FOIA Data Base - The Law Office of Jeffrey J. 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

Frederick Health and Rehabilitation Center
30 North Place
Frederick, MD 21701

Characteristics:

- A For-Profit Company with 120 Beds
- Legal Business Name –North Place Operating Company, LLC
- Ownership – Maryland GL HoldCo, LLC (Tony Oglesby)
- Operational/Managerial Control – SSC Equity Holdings, LLC (Christopher Stenger)
- Director – Timothy Schindler

As of August 2020, Frederick Health and Rehabilitation Center is rated as a one-star facility, according to Medicare.gov

Researching Nursing Homes

A note by attorney Jeffrey J. Downey:

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

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

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

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

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

2) Fax : 410-402-8179

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

Having already researched Frederick Health and Rehabilitation Center 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215184	A. BUILDING _____ B. \IVIN_G _____	R-C 01/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICK HEALTH & REHABILITATION CENTER	30 NORTH PLACE FREDERICK, MD 21701

(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 000}	INITIAL COMMENTS	{F 000}		

A Medicare/Medicaid revisit survey was conducted on January 6, 7, 8, 9, 10 and 13, 2020 by the Office of Health Care Quality. The licensed bed capacity for this facility is 120 and the resident census at the start of the survey was 111. Survey activities consisted of a review of 22 resident medical records, observation of residents and staff practices, and interviews of residents, the local ombudsman and the facility's staff. Additionally, administrative records and resident care policies relevant to identified negative findings were reviewed.

The following deficiencies are a result of the survey.

F 577 SS=C Right to Survey Results/Advocate Agency Info CFR(s): 483.10(9)(10)(11)

§483.1O(g)(10) The resident has the right to-
(i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and
(ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies.

§483.10(g)(11) The facility must--
(i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility.
(ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual

F577

1. **F 577 Right to Survey Results/Advocate Agency Info**

#1 Corrective Action:

2/10/2020

The prior Administrator immediately printed and posted the 2019 Annual Survey Results and the plan of correction in place on 1/13/20 to assure it is readily accessible to residents, family members and legal representatives of residents. She was also verbally educated on same day on importance of honoring residents' right to examine the results of the most recent survey of the facility by the District Director of Clinical Services.

#2 Identification:

The District Director of Clinical Services and prior NHA checked the survey binder and confirmed absence of 2019 Annual Survey Results and the plan of correction in the survey binder posted on the wall where prior years' survey results are located. NHA immediately printed and posted the survey results with the plan of correction.

X6) DATE 2/21/2020

LABORATORY

TITLE
D t> ? I/VIS T fr Toil.

Any deficiency statement ending with an asterisk(*) denotes a deficiency which the institution may be excused from correcting providing it is d et erm in ed that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are d sclosa b le 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.

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F 577	Continued From page 1 to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on review of facility records and interview with staff, it was determined the facility staff failed to ensure the residents' right to examine the results of the most recent survey of the facility by failing to post the results of the last recertification survey and plan of correction in a place readily accessible to residents, family members and legal representatives of residents. This was evident for 1 of 1 survey results book posted in the facility. The findings include: On 1/13/20 at 12:45 PM, the surveyor observed a yellow plastic binder in a bin labeled "survey results" located on the wall across from the main lobby of the facility. Upon review of its contents, the binder failed to reveal the results of the most recent annual survey conducted 8/22/19 - 9/10/19 and the facility's plan of correction. During an interview with the Administrator and the District Director of Clinical Services, on 1/13/20 at 12:15 PM, the Administrator confirmed that the results were not posted. She indicated that she had not printed nor posted these documents because she was waiting for the completion of the revisit survey.	F 577	**#3 Systemic Change/Education** The District Director of Clinical Services educated the Interim Administrator and Leadership staff on importance of honoring residents' right to examine the results of the most recent survey of the facility by posting the results of a recent survey and plan of correction in place readily accessible to residents, family members and legal representatives of residents. **#4 Monitoring** The NHA will be responsible for ensuring the Plan of Correction is posted. The NHA will conduct rounds weekly for four weeks then monthly for three months to validate that the Survey Binder has most recent survey results posted and plan of correction in place is readily accessible to residents, family members and legal representatives of residents. The results of these audits will be submitted to the QAPI Committee for review and further recommendations as necessary.	
{F 623}	Notice Requirements Before Transfer/Discharge SS=B CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer.	{F 623}		

