDIPINE' and as the extended-release product, NIFEDIPINE ER (PROCARDIAXL).  Only the extended-release product has been  approved for the treatment of hypertensio.n In fact, due to the risks associated with immediate-release NIFEDIPINE (including  profound hypotension, Ml [myocardilainfarction], and death) this dosage formulationshould specifically NOT be used in patients with chronic hypertension. The immediate-release NIFEDIPINE in elderly for the treatment of hypertension has been associatedwith a nearly  4-fold increase in risk for all-cause mortality when compared to other antihypertenisves. | | F 756 | |  | |  |
| I(1) Given the increasedrisk to this residen,t  i please discontinuethe immediate-release  'i nifedipine10mg. capsule. (2) As this resident has a G-tube, and the extended-release  I n i fedipineER tablet can NOT be crushed,an alternaitve calciumchannel blocker, such as amlodipine,is recommended."  The physiciandid not address the pharmacist's recommendation until 2/18/18 at which time the  , physician agreed with the recommendation, | | |
|  | however, failed to discontinue the medication.  On 2/22/18 the consultant pharmacist documented that the recommendation was resubmitted to the physician.  However, review of the Medication Administration | |

FORMCMS-2567(02-99P) revious Versions Obsolete Event ID: 0S0411 Facility ID: 16017 If conti nuation sheet Page 10 of 16

CENTER S FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED

0MB NO 0938-0391

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| STATEMENTOF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER  **215020** | (X2) MULTIPLE CONSTRUCTION  A BUILDING \_  .8 W I NG\_ \_ \_ \_ \_ \_ \_ | | | (X3) DATE SURVEY COMPLETED  C  **07/24/2018** | |
| NAME OF PROVIDER OR SUPPLIER  **FORESTVILLEHEALTH** & **REHABILITATION CENTER** | | | | STREET ADDRESS, CITY, STATE, ZIP CODE  **7420 MARLBORO PIKE**  **FORESTVILLE, MD 20747** | | | |
| (X4) ID I SUMMARY STATEMENT OF DEFICEI NCIES  PREFIXI I (EACH DEFICIENCY M USTBEPRECEDEDBY FULL TAG 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 756 | Continued From page 10  Record (MAR) revealed that the resident | | F 756 | |  | |  |
| continued to receive Nifedipine1 3  caps ules every 12 hours through- at which time the resident was discharged to the hospital.  2. "Resident has an order for TRANSDERMAL NITROGLYCERIN PATCH, that was enteredas - NITROGLYCERIN PATCH 24hr 0.2mg/hr - apply one patch transdermallyone time a day for prevention of chest pain, and 'remove per  schedule'. The TRANSDERMAL  I NITROGL YCERIN PATCH should be applied in the morning and removed qHS [every bedtime), | | |
|  | | |
| to provide a nitrate-free interval, thus avoiding  to l er ance development. To avoid confusion re: 1 | | | | |
| 'remove per schedule', please clarify order to  Iinclude exactly when the nitroglycerin patch is to  1 be rem oved."  The physician did not address the pharmacist's recommendation until 2/21/18 at which time the physician agreed with the recommendatio.n  However, review of the February 2018 and March 2018 MAR revealed that the facility staff failed to establish an appropriate time to remove the residen'ts Nitroglycerin Patch and continued to  1 document that the patch was being applied at 9:00 A.M. but was not being removed at bedtime 1 through at which time the resident was  ' discharge o t e hospital.  3. "This **lllvear** old resident has an order for **METOCLffliRAMIDE** for 'preventionof GERD [gastroesophageal reflux disease]'.  I METOCLOPRAMIDE is considered unacceptable | | |  | |

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0MB NO 0938-0391

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| STATEMENTOFDEFICIENCIES AND PLAN OF CORRECITON | | (X1) PROVIDER/SUPPLIERU/CA IDENTIFICATIONNUMBER:  **215020** | (X2) MULTIPLE CONSTRUCTION  A. BUILDING\_ \_ \_ \_ \_ \_  .B WING \_ \_ \_ \_ \_ \_ \_ | | | (X3) DATE SURVEY COMPLETED  C  **07/24/2018** | |
| NAME OFPROVJDER OR SUPPLIER  **FORESTVILLE HEALTH** & **REHABILITATION CENTER** | | | | STREET ADDRESS, CITY, STATE, ZIP CODE  **7420 MARLBORO PIKE**  **FORESTVILLE, MD 20747** | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFJCIENCYMUST BEPRECEDEDBY FULL REGULATORY OR LSC IDENTIFYINGINFORMAITON) | | ID PREFIX TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTJON SHOULD BE  CROSS-REEFRENCED TO THEAPPROPRIATE DEFICIENCY) | | (XSJ COMPLETION DATE |
| F 756 | Continued From page 11 | | F 756 | |  | |  |
|  | for use in nursing facility residents, as it has many undesirable side effects (e.g. dyskinesias, hallucinations, drowsiness, tremor, and restlessness.) The risk for IRREVERSIBLE tardive dyskinesias is significantly increased when used in older individuals. Please consider discontinuing metoclopramide. Alternative therapy, such a proton pump inhibitor - which is actually the preferential treatment for GERO - could be used if necessary." | |  | |
|  | |  |
|  | The physician did not address the pharmacist's recommendaiton until 2/21/18 at which time the physician agreed with the recommendation to discontinue the medication. | |  | |
|  | However, review of the MAR revealed that the medication was not discontinued until 2/27/18. | |  | |
| F 757 SS=D | Drug Regimen is Free from Unnecessary Drugs CF R(s): 483.45(d)(1)-(6) | | F 757 | |
|  | §483.45(d) Unnecessary Drugs-General.  Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- | |  | |
|  | §483.45(d)(1) In excessive dose (including duplicate drug therapy); or | |  | |
|  |  | |  | |
| §483.45(d)(2) For excessive duration; or | | |  | |
|  | §483.45(d)(3) Without adequate monitoring; or | |  | |
| §483.45(d)(4) Without adequate indications for its use;or | |  | |
| §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be | |  | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATIONNUMBER:  **215020** | (X2) MULTIPLE CONSTRUCTION  A BUILDING  . NGI | | | (X3) DATE SURVEY COMPLETED  C  **07/24/2018** | |
| NAME OF PROVIDER OR SUPPLIER  **FORESTVILLE HEALTH** & **REHABILITATION CENTER** | | | | STREET ADDRESS, CITY, STATE, ZIPCODE  **7420 MARLBORO PIKE**  **FORESTVILLE, MD 20747** | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT *OF* DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | 10  PREFIX TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVEACTION SHOULD BE  CROS-SREFERENCEDTOTHE APPROPRIATE DEFICIENCY) | | (XS)  COMPLETION  DATE |
| F 757 | Continued From page 12 reduced or discontinued;or | | F 757 | |  | |  |
| I§483.45(d)(6) Any combinaitonsof the reasons stated in paragraphs (d)(1) through (5) of this  section.  This REQUIREMENT is not met as evidenced by:  Based on medical record review it was determined the facility staff failed to ensure that Resident #l's drug regimen was free from unnecessary medications. Thiswas evidentfor 1 of 3 sampled residentselected for review.  j The findings include:  I   * Based on medical record review it was determined the facility staff failed to promptly respond to the consultant pharmacist's recommendaiotnsrelated to drug irregularitiesfor Resident #1. This was evident for 1 of 3 sampled residents selected for review.   The findings include:  Resident #1 was readmitted to the facility on  .- fter a hospitalization.  I  The resident's medical record was reviewed on  1 July 20, 2018, July 23, 2018 and July 24, 2018. | | |  | |
|  | | |
|  | Medical record review revealed that on 1/24/18 the consultant pharmacist reviewed the resident's medication regimen. The following recommendationwsere made to the physician:  1. "This■year old resident has an order for NIFEDIPINE30mg every 12 hours for HTN | |
|  | |  |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATIONNUMBER:  **215020** | (X2 ) MULTIPLECONSTRUCTION  A. BUILDING  BWIN\_G \_ \_ \_ \_ \_ \_ \_ \_ | | | (X3) DATE SURVEY COMPLETED  C  **07/24/2018** | |
| NAME OFPROVIDER OR SUPPLIER  **FORESTVILLE HEALTH** & **REHABILITATION CENTER** | | | | STREET ADDRESS, CITY. STAT, E ZIP CODE  **7420 MARLBORO PIKE**  **FORESTVILLE, MD 20747** | | | |
| (X4) ID II SUMMARY STATEMENTOF DEFICIENCIES PREFIX (EACH DEFICIENCYMUST BE PRECEDED BY FULL  TAG REGULATORY OR LSC IDENTIFYINGINFORMATION) | | | ID PREFIX TAG | | PROVIDER'S PLAN OF CORRECITON (EACH CORRECTIVEACTION SHOULD BE  CROSS-REFERENCETDO THEAPPROPRIATE DEFICIENCY) | | (XS) COMPLETION DATE |
| F 757 | Continued From page 13  {hypertension]. entered as - NIFEdipine Capsule 10 MG - Give 3 capsule via GTube every 12 | | F 757 | |  | |  |
| Ihours for high blood pressure. NIFEDIPINE is  available as both the immediate-release 'NIFEDIPINE' and as the extended-release product, NIFEDIPINE ER (PROCARDIAXL).  Only the extended-releaseproduct has been approved for the treatment of hypertension. In fact, due to the risks associated with immediate-release NIFEDIPINE (including  profound hypotension, Ml [myocardial infarction), and death) this dosage formulation should specificallyNOT be use,d n pat ients with chronic hypertension. The immediate-release  INIFEDIPINE in elderlyfor the treatment of  iIh ypertension has been associated with a nearly 4-fold increase in risk for all-cause mortality when  I compared to other antihypertensives.   1. Given the increased risk to this resident, pleasediscontinuethe immediate-release nifedipine 10mg. capsule. (2) As this resident has a G-tube,and the extended-release nifedipine ER tablet can NOT be crushed, an alternative calciumchannel blocker, such as amtodipine , is recommende.d"   !  !The physiciandid not address the pharmacist's  ! recommendation until 2/18/18 at which time the  physician agreed with the recommendaiton, however, failed to discontinuethe medication. On 2/22/18 the consultant pharmacist documented that the recommendation was resubmitted to the physician.  IHoweve,r review of the MedicaitonAdministration  IRecord (MAR) revealed that the resident  I continued to receive Nifedipine 10 mg., 3 | | |

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CENTERS FOR MEDICARE & MEDICAID SERVICES

FORMAPPROVED

0MB NO 0938-0391

STATEMENTOF DEFICIENCIES **(XI)** PROVIDER/SUPPLIER/CUA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED

C

**215020** B. WING **07/24/2018**

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY. STATE. ZIP CODE

**FORESTVILLE HEALTH** & **REHABILITATION CENTER 7420 MARLBORO PIKE**

**FORESTVILLE, MD 20747**

{X4) ID SUMMARY STATEMENT OF DEFICIENCIES

I D PROVIDE'RS PLAN OF CORRECTION (XS)

PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM PL ET ION

TAG REGULATORY OR LSC IDENTIFYING INFORMATION)

\

I TAG CROSS.REFERENCED TO THE APPROPRIATE DATE

I D EFICIENCY)

F757 ' Continued From page 14 F 757 capsules every 12 hours through- at which

time the resident was discharged to the hospital.