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{F 623}	Continued From page 2 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 medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) 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. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days.	{F 623}	**2. F623 Notice ofRequirements Before Transfer /Discharge** **#1 Corrective Action** Residents# 42, and #303's responsible parties' representatives will be provided with notification of facility initiated discharge or transfer. These residents were not involuntary discharges hence an appeal was not needed on both cases. Resident #300 no longer resides in the facility. **#2 Identification** The Unit Coordinator will identify current residents who were transferred out of the facility from 11/10/19 to 1/13/20 to evaluate for presence of notification of facility initiated discharge or transfer with responsible parties for those residents deemed incapable or lack capacity and/or provision of appropriate appeal agency information for involuntary discharges.	2/10/20

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{F 623} Continued From page 3

{F 623}

§483.15(c)(5) 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;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) 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 and Advocacy 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

#3 SYstemlc Change Educgtion

The District Director of Clinical Services will educate the Director of Nursing, Unit Coordinator and Unit Managers on process for Transfer and Discharge procedure including but not limited to filing out a Notification of Facility Initiated Discharge/Transfer form and providing to resident or responsible party (if resident is deemed incapable) the correct appeal address for involuntary discharges.

The Director of Nursing will then educate the licensed nurses on same transfer/discharge process as well as location of information in the residents' clinical record to validate that resident is deemed incapable or lacks capacity and/or provision of appropriate appeal agency information for involuntary discharges.

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{F 623}	Continued From page 4 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 relocation of the residents, as required at§ 483.70(). This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, it was determined that the facility failed to notify the resident's representative in writing of a transfer/discharge of a resident to an acute care facility; and failed to ensure that correct information regarding the name, address and telephone number of the entity which receives appeal requests was provided to the residents and or the resident's representative. This was found to be evident for 3 out of 3 resident's (Resident #42, #300 and #303) reviewed for transfer during the survey. Cross reference to F 867 Quality Assessment and Assurance The findings include: A recertification survey of this facility, completed on 9/10/19, identified a deficient practice in which the facility failed to notify a resident representative in writing of a transfer/discharge of a resident to an acute care facility and failed to	{F 623}	#4 **Monitoring** The Director of Nursing will randomly review 50% of facility initiated transfer/discharge to validate RP notification for residents deemed incapable or lacks capacity and/or provision of appropriate appeal agency information for involuntary discharges weekly for four weeks then monthly for three months. These audits will be submitted to the QAPI Committee for review and further recommendation as necessary.	

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{F 623}	Continued From page 5 ensure that correct information regarding the the name, address and telephone number of the entity which receives appeal requests was included in the notification documentation. 1) On 1/6/20, review of Resident #42's medical record revealed that the resident had a diagnosis of dementia and had been deemed, in 2009, not capable of understanding any information about his/her healthcare and was unable to make an informed decision. A resident representative was identified in the medical record as the resident's responsible party. Further review of the medical record revealed that the resident had been transferred to the hospital in November 2019. Review of the Notice of Transfer or Discharge form for this transfer revealed it was provided to the resident. Review of the plan of correction for the deficiencies, identified during the 9/10/19 survey, revealed that the facility had conducted audits to ensure that notices of transfer had been sent via certified mail to the resident's responsible party, (unless the resident was their own responsible party). Further review of the medical record failed to reveal documentation that Resident **#42's** responsible party had been provided the Notice of Transfer documentation. On 1/6/20 at 3:50 PM, the Director of Nursing (DON) confirmed that the resident had been sent to the hospital in November 2019. The DON went on to report that the transfer information is given to the resident representative if they are in the building at the time of the transfer, and if not in	{F 623}		

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{F 623}	Continued From page 6	{F 623}		

the building, the information should be mailed.

The DON went on to report that he would have to check for a receipt to see if the information had actually been sent for Resident **#42.**

On *1n120* at approximately 12 noon, the Administrator presented a book of registered mail receipts but was unable to provide documentation that the transfer information had been sent to Resident #42's responsible party. As of time of exit on 1/13/20, no documentation was provided to indicate this information had been provided to the responsible party.

2) Review of the statement of deficiencies for the 9/10/19 survey revealed the following: "Review of the Notice of Transfer or Discharge form revealed that, in the section for the State Long Term Care Appeal Agency, the facility provided the name of the licensing and certification office, not the appeal agency."

Further review of the Notice of Transfer or Discharge form for Resident #42's November 2019 hospital transfer revealed in the section for the State Long Term Care Appeal Agency, that the facility provided the name of the licensing and certification office, not the appeal agency information.

Review of Resident #303's record revealed that the resident was discharged to the hospital in December 2019. Review of the Notice of Transfer or Discharge form, indicated that, in the section for the State Long Term Care Appeal Agency, the facility provided the name of the licensing and certification office, not the appeal agency information.

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{F 623}	Continued From page 7 Review of Resident #300 revealed that the resident was discharged to the hospital in December 2019, Review of the Notice of Transfer or Discharge form, indicated that, in the section for the State Long Term Care Appeal Agency, the facility provided the name of the licensing and certification office, not the appeal agency information. On 1/6/20 at 4:00 PM, surveyor reviewed the concern with the Director of Nursing regarding the facility's failure to send the transfer information to the responsible party for Resident #42 and the concern regarding the continuation of providing misinformation regarding the State Long Term Care Appeal Agency.	{F 623}		2/10/20
{F 624} SS=D	Preparation for Safe/Orderly Transfer/Dschrg CFR(s): 483.15(c)(7) §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, it was determined the facility failed to document what preparation and orientation was given to a resident to ensure an orderly transfer to an acute care facility. This was found to be evident for 1 out of 3 residents (Resident #42) reviewed for transfer during the survey. Cross reference to F 867 Quality Assessment	{F 624}	**3. F624 Preparation for a Safe/Orderly Transfer or Discharge** **#1 Corrective Action** Resident #42 continues to reside in the facility and has had no further transfers or discharges to the hospital. **#2 Identification** The Unit Coordinator will identify current residents who were transferred to acute care facility from 11/10/19 to 1/13/20 to evaluate for presence of documentation on what preparation and orientation was given to residents to ensure an orderly transfer to an acute care facility.	

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{F 624}	Continued From page 8 and Assurance The findings include: A recertification survey of this facility, completed on 9/10/19, identified a deficient practice in which the facility failed to document what preparation and orientation was given to residents to ensure an orderly transfer to an acute care facility. On 1/6/20, review of Resident #42's medical record revealed that the resident had a diagnosis of dementia and had been deemed, in 2009, not capable of understanding any information about his/her healthcare and was unable to make informed an informed decision. A resident representative was identified in the medical record as the resident's responsible party. Review of the Minimum Data Set, with an assessment reference date of 10/5/19, revealed that the resident had adequate hearing, clear speech and sometimes understood others - responding to simple direct communication. On 1/6/20, review of Resident **#42's** medical record revealed that the resident had been transferred to the hospital in November 2019. Review of the nursing note related to this transfer revealed that the physician had given a new order to send the resident to the ER [emergency room] for further evaluation and that "resident was picked up from the unit at about 1430 [2:30 PM] stable vi-a 911, resident sent with notice of transfer/bed hold policy report given to the ED [emergency department] at [name of hospital]. [name of responsible party] updated." Further review of the medical record failed to reveal documentation that Resident #42 was	{F 624}	**#3 Systemic Change** The District Director of Clinical Services educated the facility's Unit Coordinator, Unit Managers, Director of Nursing on Transfer/Discharge process. The Director of Nursing will then educate the licensed nurses on same process with an emphasis on preparing and/or orienting residents to include but not limited to informing the resident where he or she is going, taking steps to assure safe transportation etc. for a hospital transfer or discharge to the hospital as well as presence of documentation to reflect actions taken. The Clinical Team will review any transfers or discharges to the hospital during morning Clinical Meeting to validate licensed nurse compliance in ensuring an orderly transfer to an acute care facility. **#4 Monitoring** The Director of Nursing will audit 50 % of facility initiated transfers or discharges to the hospital to validate licensed nurse	