2. "Resident has an order for TRANSDERMAL NITROGLYCERIN PATCH, that was entered as - NITROGLYCERIN PATCH 24hr 0.2mg/hr - apply one patch transdermally one time a day for prevention of chest pain, and ·remove per schedule'. The TRANSDERMAL NITROGLYCEIRN PATCH should be applied in

I the morning and removed qHS [every bedtime),

1 to provide a nitrate-free interval, thus avoiding Itolerance development. To avoid confusion re: 'remove per schedule', please clarify order to

includeexactly when the nitroglycerin patch is to be removed."

The physician did not address the pharmacist's recommendation until 2/21/18 at which time the physician agreed with the recommendation.

However, review of the February 2018 and March I

2018 MAR revealed that the facility staff failed to

I

establish an appropriate time to remove the I

1 resident's Nitroglycerin Patch and continued to

Idocument that the patch was being applied at I

1 9:00 A.M.was not being removed at bedtime I

'. through at which time the resident was

I

! discharged to the hospital. I

I

3. "Thi- year old resident has an order for I

I

METOCLOPRAMIDE for 'prevention of GERO

[gastroesophageal reflux disease]'. I

METOCLOPRAMIDE is considered unacceptable

for use in nursing facility residents.as it has many

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID 0S0411 Facility ID: 16017 IF conti n uat ion sheet Page 15 of 16

CENTERS FOR MEDICARE & MEDICAIDSERVICES

FORM APPROVED

0MB NO 0938-0391

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| STATEMENT OFDEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATIONNUMBER:  **215020** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING \_ \_ \_ \_ \_ \_ 2. WING | | | (X3) DATE SURVEY COMPLETED  C  **07/2412018** | |
| NAME OFPROVIDEROR SUPPLIER  **FORESTVILLE HEALTH**& **REHABILITATION CENTER** | | | | STREETADDRESS, CITY, STATE, ZIP CODE  **742 0 MAR LBORO PIKE**  **FORESTVILLE, MD 20747** | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OFDEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TOTHEAPPROPRIATE DEFICIENCY) | | (XS )  COMP LETION  DATE |
| F 757 | Continued Frompage 15  undesirable side effects (e.g. dyskinesias, hallucinations, drowsiness, tremor, and restlessness). The risk for IRREVERSIBLE tardive dyskinesias is significantly increased when used in older individuals. Please consider discontinuing metoclopramide. Alternative therapy, such a proton pump inhibitor - which is  actually the preferential treatment for GERO - could be used if riecessary." | | F 757 | |  | |  |
| I  The physician did not address the pharmacist's  recommendation until 2/21/18 at which time the physician agreed with the recommendation to discontinue the medication.  However, review of the MAR revealed that the medication was not discontinueduntil 2/27/18. | | |
| i | | |

FORMCMS-2567(02-99) Previous VersionsObsolete Event ID: OSQ411 Facility ID: 16017 If continua tion sheet Page 16 of 16

Office of Health Care Qualitl

STATEMENT OFDEFICIENCIES AND PlANOF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATIONNUMBER:

**215020**

(X2) MULTIPLECONSTRUCTION

A. BUILDING

B. WING

FORM APPROVED

(X3) DATE SURVEY COMPLETED

C

**07/24/2018**

NAME OF PROVIDER OR SUPPLIER

**FORESTVILLE HEALTH** & **REHABILITATION CE**

STREET ADDRESS, CITY, STATE, ZIP CODE

**7420 MARLBORO PIKE**

**FORESTVILLE, MD 20747**

(X4) 10 PREFIX TAG

SUMMARY $TATEMENT *OF* DEFICIENCIES (EACHDEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG

PROVIDER'S PlAN OF CORRECTION (EACHCORRECITVEACTION SHOULD BE

CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

( XS) COMPLETE DATE

s ooo Initial comments

On July 20, 2018, July 23, 2018 and July 24, 2018 a complaint investigation survey was conducted by the Office of Health Care Quality to investigatecomplaint numbers MD00124299 and MD00126285. Additional information was providedby the facility on 8/10/18. The facility is licensed for 162 comprehensive care facility (CCF) beds with an occupancy of 154 CCF beds at the initiation of the survey. Survey activities consisted of a review of three (3) residents' medical records, interviews with residentsand staff and observation of resident care and staff practices.

It was determined that there were deficiencies identified as a result of this investigation under the requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities.

s 39. 5 10.07.02.1O G Physician Services Appropriate Care of Res

.10 Physician Services

S 000

S 395

G. Appropriate Care of Residents. The attending physician shall:

1. Perform accurate, timely, and relevant medical assessments;
2. Properly define and describe resident symptoms and problems, clarify and verify diagnoses, relate diagnoses to resident problems, and help establish a realistic prognosis

I

1 and care goals;

1. In consultation with the facility's staff:
2. Determine appropriate services and programs for a resident, consistent with diagnoses, condition, prognosis, and resident wishes;
3. Ensure that treatments are medically

OHCQ

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTTAIVE'S SIGNATURE TITLE (X6) DATE

STATE FORM 6899 0S0411 Ircontinuaiotnsheel 1 of 5

Office of Health Care Quailtl

STATEMENTOF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CUA

(X2) MULTPILECONSTRUCTION

FORM APPROVED

(X3)DATE SURVEY

AND PLAN OF CORRECTOIN

IDENTIFICAOTNI NUMBER:

A. BUI L DI NG\_: \_ \_

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COMPLETED

**215020**

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**07/24/2018**

NAME OF PROVIDEROR SUPPLIER

**FORESTVILLE HEALTH** & **REHABILITATION CE**

ST REETADDRESS, CITY, STATE, ZIPCODE

**7420 MARLBORO PIKE**

FORESTVILLE, **MD 20747**

(X4) ID PREFIX TAG

SUMMARY STATEMENT OFDEFICIENCIES (EACHDEFICIENCYMUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYINGINFORMATION)

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PROVIDER'S PLAN OF CORRECTION (EACHCORRECTIVE ACTIONSHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICEI NCY)

(X5) COMPLETE DATE

s 395 Cont inued From page 1

necessary and appropriate in accordance with nursing facility regulatory requirements: and

1. Manage and document ethics issues consistent with relevant laws and regulations and with residents' wishes, includingadvising residents and families about formulaitng advance directives or other care instructions and helping identify individuals for whom aggressivemedical interventionsmay not be indicated;
2. Respond in an appropriate time frame, based on a facility-developedprotocol, to emergency and routine notification, to enablethe facility to meet its clinical and regulatory obligations;
3. Respond to notification of laboratoryand other diagnostic test results in a timely manne,r based on the resident's condition and clinical significanceof the results;

1 (6) Analyze the significance of abnormal test

' results that may reflect important changesin the

i resident's status and explain the medical

1 r ationale for interventionsor decisionsnot to intervene based on those results:

1. Respond promptly to notification of, and assess and manage adequately, reportedacute and other significant clinical condition changesin residents; and
2. Ensure that individuals receiving palliative care have appropriate comfort and supportive care measures.

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

I F F

7 56; 757

s 506 10.07.0 2.12 O Nsg Svcs;Care24 Hrs per Day

.12 NursingServices.

S 395

S 506

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STATEFORM 6191> 0 S0 41 1 If continuation sheet 2 of 5

Office of Health Care Qualitv

STATEMENTOF DEFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

1. BUILDING: \_ \_ \_ \_ \_ \_

FORM APPROVED

(X3) DATE SURVEY COMPLETED

NAME OF PROVIDEROR SUPPLEI R

**215020**

1. WING

STREET ADDRESS, CITY, STATE, ZIP CODE

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**07/24/2018**

**FORESTVILLE HEALTH** & **REHABILITATION CE**

**7420 MARLBORO PIKE**

**FORESTVILLE, MO 20747**

(X4) ID PREFIX TAG

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PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVEACTION SHOULD BE

CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY)

(X5)

COMPLETE DATE

s 506 Continued From page 2

S506

0 . Nursing Care--24 Hours a Day. There shall be sufficient licensed and supportive nursing service personnel on duty 24 hours a day to provide appropriate bedside care to assure that each patient:

1 ( 1) Receives treatment,smedication,sand diet as

1 prescribed;

I (2) Receivesrehabilitavtie nursing care as

1 needed·

I '

1. Receives proper care to prevent decubitus ulcers and deformities;
2. Is keptcomfortable, clean, and well-groomed;
3. Is protectedfrom acciden,tinjury, and infection;
4. Is encouraged, assisted, and trained in self-care and group activities.

This Regulation :s not met as evidencedby: Refer to CMS 2567

I F

686

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S 5121 10 .07 .02 . 12 R Nsg Svcs; Charge Nurse Daily Rounds

.12 Nursing Services.

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. Visitingeach patient;
2. Reviewing clinical records, medication orders, patient care plans, and staff assignments;
3. To the degree possible, accompanying physicianswhen visitingpatients.

S 512

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STATE FORM 6899 0 S0 411 1r c ontinu a tio n s hee t 3 or 5

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| Office of Health Care Qualit\ | |  | | | | | | | | | | | | | |
| STATEMENT OF DEFICIENCIES  AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPLPIER/CUA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: \_ \_ \_ \_ \_ | | | | | | |  | \_ |  | (X3) DATE SURVEY COMPLETED | |
|  | | **215020** | | .B WIN\_G \_ | \_ | \_ | \_ | \_ | \_ | \_ | \_ |  | \_ | C  **07/24/2018** | |
| NAME OF PROVIDER OR SUPPLIER  **FORESTVILLE HEALTH & REHABILITATION CE** | | | STREET ADDRESS, CITY, STAT,E ZIP CODE  **7420 MARLBORO PIKE**  **FORESTVILLE, MD 20747** | | | | | | | |  |  |  |  | |
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|  |  | | | DEFICIENCY) | | | | | | | | | |  |
| s5121Continued From page 3 | | | | S 512  S 516  S6018 |  | | | | | | | | | |  |
| S 516  S6018 | This Regulation is not met as evidenced by: Refer to CMS 2567  F 756; F 757  10.07.02.12T Nsg Svcs;Coordination Nursing/Dietetics  .12 Nursing Services.  T. Coordination of Nursing and Dietetic Services. Nursing and dietetic services shall establishan effectivepolicy to assure that:   1. Nursing personnelare aware of the nutritional needs and food and fluid intake of patients and ensure that special feedingsand nourishment are provided when required; 2. Nursing personnel assist promptly when necessary in the feeding of patients; 3. The dietetic service is informed of physicians' diet ordersand of patients' problems; 4. Food and fluid intake of patients is observed, and deviations from normal are recorded and reported to the: 5. Charge nurse, 6. Physician, and 7. Dietetic service.   This Regulation is not met as evidenced by: Refer to CMS 2567  F 693  10.07.09.08 C (14) Right to purchase copies of records  .08 Resident's Rights and Services.  C. A resident has the right to: | | |

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STATE FORM 6899 0S0411 If continualion sheet 4 or 5

Office of HealthCare Qualit\

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| STATEMENTOF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  **215020** | (X2) MULTIPLE CONSTRUCTION  A. BUI L DI N G: \_  .B WIN\_G \_ \_ \_ \_ \_ \_ \_ \_ \_ | | (X3) DATE SURVEY COMPLETED  C  **07/24/2018** | |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY, STATE, ZIPCODE  **FORE STVILLE HEALTH** & **REHABLI ITATION CE 7420 MARLBORO PIKE**  FORESTVILLE, **MD 20747**  (X4) IDI SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) | | | | | | |
| PREFIX (EACH DEFICIENCY MUST BEPRECEDED BY FULL | | | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | COMPLETE DATE |
| TAG | REGULATORY OR LSC IDENTIFYING INFORMATION) | |
| S6018 | Continued From page 4  (14} Purchase copies of all or part of the resident's records upon request by giving2 working days advance notice to the nursing facility;  This Regulation is not met as evidenced by: Refer to CMS 2567  F 573 | | S6018 |  | |  |
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STATE FORM 6199 0S0411 If continuation sheet 5 of 5



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Maryla nd Department of Health and Mental Hyg ie ne

20 l W. Preston Street • Baltim or e, Maryland 2120 I

Martin O' Malley. Governor - Anthony G. Rrown. Lt. Governor - Joshua M. Sharls tl·1n. M.I>.. S.:..:rc1ary

August 4, 2014

Ms. Sytina Smith, Administrator Forestville Health & Rehabilitation Center 7420 Marlboro Pike

Forestville, MD 20747

###### PROVIDER# 215020

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

Dear Ms. Smith:

On July 14, 2014, 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 arefound 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 due date 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;

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

Toll Free l -877-4MD-DHMH • TT Y/MarylandRelay Service 1-800-735-22.58 Web Site: [www.dhmh.mary lan](http://www.dhmh.marylan/)<l.gov

Ms. Sytina Smith, Administrator Forestville Health & Rehabilitation Center August 4, 2014

Page2

* 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 attached 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 August 28, 2014. 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 substantialcompliance within 3 months after the last day of the survey (i.e.October 14, 2014) 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 January 14, 2015, your Medicare provider agreement will be terminated.

1. 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 yo u 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 July 14, 2014 and will continue until substantial compliance is achieved. Additionally, we may impose a revised remedy(ies), based on

Ms. Sytina Smith, Administrator Forestville Health & RehabilitationCenter August 4, 2014

Page 2

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 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 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 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 containe9 in this letter, please contact me at 410-402-820 I or fax 410-402-8234.

Sin\_Aere l y,

*(Lc),Lu\_, /Jl l(At,*

Debra Munford

Health Facilities Survey Coordinator Long Term Care

Enclosures: CMS 2567

State Form

cc: Alice Hedt Jane Sacco File II



August 12, 2014

Healt h Facilities Survey Coordinator Long Term Care

Office of Health Car e Quality Spring Grove Center

Bland Bryant Building 55 Wade Avenue

Catonsvill e, MD 21228-4663

Re: CommuniCare Health Services-Forestville Health and Rehabilitation Center Provider#: 215020

Survey Date: July 14, 2104 Dear Ms. Deb M unford:

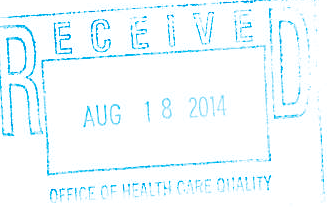
Enclosed please find our completed plan of correction dated Augu st 12, 2014 responding to the survey conducted at our facility, July 14, 2014. I would like to note that the cited deficiencies did not include the scope and severit y.

Our plan of correction should be considered to serve as our allegations of compliance to the cited deficiencies. This plan of correction is being filed as a matter of compliance.

CommuniCare Health Services- Forestville Health and Rehabilitation Cent er takes the cited deficienciesvery seriously and is committed to implementing the plan of correction as expeditiously as possible. Please be assured that CommuniCare Health Services- Forestville Health and Rehabilitation Center is undertaking measures to ensure compliance by August 28, 2014.

Please contact me with any questions or concerns you may have. Thank you in advance for your cooperation and assistance in this matter.

Sincerely,

Services- Forestville Health and Rehabil it ation Center

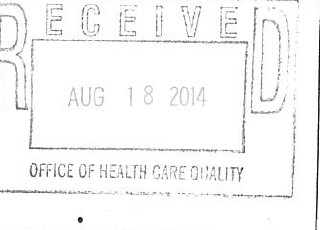


Sytina Smith, LNHA Executive Director

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/04/2014 FORM APPROVED 0MB NO . 0938-0391

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ny deficiency statement ending with an ast risk (') denotes a deficiency which the instilution may be excused from correcting providing it is determine that lher safeguards provide sufficient protection to the patients. (See instruclions.) Except for nursing homes, the findings stated above are disclosable 90 d.:iys 1llowing the date or surveywhether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 3ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

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| NAME OF PROVIDER OR SUPPLIER  **FORESTVILLE HEALTH** & **REHABILITATION CENTER** | | | | STREET ADDRESS, CITY, STATE, ZIP CODE  **7420 MARLBORO PIKE**  **FORESTVILLE, MD 20747** | | | |
| (X4)1D 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) COMPLETION DATE |
| F 000 | INITIAL COMMENTS | | F 000  F 514 | | Resident #4 was discharge. d 2014.  The hospita l documentat io n was immediately obtained. This  info rmation was emailed and faxed to the surveyor explaining that the Lovenox was discontinued due to the resident's poor kidney function.  Therefore, the rational for discontinuing the Lovenox upon admiss io n was correct.  The NP who documented in the progress notes that Lovenox was being given, admitted to the surveyor that the information he documented was directly from the transfer  summary and that he did not realize the Lovenox being discontinued upon admission.  The hospit al document was filed in the residents' closed medical record for reference. | | 8/28/14 |
| I On July 14, 2014 an investigation was conducted  I at this facility by the Office of Health Care Quality  : to investigate four complaints MD00085252,  1 MD00083949, MD00083760 and MD00083372,  and one facility reported incident MD00085261.  Survey activities consisted of a review of five  resident's medical records and interview of the facility staff in addition to a review of the administrative records.  The following deficie ncies are a result of the  1 complaint MD00083949 investigation: F 514 J 4 83.75(1)(1) RES  I RECORDS-COMPLETE/ACCURATE/ACCESSIB  LE  IThe fac ili ty must maintain clinical records on each resident in accordance with accepted professional  standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State;  . and progress notes.  I  This REQUIREMENT is not met as evidenced by:  Based on record review and interviews, it was determined that the facility taff failed to maintain  I1 clinical records in the most complete and   * accurate form (Resident# 4). | | |

* ogram participation.

lRM CMS-2567 (02-99 ) Previous VersionsObsolete Event ID. 4GG411 Facilily10: 160 17 If contin uation sheet Page 1 of 2