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{F 624}	Continued From page 9 oriented or prepared for the transfer in a manner that the resident could understand and no documentation was found of the resident's understanding of the transfer. On 1/6/20 at 4:00 PM, surveyor reviewed the concern with the Director of Nursing regarding the failure to document the resident's preparation and orientation to the hospital transfer. On 1/7/20, the unit nurse manager #12 reported that, when a resident is discharged to the hospital, the nurse is supposed to ask the geriatric nursing assistant to stay with the resident until the EMTs arrive. The unit manager went on to report that the nurse was supposed to document that they told the resident that they are being sent to the emergency room and that a staff member was staying with the resident until the EMT arrived.	{F 624}	compliance on presence of documentation on process of preparing and/or orienting residents to include but not limited to informing the resident where he or she is going, taking steps to assure safe transportation etc. to ensure an orderly transfer to an acute care facility weekly for four weeks then monthly for three month s. These audits will be reviewed and submitted to the QAPI committee for review and further recommendations as necessary.	2/10/20
{F 625} SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under§ 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding	{F 625}	**4. F625 Notice of Bed Hold Policy and Return** **#1 Corrective Action** Resident #42 continues to reside in the facility and has had no further transfers or discharges to the hospital. **#2 Identification** The Unit Coordinator will identify current residents who were transferred to an acute care facility from 11/10/19 to 1/13/20 to evaluate for presence of notification to residents' representatives (if deemed	

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(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 PLAM OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
{F 625}	Continued From page 10 bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, it was determined that the facility failed to notify the resident's representative in writing of the bed hold policy at time of discharge to the hospital. This was found to be evident for 1 out of 3 residents (Resident #42) reviewed for transfer during the survey. Cross reference to F 867 Quality Assessment and Assurance The findings include : A recertification survey of this facility, completed on 9/10/2019, identified a deficient practice in which the facility failed to notify the resident representative in writing of the bed-hold policy upon transfer of a resident to an acute care facility. 1) On 1/6/20, review of Resident #42's medical record revealed that the resident had a diagnosis of dementia and had been deemed, in 2009, not	{F 625}	incapable) In writing of the bed hold policy at time of discharge to the hospital If present or available or if business office manager provided a bed hold policy post transfer to residents' representatives (if deemed incapable). **#3 <u>Systemic Change</u>** The District Director of Clinical Services educated the facility's Unit Coordinator, Unit Managers and Director of Nursing on Transfer/Discharge process. The Director of Nursing or Designee will then educate the licensed nurses on same process with an emphasis on notifying residents' representatives (if deemed incapable) in writing of the bed hold policy at time of discharge to the hospital. The District Director of Clinical Services educated the Business office manager on the need to follow-up with residents' and/or representative(s) the next business day and provides notice, in writing, of the facility's bed hold and readmission policies to the residents and/or residents' representatives. The Admissions Director has been educated as well and will serve as a back-up personnel for the Business office manager in regards to following with bed hold policy.	