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

P R INT E D : 08/04/2014

FORM APPROVED

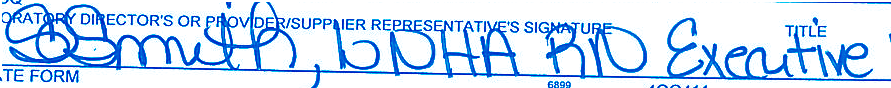
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| NAME OF PROVIDER OR SUPPLIER  **FORESTVILLE HEALTH** & **REHABILITATIONCENTER** | | | | | | | STREE T ADDRESS. CITY. STATE, ZIP  **7420 MARLBORO PIKE**  **FORESTVILLE, MD 20747** | | CODE | | |
| PREFIXI  (X4) ID  TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCYMUST BE PRECEDED BY FULL REGULATORYOR LSC IDENTIFYING INFORMATION) | | | | ID PREFIX TAG | | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | | (XS) COMPLETION DATE |
| F 5 141 Con | t inued | From page 1 | | l | | F 514 | | Others have the potential to be affected by this deficient practice.  The lice nsed staff will be in serviced to obtain the rational from the  physic ian for discontinuing a medication ordered on the transfer summary. This information will be documented in the residents' medical record for reference.  The ADON's or designee will complete chart reviews of the new admissions to ensure that medications discontinued from the transfe r summary upon admission have s upporting documentation of the reason for the discontinuation.  The ADON ' s or desig nee will monitor the process mont hly X 3 months and report findings to QA. | | | **8/28/14** |
| j The findings include:  IReview of Resident# 4's medical record revealed the foll  J 1. On -- the resident was admitted to the facility from the hospital with orders that included  ILovenox (anticoagulant) while in the  !rehabi li tation.  The physician's/nurse practitioner's progress  'j notes, dated 12/18/13, 12/20/13 and 12/21/13, state the resident is to continue on Lovenox to  i prevent Deep Vein Thrombosis (blood clot).  I Doctor's progress notes, dated 1/6/14 and 1/13/14 , also reference the continuation of Lovenox.  2. Review of the resident's Medication Administration Records (MAR) revealed the order for Lovenox was not transcribed onto the MAR. The medication was discontinued on the physician's order sheet and further medical record failed to reveal the name of the practitioner who discontinued the Lovenox or a rationale for not continuing the treatment.  The findings were discussed with the director of nursing on 7/14/14 at 12:55 PM.  1  I I I  j  l  I  i | | | | |  | | |
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ORM CMS-2507(02-99} Previous v ersionsObsolete Event ID: 4GG411 Facility ID: 16017 If continuation sheet Page 2 of 2

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1} PROVIDER/SUPPLIER/CUA IDENTIFICATIONNUMBER:  **215020** | (X2) MULTIPLE CONSTRUCTION  A. BUI LDI NG:  B. WIN\_G \_ \_ \_ \_ \_ \_ \_ \_ | | **(X3)** DATE SURVEY COMPLETED  C  **07/14/2014** | |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE  **FORESTVILLE HEALTH** & **REHABILITATION** Cl **7420 MARLBORO PIKE**  **FORESTVILLE, MO 20747** | | | | | | |
| **(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) COMPLETE DATE |
| s ooo 10.07 .02 Initial comments  . I On July 14, 2014, an investigation was conducted  Iat this facility by the Office of Health Care Quality  to investigate four complaints M000085252, MD00083949, MD00083760 and MD00083372,  and one facility reported incident MD00085261. Survey activities consisted of a review of five residen'ts medical records and interview of the facility staff in addition to a review of the administrative records.  The following deficiencies are a result of the complaint MD00083949 investigation:  S 480· 10.07.02.12 G Nsg Svcs;Responsibilities DoN  .12 Nursing Services.  G. Responsibilities of the Director of Nursing. The responsibilities of the director of nursing shall include:   1. Assisting in the development and updating of statements of nursing philosophy and objectives, defining the type of nursing care the facility shall provide; 2. Preparation of written job descriptions for nursing personnel; 3. Planning for the total nursing needs of patients to be met and recommending the assignment of a sufficient number of supervisory and supportive personnel for each tour of duty; 4. Development and maintenance of nursing service policies and procedures to implement the program of care; 5. Participation in the coordination of patient services through appropriate staff committee meetings (pharmacy, infection control, patient care policies, and utilization review) and departmental meetings; 6. Cooperation with administration in planning | | | sooo  **$ 480** | SEEFTAG514 | |  |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:  **215020** | (X2) MULTIPLE CONSTRUCTION  A. BUI LDI NG \_ : \_ \_ \_ \_ \_ \_ \_  B. WIN\_G \_ \_ \_ \_ \_ \_ \_ \_ \_ | | **(X3)** DATE SURVEY COMPLETED  C  **07/14/2014** | |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE  **FORESTVILLE HEALTH** & **REHABILITATION** Cl **7420 MARLBORO PIKE**  **FORESTVILLE, MD 20747**  (X4) IDI SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (XS) | | | | | |
| PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG , REGULATORY OR LSC IDENTIFYING INFORMATION)  I | | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCEDTO THE APPROPRIATE DEFICIENCY) | | COMPLETE  DATE |
| **S480** Continued From page 1  theorientation program and the staff development program to upgrade the competency of the personnel;   1. Ensurance that the philosophy and objectives are understood and practiced by nursing personnel; 2. Participation in planning and budgeting for nursing services; 3. Establishment of a procedure to ensure that nursing personnel, including private duty nurses, have valid and current Maryland licenses; 4. Execution of patient care policies (unless delegated to principal physician, medical director); 5. Participation in the selection of prospective admissions to ensure that facility's staff is capable of meeting the needs of all patients admitted; 6. Coordination of the interdisciplinary patient care management efforts; 7. Supervision of medicine aides to ensure that there is no deviation from the limitations and restrictionsplaced upon them.   This Regulation is not met as evidenced by: Refer to CMS 2567, tag F 514  **S 512** 10.07.02.12 R Nsg Svcs; Charge Nurse Daily Rounds  .12 Nursing Services.  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, | | **S480**  **S512** | SEE F TAG 514 | |  |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:  **215020** | (X2) MULTIPLE CONSTRUCTION  A.BUI LD I NG\_: \_ \_ \_ \_ \_ \_ \_ \_  B.WING | | (X3) DATE SURVEY COMPLETED  C  **07/14/2014** | |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY. STATE, ZIP CODE  FORESTVILLE HEALTH & REHABILITATIONCi **7420 MARLBORO** PIKE  FORESTVILLE, **MD 20747** | | | | | | |
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| s 512 | Continued From page 2  patient care plans, and staff assignments;  (3) To the degree possible, accompanying physicians when visiting patients.  This Regulation is not met as evidenced by: Refer to CMS 2567, tag F 514 | | S512 |  | |  |
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Forestville

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March 6, 2015

Health Facilities Survey Coordinator Long Term Care

Office of Health Care Quality SpringGrove Center

Bland Bryant Building 55 Wade Avenue

Catonsville, MD 21 228- 4663

Re: CommuniCare Health Services-Forestville Health and Rehabilitation Center Provider#: 215020

Survey Date:February 4, 2015

Dear Ms. Francis Curtis:

Enclosedplease findour completed plan of correction dat ed March 6, 2015 responding to the survey conducted at our facility, February 4,2015.

Our plan of correction should be consjdered to serve as our allegations of compliance to cited deficiencies: F 465.

CommuniCare Health Services- Forestville Health and Rehabilitation Center takes the cited deficiencies very seriously and is committed to implementing the plan of correction as expedit iously as possible. Please be assured that CommuniCare Health Services- Fore stville

Health and Rehabilitation Center isundertaking measures to ensure compliance as of M arch 21,

2015.

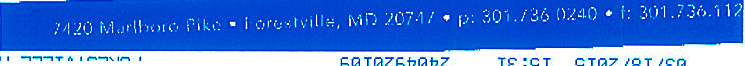
Please contact me with any questions or concerns you may have. Thank you in advance for your cooperation and assistance in this matter.

Sincerely,

e ices- Forestville Health and Rehabilitation *Center*



Sytina Smith, LNHA Executive Director

A Mernb er of The ComrnvnlCo fe Family of Componl1:

communlcarehealth,com

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STATE OFMARYLAND

* + **DHMH**

Maryland Department of Health and Mental Hygiene

Office of Health Care Quality

Spring Grove Center • Bland Bryant Building

55 Wade Avenue• Catonsville, Maryland 21228-4663

Lawrence J. Hogan, Jr., Governor- Boyd K. Rutherfo,rd Lt. Governor- Van T. Mitchell, Secretary

February 19, 2015

Ms. Sytina Smith, Administrator Forestville Health & Rehabilitation Center 7420 Marlboro Pike

Forestville, MD 20747

#### PROVIDER# 215020

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

Dear Ms. Smith:

On February 4, 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 IO 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 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 1-877-4MD-DHMH- ITY/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. 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 21, 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.May 4, 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 August 4, 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 achieved substantial compliance, we may impose remedies previously mentioned in this letter beginning February 4, 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 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, MD, 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 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 daysofreceipt 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.

incerely, .*n*·- /J

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acJ,ueline Cooper

:ealth Facilities Survey Coordinator Long Term Care Unit

Office of Health Care Quality

Enclosures: CMS 2567

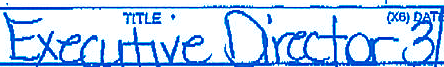
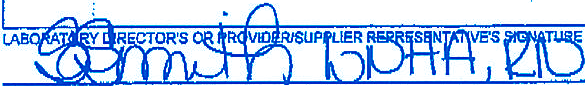
State Form