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{F 625}	Continued From page 11 capable of understanding any information about his/her healthcare and was unable to make an informed decision. A resident representative was identified in the medical record as the resident's responsible party. Further review of the medical record revealed that the resident had been transferred to the hospital in November 2019. Further review of the medical record failed to reveal documentation that the resident's responsible party had been provided a copy of the bed hold policy at the time of hospital discharge. Documentation was found that the bed hold information had been provided to the resident at time of transfer to the hospital. Review of the plan of correction for the deficiencies identified during the 9/10/19 survey revealed the following: "Copy of the Transfer form and bed hold policy will be sent certified mail to the responsible party. The return receipt for the mail will be placed in the medical record. Unit Coordinator will audit 100% of transfers for the checklist indicating bed hold policy transferred with resident and a copy in certified mail sent to the Responsible party weekly x four weeks or until compliance is met." Further review of the medical record failed to reveal documentation that Resident **#42's** responsible party had been provided the bed hold policy. On 1/6/20 at 3:50 PM, the Director of Nursing (DON) confirmed that the resident had been sent to the hospital in November. The DON went on to reported that the bed hold information is given to the resident representative if they are in the building at the time of the transfer, if not in the	{F 625}	**#4 Monitoring** The Director of Nursing will audit SO% of facility initiated transfers or discharges to the hospital to validate licensed nurses' compliance on the process of notifying residents' representatives (if deemed incapable) if present or available, in writing of the bed hold policy at time of discharge to the hospital and/or Business office manager on compliance in following up with residents' representative the next business day and provides noti ce, in writing, of the facility's bed hold policy weekly for four weeks then monthly for three months. These audits will be reviewed and submitted to the QAPI committee for review and further recommendations as necessary.	

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{F 625)	Contnued From page 12 building, the information should be mailed. The DON went on to report that he would have to check for a receipt to see if the information had actually been sent for Resident #42. On 1/7/20 at approximately 12 noon, the Administrator presented a book of registered mail receipts but was unable to provide documentation that the bed hold documentation had been sent to Resident #42's responsible party. As of time of exit on 1/13/20, no documentation was provided to indicate this information had been provided to the responsible party.	{F 625}		
{F 641}	Accuracy of Assessments SS=D CFR(s) : 483.20(9) §483.20(9) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, it was determined the facility staff failed to ensure that Minimum Data Set (MOS) assessments were accurately coded. This was evident for 1 (#68) of 3 residents reviewed for MOS accuracy. The MOS is a complete assessment of the resident which provides the facility information necessary to develop a plan of care, provide the appropriate care and services to the resident, and to modify the care plan based on the resident's status. Cross reference F 867 Quality Assessment and Assurance The findings include:	{F 641}	**S. F 641 Accuracy of Assessments** **#1 Corrective Action** Resident #68 MOS assessment was reviewed for accurate coding of diuretics and modified on January 7, 2020 at 03 22 PM. **#2 Identification** The Director of Care Management will review current residents with an MOS ARD of 11/10/19 to 1/13/20 to evaluate for proper MOS Coding in section N for Diuretics use and any other medic tion use under Section Nor other MOS Coding during the MOS ARD look back time frame period.	2/10/20

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{F 641}	Continued From page 13	{F 641}	**#3 Systemic Correction/Education**	

Review of Resident #68's medical record on 1/7/20 revealed that the October 2019 Medication Administration Record (MAR) which documented that the resident received the medication **Lasix** every day. Lasix is classified as a diuretic. It can treat fluid retention (edema) and swelling caused by congestive heart failure, liver disease, kidney disease, and other medical conditions. Review of the quarterly MOS with an Assessment Reference Date (ARD) of 10/22/19 revealed that Section N0410G, was coded "O" which indicated that a diuretic was not given during the 7 day lookback period prior to 10/22/19. The facility failed to code the MOS to reflect the resident's diuretic use.

Staff #4 was made aware of these findings on 1/7/20 at 3:00 PM.

During an interview on 1/8/20 at approximately 11:50 AM, Staff#18 (the MOS coordinator) and Staff #17 (The District Director of **Case** Management) confirmed the **above** findings.