cc: Alice Hedt Jane Sacco File II

DEPARTMENT - F HEALTH AND HUMANSERVICES CENTERS FOR MEDICARE & MEDICAi SERVICES

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| FORES1VILLE HEALTH& REHASILITATIONCl:NTER  (X4) ID ! SUMMAAY STATEMEN'f Or OEFICIENCJES | | | | 7420 MARLBOROPll<E  FOReSTVILLE, MD 20747 | | | |
| PREFIX .  TAG j | (EACH 01:FlC!ENCYMUSTBtaPRECEDED BYFULL REGULATORY OR LSC IDENYIFYING INFORIAATIOH) | | ID PROiJIDER PLANOF CORRECTION PR IX ;I (EACHCORRECTIVEACTION 6HOUUl BE  TAG CROSs-REFERENCEOTO THEAPPROPRIATE  DEFICIENCY) | | | : | ICOMPliTION  I (XS  DATE  i |
| F 000!INITIAL COMMENTS F OOOi  !  i  J  : On Februaiy4, 2015, a survey was conducted at I I this nursing care facRity to ascertain that sefe i co <;1iti o s were bei gmani tainedduringa i cility-widerenovation. survey activities '  inc luded a tour of theareas bei ng renovated and disc u $$io11 with the facility administrator and the  1, representatiVe for the general contractor  '. overseeing the renovation.  I  'I  I  '. Based on thefindingsmade during this survey,  i the followingdeficiency was found to be in ,  ; evidence. 'i  F 465; 483.70(h) ! F 465 iThe contractors immediately  SS-0! SAFE/FUNCTIONALJSANITARY/COMFORTABLI: )prevente d the rooms under 03/21/15  ! EENVIRON . iconstruction from being entered by  . i !removing the door knob handles on all  : The facility must providea safe, functional, of the rooms. The room containing  ! sanitary, and comfortable environmentfor the small electrical drill and cove base  I residents, staff and the public. ! was lockedand could only be entered  i  ' 1with a key kept by thesuperintendent  [ This REQUIREMENTis not met as evidenced !  i by: jAll residents have the potential to be  ! *On* February 4,2015, a survey of this nursing affected by this deficient practice.  *!* care facffity was conductedto ascertain whether I.None of the residents entered the l; safe conditionswerebefng ma intained. Based Iconstruction area and no negative on observation of the facility, it was revealed that  ; active work areas were accessible to residents l outc eresulted by this deficient  !' and not under thecontrolof staff or ! p ractice.  representativesof the general contractor. As  i such, the envri onment of care for the residents  ! was not maintani edin a safe manner aswas ,· T h e con tractors had a plastic wall  ! possible. 1.separating the rooms under  i !construction from the rooms with  ; The findingsincluded: iresidents which extended completely  ! Idown the right sideof the hallway.  f&f | | | | | | | |

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AJ'\y deficie n cy statement endin9 With enasterisk (") deriotes a deficiency which theinstitutionmayb& excused *from* COtTectingprovidingIt Is determined at other safeguardsprovide sufficientprotection IOthepatlei\ts. (See,Instructions.) l;xceptfor nursing hemes, thefindings stalsd abcva are dlscio!IGl)le 90 days f'ollowing th& date ofsurvey wh her ornotIii p1$1\ ofcorrection isprovided. For nursing hemes,theabovefindings andplansof correctfon are disdoS3ble 14 days following thedate t (IQC1,Jmen are made availabletothel'acJl lty. If deficiencies are cited, Wl llfll:)roved plan ofcorrection is requisite to continued progrom psrlicipatign.

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DEPARTMETNOFHEALTH AND HUMAN SERVICES CENTERS FORMEDICARE & MEDICAIDSERVICES

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| i i i  F 465; Continued From page 1 F 465i !  i i  i On February 4, 2015, a tour of the lower level of 1 I I  i I  : the facility was conducted soas to ascertain that · I I  l active renovation work areas were controlledto ! i  ! prevent entry by residents or other unauthorized / I i  ! persons. Further. to determine the environment · i  :' of careutilized by residents was maintained in a !1 iDuring the installation of the ceiling 03/21/15  isafe and sanitarymanne.r 1 !grids and tiles, the contractors  irernoved. the plastic wall temporarily iinorder to complete that task, with  l Observation of the first.(lower) level of the facility, ; • 1plan to place the plastic wall back as  !north wing, revealedthat bedrooms on the one : previous.  j side of the corridor were occupied by residents I 1  ; while the bedrooms on the other side of the l I  ; corridor were under renovation. Uponentering ; !Plasticwall will be in.stalled to  : one ofthe bedrooms being renovated, it was ! ise parate the rooms under construction  ; re vealed that: 1 :throughoutthe renovation project.  ! !! Thecontractors will maintain. the  I  : a. Anyon e could enter the bedrooms being method of removing the door knob  ! actively renovated as door ware not secured handle from all rooms under  i against entty by residents or unauthorized !construction and lock any rooms used  1per sons. Ito store materials and tools.  1 I  ; b. One side of the corridor was found with \t he superintendent, maintenance staff,  j equipment such as linen carts, soiled laundiy iand nursing staff removed all carts,  i carts, etc., which would beconsideredas an l  : obstruction to a means of egress for emergency \incl uding clean linen and soiled  \ e vacuatio.n \ 1Ia undry carts outof the hallway. All  \carts will beplaced in the newly  i c, Withni thebedrooms being renovated were I 1renovated dirty and clean utility rooms  l power tools such asdrills, connected by electricali !  ; powercord to electrical receptacle,as well as ;  \ parts, materials, etc. 1 I  i  Id.In additoi n, bathrooms or uiility rooms just \ i  i  \ outside of the north wing corridor were under I  I renovation, not secured against entry byresidents: \ j or other unauthorizedpersons. i I | | | | |

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DEPARTMEN! OF Ht;ALTH AND HUMAN SERV\CES

CEN1ERS FOR MEDICARE & MEDICAID SERVICES

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| NAME OFPROVIDER OR SUPPLIER  FORESTVILLE HEALTH &REHABILITATION CENTER | | | STREETADDRESS. CITY, STATE.ZIP COOE  7420 MARLBORO PIKE  FORESTVU.Le, MD 20747 | |
| (X4) 10 ! SUMMARY STATEMENT OFDffiCIENCIES 10 I PROVIDER'S PLANOFCORRECTION . 1 ()[5] PREFIX : (EACHDEFICIENCY MUST BEPRECEDED BY FULL PREFIX l (EACH CORR!;C'Tl'VEACTIONSliOULD BE I **COMPL£TION** iAG ; ReGUlATORY ORLSC IOENTIFVING INFORMATION) TAG i CROSS.REFERENCED TOTHl;APPROPR/ATE. ! DATE  I I DEFICIENCY) ;  I | | | | |
| 1 I •  F 465 i Continued From page 2 F465!rnesuperintendent, maintenance staff. 03/21/15  I  ! :nursing statt: and administrator will  : All nursing care facilities must provide a safe , : !monitotrhe process to ensure  '. functional, sanitary, and comfortable environment ' · \compli anceby rounding frequently  ! for residents, staffand the public. Therefore, ] 1and correcting any concerns regarding  ; when renovation activities or maintenance '. !the process immediately upon noting.  i ; services are to be provided, the management and1 !This will continue throughout the  staff must act to preventresident or other i ,renovationproject  . unauthorized persons to areas Where unsafe !  i conditions could be found. ! IThemaintenance staff will report  I  )findings to QA monthly X 3 months.  !  I  !  I  i  i  1  I  !  i  i  l  i  i  'I  I  !  ! | | | | |



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| NAME OFPROVIDER OR SUPPLIER STREETADDRESS, CITY, STAra. ZIPCOOe  FORESTVILLE HEALTH & REHABILITAIOTN CE 7420 MARLBORO PIKE  FORESTVILLE, MO 20747 | | | | |
| (X4} 10 : SUMMAR')' STATEMENT OF0EFIClfNCIE$ ID PROVIDER'S PLANOFCORRECTION (XS)  PR l:'FIX : (EACH DEFICIENCY MUST BEPRf:CEDEO BYFllU. PREFIX (EAOHCORRECTIVE ACTIONSHOULD BE COMPIETE  TAG i REGULAiORY OR LSC IDENTIFYING INFORMAnON) TAG CROSS-REFERENCEDTOTHEAPPROPRIATE OATe  DEFICIENC Y) | | | | |
| s ooo;i 10 .07.02 Initial comments '' SOOO  I  i  , On February 4, 2015, a survey was conducted at !  : this nursing care facility to ascertain that safe ;  : conditions were being maintained during a  ; facility wide ret1ovation . Survey activities  I: included a tour of the areas being renovated and discussion with thefacility administratorand the  ! representativefor the general contractor overseeing therenovation.  1  : Based on the findings made during this survey,  ! the following deficiency was found to be in  : evidence.  S165' 10.07.02.34 **B (1)** Hskpg **pest** ctrl, **S1652**  : laundiy;celanliness  , .34 Housekeeping Services. Pest Control, and  : Laundry.  l B. Cleanliness andMaintenance. The following I  j  shall be observed: !  1  i(1) The building and allits parts and facilities shallI  ! be keptIn good repari, neat andattractive. The ·  : safety and comfort of the patients shall be the   * firstconsideration.   Agency Note: Refer to Regulation .26S of this  chapter for window screening req1,1irements.  This Regulation is notmetas evidenced by:  Refer to CMS 2567, c/o tag F465. | | | SEE POC F-TAG 465 03/21/15 | |

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FORM APPROVED

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FORESTVILLE HEALTH & REHASIUTA'TJON CE 7420 MARLBORO PIKE

FORESTVILLE, MO 20747

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December 3, 2014

Healt h Facilities Survey Coordinator Long Term Care

Office of Health Care Quality Spr ing Grove Center

Bland Bryant Building 55 Wade Avenue

Cat onsville, MD 21228-4663

Re: CommuniCare Health Services -Forestvi lle Health and Rehabilitation Center Prov ide r#: 215020

Survey Date: October 28, 2014 Dear Ms. Francis Curt is:

Enclosed please find our completed plan of correction dated December 3, 2014 responding to the annual compliance survey conducted at our facility, October 28, 2014.

Our plan of correction should be considered to serve as our allegations of compliance to the cited deficiencies. This plan of correction is being fi led as a matter of compliance.

Comm uniCare Health Services- Forestville Health and Rehabi litat ion Center takes the cited deficiencies very seriously and is committed to implementingthe plan of correction as expedit iously as possible. Please be assured that CommuniCare Health Services- Forest ville Health and Rehabilitation Center is undertaking measures to ensure complianceby December 12, 2014.