The District Director of Care Management has educated the Director of Care Management and the other MDS staff on importance of MDS Coding accuracy, following the RAI guidelines including, but not limited to Section N for Diuretics and any other medication use under Section N or other MOS Coding during the look back period of MOS as outlined in the MOS RAI Manual. The MDS Nurses' office will be moved to different location where there is less traffic and quieter for the MOS nurses to focus and concentrate to assure MOS accuracy.

#4 Monitoring

The Director of Resident Care Management will audit 50% of MDSs completed for the week to validate MOS coding accuracy including but not limited to section N that covers diuretic use and/or other medications use or other MOS Coding during the look back period weekly for four weeks, then monthly for three months. These audits will be reviewed and submitted to the QAPI committee for review and further recommendations as necessary.

2/10/20

{F 656} SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)	{F 656}	

§483.21(b) Comprehensive Care Plans
§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.1O(c)(2) and §483.1O(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and

6. F656 Development of Comprehensive Care Plans

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{F 656}	Continued From page 14 (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on review of the medical record and interview with facility staff, it was determined the facility failed to follow a resident's plan of care to utilize hipsters and bed alarm and failed to ensure the plan of care included the use of bed rails. This was evident for 1 (#300) of 3 residents reviewed for Comprehensive Care Plans. A care plan is a guide that addresses the unique needs of each resident. It is used to plan, **assess,** and evaluate the effectiveness of the resident's care.	{F 656}	**#1 Corrective Action** Resident# 300 no longer resides in the facility. **#2 Identifica tion** The Unit Coordinator will review current residents whose plan of care reflects use of hipsters and bed alarms as well as residents with bed rails from 11/10/19 to 1/13/20 to evaluate for inclusion in the plan of care. **#3 Systemic Correction/Education** The District Director of Clinical Services educated the Director of Nursing, Unit Coordinator and Unit Managers on importance of following the plan of care including but not limited to implementation of hipsters, bed alarm use as well as inclusion of bed rails use in the plan of care. The Director of Nursing or Designee will then educate the licensed nurses on same content. The Unit Managers will print an order listing report to review orders received the past 24 or 72 hours to validate during rounds about staff compliance in implementation of new orders such as hipster, bed alarms, bed rails etc. and will be discussed during the Clinical team and the need for further follow-up if warranted.	2/10/20

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{F 656}	Continued From page 15 The findings include: Resident #300's record was reviewed on 1/6/20 at 2:50 PM. The record included physicians' orders for: Encourage hipsters worn at all times as tolerated every shift. Hipsters on as tolerated every shift for recurrent falls, Bed and Chair alarm to remind resident to call for assistance with transfers - Check for placement and function every shift for fall prevention. Bilateral ½ side rails to help with mobility. The Treatment Administration Record (TAR) for January 2020 included the bed/chair alarm and hipster orders and were signed off, by a nurse, each shift from 0700 1/1/20 - 0700 1/9/20 as administered, with documentation that the resident refused hipsters as tolerated on 2 occasions at 1500 on 1**/1**/20 and 1/8/20. A plan of care was in place for high risk for falls. The care plan interventions included but were not limited to: Apply hipsters to wear both in bed and when up in wheelchair. Hipsters as tolerated. Bed and chair alarm to remind resident to call for assistance with transfers, check for placement and function. The resident's use of bed rails was not included in any of Resident #300's care plans. Resident #300 was observed on 1/8/20 at 3:00 PM sitting on the side of his/her bed at the foot of the bed putting his/her socks on. The resident did not appear to be wearing hipsters under his/her	{F 656}	**#4 Monitoring** The Director of Nursing will audit 50% of current residents who have new orders for hipsters, bed alarms to validate implementation compliance through review of orders, rounding in residents' rooms as well as inclusion of bed rails use etc. in the plan of care weekly for four weeks then monthly for three months. These audits will be reviewed and submitted to the QAPI committee for review and further recommendations as necessary.	

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{F 656}	Continued From page 16 slacks. The resident was interviewed on 1/9/20 at 9:34 AM. He/she was again sitting on the side of the bed at the foot of the bed. He/she was wearing thin slacks. The resident did not appear to be wearing hipsters and when asked, Resident #300 denied having hipsters on. At 11:30 AM on 1/9/20, the resident was lying on his/her bed and did not appear to have hipsters on. During each of these observations, ½ bed rails were observed in the raised position on both sides of Resident #300's bed and no bed/chair alarm was observed. At 12:05 PM on 1/9/20, the surveyor observed Resident #300 with Staff #4 (the District Director of Clinical Services) and Staff #5 (the Assistant Director of Nursing). The resident was lying on his/her bed with ½ bed rails raised on both sides of the bed. Staff #5 verified that the resident was not wearing hipsters and that the bed alarm was not on the bed or in the resident's wheelchair. When asked where the alarm was, Resident #300 stated "I don't think there is one". Staff #4 located the bed alarm and pad dangling over the outside of the bed rail to the resident's left. The alarm wires were entangled with the bed control cord and the bed rail. Staff #4 and #5 were made aware and confirmed that the facility failed to follow the resident's plan of care for the use of bed/chair alarm and hipsters and that the facility failed to include Resident #300's use of bed rails in his/her plan of care.	{F 656}		
{F 657} SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be-	{F 657}	**#1 Corrective Action** Resident# 300 no longer resides in the facility. Resident #23's care plan was reviewed and revised.	2/17/20

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{F 657}	Continued From page 17 (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in **a** resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each **assessment,** including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and interview with staff, ii was determined that the facility staff failed to review and revise resident care plans after each assessment or as resident care needs became apparent or changed over time. This was evident for 2 (#300 and #23) of 3 residents reviewed for Care Plan Timing and Revision. A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess and evaluate the effectiveness of the resident's care. The findings include:	{F 657}	**#2 Identification** The Social Services Director will review current residents' code status as outlined in his or her MOLST from 11/10/19 to 1/13/20 to evaluate for accurate order and care plan revision entry if changes were or were not made based on his or her progress, lack of progress or changing needs prior to or during a care plan meeting. The Social Services staff and Unit Coordinator will review current residents who have had a care plan meeting from 11/10/19 to 1/13/20 to evaluate for presence of documentation reflecting a resident's plan of care has been reviewed and if any revisions were or were not made based on his or her progress, lack of progress or changing needs prior to or during **a care** plan meeting a:; well a!i presence of care plan note from Social Services or member of an Interdisciplinary team (IDT) validating review of MOLST, care plan review and care plan meeting held. **#3 Systemic Correction[Education** The District Director of Clinical Services educated the Interdisciplinary Team (IDT) on importance of following process of care planning and revision to include but not limited to assuring MOLST Code status order matches PCC order and care plan entry.	