A Mem b e r of The Co mmu niC ar e Fa mily of Comp anies

c o m m un ic a reh e a lth . c o m 7420 Marlb oro Pike • Fo rest vil l e, MD 207 47 • p: 301. 736 0240 • f· 301.736.1129

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**Pleasecontact me with any questions or concerns you may have. Thank you in advance for your cooperation and assistanc e in this matter.**

**Sincerely,**

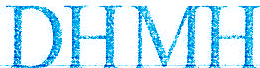
**rvices- Forestville Health and Rehabliitation Center**

**Sytina Smith, LNHA RN Executive Director**

**Enclosure**

A Member of Th e Commun iCare Family *of* Comp an ies

c om m u n ic a re h e a lt h. c om 7420 M arlb oro Pike • Fo rest vi ll e, MD 20747 • p· 301.7 36.0240 • f 301.736.1129

STATE OF MARYLAND

Maryland Departinent of Health and Mental Hygiene

##### Office of Health Care Quality

Spring Grove Center • Bland Bryant Building

55 Wade Avenue • Catonsville , Maryland 21228-4663

Martin O' Mallcy, Governor - Anthony G. Brown. Lt. Governor - Joshua M. Sharfste,in M.D., Secretary

##### November 17, 2014

Ms. Sytina Smith, Administrator Forestville Health & Rehabilitation Center 7420 Marlboro Pike

Forestville, MD 20747

**PROVIDER# 215020**

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

Dear Ms. Smith:

On October 28, 2014, a Medicare/Medicaid Quality Indicator surveywas 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 fa<.:ility 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 GovernmentArticle.

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 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;

What measures will be put into place or what systemic changes you will make to ensure

Toll Free I-877-4MD-DHMH• TTY for Disabled - Maryland Relay Service 1-800-735-2258 Web Site: [www.dhnih.maryland.gov](http://www.dhnih.maryland.gov/)

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 attached 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 December 12, 2014. 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.January 20, 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 April 28, 2015, your Medicare provider agreement will be tenninated.

1. 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 October 28, 2014 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 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 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 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,

*Jj*

Frances Curtis

Health Facilities Survey Coordinator Long Term Care

Enclosures: CMS 2567

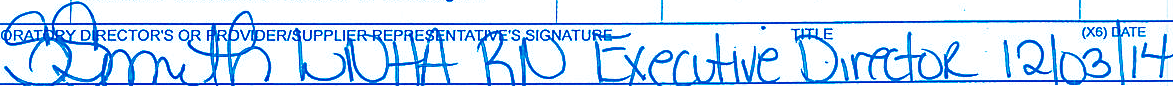
State Form

cc: Alice Hedt Jane Sacco File II

CENTERS FOR MEDICARE & MEDICAID SERVICES

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| **215020** | 8. WIN\_G \_ \_ \_ \_ \_ \_ \_ \_ \_ | | | C  **10/28/20 14** | |
| NAME OF PROVIDER OR SUPPLIER  **FORESTVILLE HEALTH** & **REHABILITATIONCENTER** | | | | STREET ADDRESS, CITY, STATE, ZIP CODE  **7420 MARLBORO PI KE**  **FORESTVILLE, MD 20747** | | | |
| (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 CORRECTIVEACTIONSHOULD BE CROSS-REFERENCEDTO THE APPROPRIATE DEFICIENCY) | | ( XS) COMPLETION DATE |
| F 000  F 246  SS=D | INITIAL COMMENTS  On October 23, 2014 through October 24, 2014  and October 27, 2014 through October 29, 2014, an annual Medicare/Medicaid survey was conducted by the Office of Health Care Quality. The census was 125 and the licensed bed capacity is 162. Survey activities consisted of a review of 70 medical records during stage 1 and 31 medical records during stage 2 and included interviews with residents, families, facility staff and the ombudsman, as well observations of resident's and staff practices. Administrative reports and facility policies and procedures were reviewed as well. Additionally, 2 complaints MD00086826and MD00086855was investigated during the stage 2 survey sample and found to be unsubstantiated.  The following deficiencies are a result of the stage 2 medical record reviews:  483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES  A resident has the right to resideand receive services in the facilitywith reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.  This REQUIREMENT is not met as evidenced by:  Based on observation and interview, the facility failed to ensure call bells are within reach (Resident# 122). This is evident for 1 out of 31  residents selected for review in the stage 2 | | F OOO  F246 | | Resident #122 call bell was properly placed within reach immediately.  Othershave the potential to be affected by this deficient practice.  The GNA's and Nurses will be in­ servicedon properly placing the call bell within the resident's reach while in the resident's room.  The GNA' s and Nurses will complete routine rounds on their shifts to ensure that the call bells are placed within the resident's reach while in the resident's room.  The Unit Managers will complete random rounds to ensure the staff is compliant with placing the call bells within the resident's reach while in the resident's room.  The Unit Manager or designee will monitor for compliance monthly X 3. | | 12/12/14 |
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0MB NO. 0938-0391

, deficiency statement ending with an asterisk c•) denotes a deficiency which the institution may be excused from correcting providing it is determined that r safeguards provide sufficient protection to the patients. (Seeinstructions.) Except for nursing homes, the findings stated above are disclosable 90 days Jwing the dale of survey whether or not a plan of correction is provided. For nursing homes. the above findings and plans of or ection \_a e disclos ble 14 s following the dale these documents are made available to the facility. I f deficiencies are cited, an approved plan of correction 1s requis ite to continued ram participation.

:M CMS-2567(0-299)Previous Versions Obsolete Event ID: YSOL11 Facility ID: 16017 If continuation sheet Page 1 of 7

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| STATEMENT OF DEFICIENCIES AND PL-A-N-OF-CO-RR-ECT-I-O-N- | | (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:  **215020** | (X2)MULTIPLE CONSTRUCTION  A.--BUILD ING \_- -\_ -·-- - -\_- -\_- -\_ - - - -  B.WI NG\_ \_ \_ \_ \_ \_ \_ \_ \_ | | | (X3) DATE SURVEY COMPLETED  C  **10/28/2014** | |
| NAMEOF PROVIDER OR SUPPLIER  **FORESTVILLE HEALTH** & **REHABILITATION CENTER** | | | | STREETADDRESS, CITY,STATE, ZIP CODE  7420 MARLBORO PIKE  FORESTVILLE, MD 20747 | | | |
| (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 ro THE APPROPRIATE  DEFICIENCY) | | (XS) COMPLETION DATE |
| F 246  F 282 SS=E | Continued From page 1 survey sample.  The findings include:  Review of the medical record reveals Resident #122 is noted to be chair bound and blind in the right eye with low vision in the left eye.  Tour of the ground floor on 10/24/2014 at 9:24 AM, revealed Resident #122 was sitting in his/her wheelchair next to television. Further observation revealed his/her call bell was lying on the bed and out of the resident's reach. The resident was asking for help, stating he/she was cold. Further observation revealed the resident's window was open approximately 2 inches at the bottom. The resident reported he/she wanted the window shut and the window was closed by the surveyor.  Observation of the resident on 10/27/2014 at 12:27 PM revealed the resident was seated in his/her wheelchair next to the television. The residents' call bell was lying on the bed and out of the Resident's reach.  The Unit Manager was immediately notified and confirmed the call bell was not in reach of the resident who is capable of using the call bell. The Unit Manager immediately placed the call bell within reach of the Resident.  483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. | | F 246  F 282 | | Resident #52 was examined by the Dentist on 10/28/14 with recommendations to follow.  Resident #98 refused to be examined   * by the Dentist on 10/28/14. Supporting documentation reflected in the resident' s medical record.   Others have the potential to be affected by this deficient practice.  The MDS triggers for dental and care plans will be audited for the current resident's. Resident's found to have dental concerns will be scheduled for a dental consult.  Upon admissions, the admitting nurse will complete an oral assessment and make note of the residents' dental condition and the need for a dental consult based on the assessment.  The Unit Manager will review the oral assessment and obtain orders from the PMD for the dental consult if needed; reco mmendations will be followed. | | 12/12/14 |

RM CMS-2567(02-99) Previous Versions Obsolete Event ID:YSOL11 Facility ID: 16017 ff continuation sheet Page 2 of 7

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| NAME OF PROVIDER OR SUPPLIER  **FORESTVILLE HEALTH** & **REHABILITATION CENTER** | | | | STREET ADDRESS, CITY, STATE, ZIP CODE  **7420 MARLBORO PIKE**  **FORESTVILLE, MD 20747** | | | |
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| F 282 | Continued From page 2  This REQUIREMENT is not met as evidenced­ by:  Based on medical record review, observation and interview the facility failed to obtain dental consults per the plan of care (Residents' # 52 and # 98). This is evident for 2 of 31 residents reviewed in the Stage 2 survey sample.  The findings include:   1. Review of Resident # 52's medical record revealed a care plan "Resident has missing teeth; teeth in poor condition" with the intervention for "dental consult as needed" dated 11/14/14.   Observation and interview with the resident on 10/27/2014 at 8:48 AM during medication pass observation revealed the resident had missing teeth and extensive decay of the remaining teeth. The resident reported that he/she has not seen a dentist.  Interview with the Director of Nursing on 10/28/14 at 8:40 AM confirmed the facility staff failed to follow the plan of care and obtain a dental consult until surveyor intervention.   1. Review of Resident# 98's medical record revealed a care plan "Resident has missing teeth; teeth in poor condition" with the intervention for "dental consult as needed".   Observation of the resident on 10/29/14 at 9:57 am revealed the resident has tooth fragments with visible decay noted.  Interview with the Director of Nursing on 10/29/14 at 9:59 am confirmed the facility staff failed to obtain a dental consult as ordered. | | F 282 | | The MDS N urse' s will also provide the trigger report upon completion of the initialMDSassessment's to the Unit Manager noting the need for a dental consult.  In-service training will be completed for the participating disciplines on the in-house protocol.  The Unit Managers or designee will monitor compliance monthly X 3 months. | |  |

M CMS-2567(02-99) Previous Versions Obsolete Event ID: YSOL11 Facility ID: 16017 If continuation sheet Page 3 of 7

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| F 313  SS=D  F 411 | 483.25(b) TREATMENT/DEVICES TO MAINTAIN HEARINGN ISION  To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist tlie resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializingin the  tre tment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.  This REQUIREMENT is not met as evidenced by:  Based on medical record review and interview, the facility failed to provide treatmenUservicesto maintain vision (Resident #122). This is evident for 1 out of 31 residents selected for review during the stage 2 survey sample.  The findings include:  Review of the medical record revealed Resident # 122 is blind in the right eye and has low vision in the left eye. The Resident was last seen by an ophthalmologist on 3/12/2012. The assessment and plan from the ophthalmologists ' visit read "unable to evaluate today and will reschedule in a few months." The Resident has not been seen by an ophthalmologist since 3/12/2012.  Interview with the Director of Nursingon 10/29/14 at 9:25 AM confirmed the facility staff failed to have the resident seen by an ophthalmologist to assess if the residents ' vision had declined or could be improved.  483.SS(a)ROUT INE/EMERGE NCY DENTAL | | **F** 313  F 411 | | PMD was made aware of resident #122 needs for a visual consult, and the order was obtained.  Resident # 122 is scheduled for an exam 12/05/14.  Others have the potential to be affected this deficient practice.  The MDS triggers for vision will be audited for the current resident' s.  Resident' s found to have vision concerns will be scheduled for a visual consult.  Upon admissions, the admitting nurse will complete a vision assessment and make note of the residents' visual status and the need for a visual consult based on the assessment.  The Unit Manager will review the visual assessment and obtain orders from the PMD for the visual consult if needed; recommendations will be followed.  The MDS Nurse' s will also provide the trigger report upon completion of the initial MDS assessment' s to the Unit Manager noting the need for a visual consult. | | 12/12/14 |

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| STATEMENT OF DEFICIENCIES  AND PLAN OF CORRECTION ·- | | **{X1)** PROVIDER/SUPPLIER/CUA  --- ID--E-NT··I-FICA-TIO- ·N· N--UM-B·E·R·: - - -  **215020** | (X2) MULTIPLE CONSTRUCTION  A.-BUILDING -\_--. ,  8. WIN\_G \_ \_ \_ \_ \_ \_ \_ \_ | | | (X3) DATE SURVEY  \_- - O /vl\_l LE J'E 0  C  **10/28/2014** | |
| NAME OF PROVIDER OR SUPPLIER  **FORESTVILLE HEALTH** & **REHABILITATION CENTER** | | | | STREETADDRESS. CITY, STATE, ZIP CODE  7420 MARLBORO PIKE  **FORESTVILLE, MD 20747** | | | |
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| F 411  SS==D | Continued From page 4  SERVICES IN SNFS  The facility must assist residents in obtaining routine and 24-hour emergency dental care.  A facility must provide .or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist.  This REQUIREMENT is not met as evidenced by:  Based on medical record review, observation and interview, the facility staff failed to provide dental services (Resident# 209). This is evident for 1 out of 31 residents selected for review from the Stage 2 survey sample.  The findings include:  Observation of Resident# 209 on 10/27/2014 at 09:27 AM revealed the resident had one single tooth visible on the bottom of his/her mouth that was black at the base. Review of the medical record revealed the resident was admitted to the facility on. and no dental assessment  had been completed. The resident had not been seen by a dentist since admission.  Interview with the Director of Nursing (DON} on 10/28/2014 at 10:10 AM confirmed the facility | | F 411 | | In-service training will be completed for the participating disciplines on the in-house protocol.  The Unit Managers or designee will monitor compliance monthly X 3 months.  Resident had a dental exam upon admission o by the admitting nurse and the Dietician.  Resident #209 was examined by the Dentist on 10/28/14 with recommendations to follow.  Others have the potential to be affected by this deficient practice.  The MDS triggers for dental will be audited for the current resident's.  Resident's found to have dental concerns will be scheduled for a dental consult.  Upon admissions, the admitting nurse will complete an oral assessment and make note of the residents' dental condition and the need for a dental consult based on the assessment. | | 12/12/14 |

RM CMS-2567(02-99} Previous Versions Obsolete EventIO:YSOL11 Facility ID: 16017 If continua tion sheet Page 5 of 7

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| >TATEMENT OF DEFICIENC IES  \r:c!(? PLAN OF CORRECTIO | | (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER: .. \_-  **215020** | (X2) MULTIPLE CONSTRUCTION  A c-BUI LDI NG -\_ - -\_ - .- - - \_ -\_ \_ \_ .  B. WIN\_G \_ \_ \_ \_ \_ \_ \_ \_ | | | (X3) DATE SURVEY  . \_ COMPLETED  C  **10128/2014** | |
| NAME OF PROVIDER OR SUPPLIER  **FORESTVILLE HEALTH** & **REHABILITATION CENTER** | | | | STRE ET ADDRESS, CITY, STATE. ZIP CODE  **7420 MARLBORO PIKE**  **FORESTVILLE, MD 20747** | | | |
| (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)  COMPLETION  DATE |
| F 411  F 412  SS=D | Continued From page 5  staff failed to assess and obtain dental services until surveyor intervention.  483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS  The nursing facility must provide or obtain from an outside resource, in accordance with  §483.75(h) of this part , routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.  This REQUIREMENT is not met as evidenced  **by:**  Based on medical record review, observation and interview, the facility staff failed to provide dental services (Resident #86). This is evident for 1 out of 31 residents selected for review from the stage 2 survey sample.  The findings include:  Observation of Resident# 86 on 10/23/2014 at 12:28PM revealed visible built up white and yellow debris on the teeth and along the gum line. Review of the medical record revealed the resident was admitted to the facility on  - Further *review* of the medical record revealed the facility staff failed to conduct a dental assessment or obtain dental services.  lnteNiew with the Director of Nursing (DON) on 10/28/2014 at 10:10 AM confirmed the facility | | F 411  F 412 | | The Unit Manager will review the oral assessment and obtain orders from the PMD for the dental consult if needed; recommendations will befollowed.  The MDS N ur se' s will also provide  the trigger report upon completion of the initial MDS assessment's to the Unit Manager noting theneed for a  dental consult.  In -service training will becompleted for the participa ting disciplines on the in-house protocol.  The Unit Managers or designee will monitor compliance monthly X 3 months.  Resident had a dental exam upon admission on - by the admitting nurse and the Dietician.  Resident #86 was examined by the Dentist on 10/28/14 with recommendations; however, resident refused the dentist recommendations. Supporting documentation reflected in the resident's medical record.  Others have the potential to be affected by this deficient practice. | | 12/12/14 |

M CMS-2567(02-99) Previous Versions Obsolete Event ID:YSOL11 Facility ID: 16017 If continuation sheet Page 6 of 7

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| NAME OF PROVIDER OR SUPPLIER  **FORESTVILLE HEALTH** & **REH ABILITATIONCENTER** | | | | STREET ADDRESS, CITY, STATE, ZIP CODE  **7420 MARLBORO PIKE**  **FORESTVILLE, MD 20747** | | | |
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| F 412 | Continued Frompage6  staff failed to assess and obtain dental services. | | F 41 2 | | The MDS triggers for dental will be audited for the current resident's.  Resident's found to have dental concerns will be scheduled for a dental consult.  Upon admissions, the admitting nurse will complete an oral assessment and make note of the residents' dental condition and the need for a dental consult based on the assessment.  The Unit Manager will review the oral assessment and obtain orders from the PMD for the dental consult if needed; recommendations will be followed.  The MDS Nurse's will also provide the trigger report upon completion of the initial MDS assessment's to the Unit Manager noting the need for a dental consult.  In-service training will be completed for the participating disciplines on the in-house protocol.  The Unit Managers or designee will monitor compliance monthly X 3 months. | |  |

RM CMS-2567(02-99) Previous Versions Obsolete Event ID:YSOL11 FacilityID: 16017 If continuation sheet Page 7 of 7

Office of Health Care Quali

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:

**215020**

(X2) MULTIPLECONSTRUCTION

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FORM APPROVED

(X3) DATE SURVEY COMPLETED

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**10/28/2014**

NAMEOF PROVIDER OR SUPPLIER

**FORESTVILLE HEALTH** & **REHABILITATION CE**

STREET ADDRESS, CITY, STATE, ZIP CODE

**7420 MARLBORO PIKE**

FORESTVILLE, **MD 20747**

(X4) ID PREFIX TAG

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

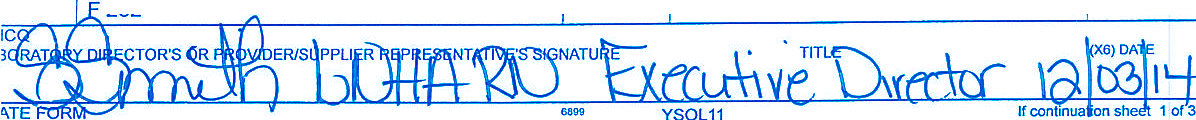
ID PREFIX TAG

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

CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

**(XS)** COMPLETE DATE

S ooo 10.07.02 Initial comments



On October 23, 2014 through October 24, 2014

and October 27, 2014 through October 29, 2014, an annual Medicare/Medicaid survey was conducted by the Office of Health Care Quality. The census was 125 and the licensed bed capacity is 162. Survey activities consisted of a review of 70 medical records during stage 1 and 31 medical records during stage 2 and included interviews with residents, families, facility staff and the ombudsman, as well observations of resident's and staff practices. Administrative reports and facility policies and procedures were reviewed as well. Additionally, 2 complaints MD00086826 and MD00086855 was investigated during the stage 2 survey sample and found to be unsubstantiated.

The following deficiencies are a result of the stage 2 medical record reviews:

s 512 10.07.02.12R Nsg Svcs; Charge Nurse Daily Rounds

.12 Nursing Services.

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 not met as evidenced by: Refer to CMS 2567

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S 512

##### SEE POC F-TAG 282,246,313,412 12/12/14

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| STATEMENT OF DEFICIENCIES  - P½ . c\_:> c\_:> R\_ "f (?!-!\_ \_ | | (X1} PROVIDER/SUPPLIER/CUA  - IDENTIFICATIONNUMBER:  **215020** | (X2} MULTIPLE CONSTRUCTION  **A. £Ull.:.OING:** - -·\_-- -- - - --::=\_·-\_ -=--..:  B. WING \_ \_ \_ \_ \_ \_ \_ \_ \_ | |  | (X3} DATE SURVEY  **COMPLETE**\_**D**  C  **10/28/2014** | |
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| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE  **FORESTVILLE HEALTH** & **REHABILITATION CE 7420 MARLBORO PIKE**  **FORESTVILLE, MD 20747** | | | | | | | |
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| S 512  S1040 | Continued From page 1  See CMS2567 F246  F 313  F 512  10.07.02.17 Dental Svcs  .17 Dental Services.   1. Provision for Dental Care. Patients shall be assisted to obtain routine and emergency dental care. 2. Advisory Dentist. There shall be an advisory dentist, licensed to practice in the State, who shall: 3. Recommend oral hygiene policies and practices for the care of the patients and for arrangements for emergency treatment; 4. Assist in the formulation of dental health policies; 5. Provide direction for in-service training to give the nursing staff an understanding of patients' dental problems. 6. Assistance by Nursing Personnel. Nursing personnel shall assist the patient in carrying out routine dental hygiene. 7. Arrangements for Dental Service. If dental services are not provided on the premises, there shall be a cooperative agreement with a dental service. 8. Transportation. Arrangements shall be made, when necessary, for the patient to be transported to the dentist's office.   This Regulation is not met as evidenced by:  Refer to CMS 2567 F282 | | S 512  S1040 | SEE POC F-TAG 282,411,412 | | | 12/12/14 |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CUA  l ENTIFIC T!() l'i BE : \_::\_:  **215020** | (X2) MULTIPLE CONSTRUCTION  A - BUI LDI N G-,- \_ - - - -· ·- -  B. WIN\_G \_ \_ \_ \_ \_ \_ \_ \_ \_ | | (X3) DATE SURVEY  - --C- O- M- P- L-E-T--ED-  C  **10/28/2014** | |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY. STAT, E ZIP CODE  **FORESTVILLE HEALTH** & **REHABILITATION CE 7420 MARLBORO PIKE**  **FORESTVILLE, MD 20747** | | | | | | |
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| S1040  S5097 | Continued From page 2  Refer to CMS 2567 F 411  F 412  10.07.09.08 C (3) Right to dignified existence  .08 Resident's Rights and Services.  C. A resident has the right to:  (3) A dignified existence, self-determination, and communication with and access to individuals and services inside and outside the nursing facility;  This Regulation is not met as evidenced by: See CMS2567  F246 | | S1040  S5097 | SEE Poe F-TAG 246 | | 12/12/14 |

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Maryland Departinent of Health and Mental Hyg•iene

Office of Health Care Quality

Spring Grove Center • Bland Bryant Building "' ------· ·.=..*·:;:'...:*

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55 Wade Avenue • Catonsville, Maryland 21228-4663

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Martin O' Mallcy, Governor -Anthony G. Brown, Lt. Governor - Joshua M. Sharfstcin, M.D., S.ccrctaiy \ .,,,

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October 27, 2014

Ms. Sytina Smitl1, Administrator Forestville Health & Rehabilitation Center 7420 Marlboro Pike

Forestville, MD 20747

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###### PROVIDER# 215020 ·\.

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

Dear Ms. Smith:

On October 22, 2014, a environmental survey was conducted at your facility by the Office of Healtl1 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 I0, and the State Government Article.

1. PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within IO 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 submission of the PoC.

Your PoC must contain th·e 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;

What measures will be put into place or what systemic changes you will make .to ensure

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Toll Free 1-877-4MD-DHMH • TT Y for Disabled - Maryland Relay Service 1-800-735-2258

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

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 attached. 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 December 6, 2014. 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 (Le.January 14, 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 April 22, 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 achieved substantial compliance, we may impose remedies previously mentioned in this letter beginning October 22, 2014 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 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. LJCENSURE ACTION

As you are aware, the cited Federal deficiencies have a counter part in State regulations. These deficiencies are cited on the enclosed State Fonn. 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 administrativeaction 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,

*JJ*

Frances Curtis

Health Facilities Survey Coordinator Long Term Care

Enclosures: CMS 2567

State Fom1

cc: Alice Hedt Jane Sacco File II

CENTERS FOR MEDICARE & MEDICAID SERVICES

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:  **215020** | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  8W.ING | | | | (X3) DATE SURVEY COMPLETED  C  **10/22/2014** | |
| NAME OF PROVIDER OR SUPPLIER  **FORESTVILLE HEALTH** & **REHABILITATION CENTER** | | | | STREET ADDRESS, CITY.STATE. ZIP CODE  **7420 MARLBORO PIKE**  **FORESTVILLE, MD 20747** | | | | |
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| F 000 | **INITIAL COMMENTS**  On October 22, 2014, a environmental survey was conducted at this nursing care facility to ascertain if an ongoing renovation project was maintaining safe conditions and to review two newly created bedrooms for initial approval for licensure and certification. Survey activities included a tour of the exterior and interior of the complex, as well as a detailed inspection of two newly created bedrooms. The two new bedrooms were enumerated as rooms 152 (double occupancy) and room 252 (single occupancy).  While conducting the review, the facility bed listing was reviewed and it was determined that the total capacity was 162 (same as found to be reflected on the current two-year Maryland license). The two new bedrooms were created by reducing three other resident bedrooms from an occupancy level of three beds to two beds per room. These reductions were found to correspond with the newest bed listing for the facility ' s license. Based on an inspection of the two new bedrooms, they were found to comply with both Medicare/Medicaid requirements as well as state of Maryland licensure requirements.  Based upon the findings obtained during this survey, no deficiencies were found to be in evidence. | | FOOO | |  |  | | I |

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ny deficiency statement ending with a asterisk (•) denotes a deficiency which the institution may be excused fro correcting providing it determined Iha

:her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, th findings stated above a e d1sclo able 90 days

,flowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of rr:ecllon \_a e d1sclos ble 14

1ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction 1s requ1s1te to continued

* + ogram participation.

)RM CMS-2567(02-99) Previous Versions Obsolete Event ID: OQRF11 Facility ID: 16017 If continuation sheet Page 1 of 1

Office of Health Care Qualit\i

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  **215020** | (X2) MULTIPLE CONSTRUCTION  A.BUI LDI NG:  B. WIN\_G \_ \_ \_ \_ \_ \_ \_ \_ \_ | | (X3) DATE SURVEY COMPLETED  C  **10/22/2014** | |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE  **FORESTVILLE HEALTH** & **REHABILITATION CE 7420 MARLBORO PIKE**  **FORESTVILLE, MD 20747** | | | | | | |
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| S oo | o 10.07.02 Initial comments  On October 22, 2014, a environmental survey was conducted at this nursing care facility to ascertain if an ongoing renovation project was maintaining safe conditions and to review two newly created bedrooms for initial approval for licensure and certification. Survey activities included a tour of the exterior and interior of the complex, as well as a detailed inspection of two newly created bedrooms. The two new bedrooms were enumerated as rooms 152 (double occupancy) and room 252 (single occupancy).  While conducting the review, the facility bed listing was reviewed and it was determined that the total capacity was 162 (same as found to be reflected on the current two-year Maryland license). The two new bedrooms were created by reducing three other resident bedrooms from an occupancy level of three beds to two beds per room. These reductions were found to correspond with the newest bed listing for the facility ' s license. Based on an inspection of the two new bedrooms, they were found to comply with both Medicare/Medicaid requirements as well as state of Maryland licensure requirements.  As part of the review of this nursing care facility, it was revealed that the nursing care units on both levels of the building were in excess of the size as allowed by the Maryland licensing code. The upper level nursing care unit was found to serve 80 beds and the lower level nursing unit was found to serve 82 beds. The maximum allowable size for a nursing care unit was to be less than or equal to 60 beds. As a result, the following deficiency was found to be in evidence. | | S 000 | Forestville Health and Rehabilitation Center is requesting a waiver for the licensure standard S1285. Please see the attached waiver request. | | 12/06/14 |



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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATIONNUMBER:  **215020** | (X2) MULTIPLE CONSTRUCTION   1. BUILDING\_ : \_ \_ \_ \_ \_ \_ \_ 2. WING | | (X3) DATE SURVEY COMPLETED  C  **10/22/2014** | |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE. ZIP CODE  FORESTVILLE HEALTH & **REHABILITATION CE** 7420 MARLBORO PIKE  FORESTVILLE, **MD 20747** | | | | | | |
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| S1285  S128 | Continued From page 1  5 10.07.02.27 A Nursing Care Unit; Size  .27 Nursing Care Unit.  A Size. Nursing care units may not exceed 60 beds. The Department may specify the numbers and types of personnel for each unit which exceeds 40 beds.  This Regulation is not met as evidenced by: Based on observation of this nursing care facility on October 22, 2014, it was determined that the nursing care units were in excess of the maximum size requirement of 60 beds per unit. The findings included the following:  On October 22, 2014, an environmental health  survey was conducted at this nursing care facility to determine if safe conditions were being maintained during a facility-wide renovation project. In addition, the survey was conducted to inspect two newly created bedrooms for initial use and occupancy. While conducting this survey, it was determined that the two nursing care units were in excess of the maximum size as allowed by the licensure requirements.  The nursing care unit for the upper level of the facility was found to serve 80 beds. The nursing care unit for the lower level of the facility was found to serve 82 beds.  The maximum size for a nursing care unit shall be no more than 60 beds. | | S1285 S1285 |  | |  |

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OQRF11 If continuation sheet 2 of 2

(SEO Tags:  Trial attorney, nursing home lawyer, nursing home attorney, overmedication, medication error, pressure sores, bed sores, sepsis, wrongful death, wounds, falls, attorney handling medication errors, nursing home abuse attorney, assisted living attorney, assisted living accidents, dehydration, malnutrition, DC abuse attorney, nursing home injury, skilled rehab injury, skilled rehab attorney, drugs, pharmaceutical drugs, antipsychotic drugs, negligence attorney, nursing home abuse attorney, adult protective service lawyer, overdose, legal liability for overdose, nursing home abuse lawyer, , nursing home chains, statistics on nursing home abuse, Maryland abuse attorney, Maryland Prince Georges County Attorney, Forestville Health and Rehab, nursing home attorney PG county)