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{F 657}	Continued From page 18 1) Resident #300's medical record was reviewed on 1/8/20 at 3:00 PM. The record contained a MOLST (Maryland Medical Orders for Life-Sustaining Treatment) form dated 12/9/19. The MOLST documented that it was the resident's wishes to not receive CPR but to receive Palliative and Supportive Care in the event of cardiac and/or pulmonary arrest. A review of the current physicians' orders, however, contained an order originally written on 10/21/19 for "Full Code". Full Code indicates that, in the event of cardiac and/or pulmonary arrest, any and all medical efforts that are indicated, including artificial ventilation and CPR, should be attempted . A plan of care was initiated on 10/29/19 for Resident #300 choice to have CPR. Resident #300's plan of care was not revised to reflect his/her CPR Status changed on 12/9/19. Staff #4 was made aware and confirmed of these findings on 1/8/20 at 3:10 PM. During 3 separate interviews, licensed nursing staff indicated that they would look at the resident's MOLST form to determine a resident's CPR status, if they discovered a resident unresponsive. 2) Review of Resident #23's medical record, on 119/20 at 2:45 PM, revealed a Quarterly Minimum Data Set (MOS) assessment with an Assessment Reference Date (ARD) of 12/28/19. The MOS is a complete assessment of the resident which provides the facility with the information necessary to develop a plan of care, provide the appropriate care and services to the resident, and to modify the care plan based on the resident's status. Further review of the record revealed that Resident #23's interdisciplinary care plan meeting was held on 1/7/20 after the quarterly MOS assessment.	{F 557}	The Interdiscip1inary care plans are reviewed or revised post scheduled MOS assessment or as needed and prior to attending care plan meeting. Then IDT will meet and discuss with resident and/or his or her responsible party any changes or revision during care plan conference. The review will include active care plans including but not limited to assuring MOLST Code status order matches PCC order and care plan entry. IDT Care plan Revision or Review is validated through documentation reflecting a resident's plan of care has been reviewed, any revisions and if care plan goals were or were not met based on resident's current status. The Social Services staff or member of IDT in Social Worker's absence will enter a care plan note post care plan conference validating care plan meeting held, review of MOLST, care plans etc.. **#4 Monitoring** The Director of Nursing will randomly review 25 % of scheduled care plan meeting held for the week to validate IDT compliance in care planning and revision as evidenced by MOLST Code status matches PCC order and care plan revision entry for any changes as well as validation present	

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{F 657}	Continued From page 19 A Care Conference note summarized the resident's preference to stay in bed, but Resident #23 would get up at times to go to some activities, dining room or outdoors; that his/her spouse visits most days and that the Resident's wishes for life sustaining measures were reviewed with his/her spouse. No documentation was found in Resident #23's record to reflect that his/her total plan of care, including problems, goals and interventions, were reviewed and if any revisions were/were not made to the residents plan of care based on his/her progress, lack of progress or changing needs. An interview was conducted on 1/10/20 at 11:00 AM with several members of the interdisciplinary treatment team. When asked about the process for reviewing and revising the plans of care Staff #12 a Unit Manager responded that nursing will go over each issue identified on the plan of care and will write a care plan review note for each problem and goal, the team will evaluate and make any changes. This review note is "pushed over" to update the plan of care. She was asked when the documentation is completed in relation to the meeting. Staff #12 stated "it should be done immediately, however, Resident #23's was not done yet, we're behind in completing his/her care plan review note." At approximately 12:00 PM on 1/10/20, Staff #12 provided the surveyor with a 2 page copy of Care Plan Notes for Resident #23, which were completed after the above interview. Several Goals had recommendations to continue the goal, but did not specify the residents progress toward reaching his/her goal. Some notes	{F 657}	reflecting that care plans have been reviewed and if any revisions, and if care plan goals were or were not met based on his or her progress, lack of progress or changing needs. These audits will be reviewed and submitted to the QAPI r.ommittee for review and further recommendations as necessary.	

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{F 657} Continued From page 20

indicated the resident was stable, however, it was not clear what was meant by stable, or how it was determined. The review did not reflect the measures used by the team when they determined the need to continue or revise Resident #23's plan of care goals and/or interventions.

{F 684} Quality of Care
SS=E 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 residents receive 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, observation and interview, it was determined that the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice as evidenced by by 1) failure to ensure that recommendations made by the registered dietitian were added to the care plan and addressed and implemented in a timely manner; 2) failure to ensure that the registered dietitian completed an accurate assessment of the resident's dietary supplements as evidenced by inaccurately assessing the amount of protein that a resident was receiving from an ordered liquid protein supplement; 3) failed to provide treatment and care in accordance with the resident's comprehensive person-centered care plan, the resident's choices and as per the

{F 657}

#1 **Corrective** Action

{F 684} 2/10/20

Resident# 42's Glucerna and Promod order was clarified with MD and RP notification.
Resident #17's physician was notified and order was received for Promod 30 cc three times a day.
Resident# 300 No longer resides in the facility.
Resident #23 was assessed and evaluation for use or non-use of hipster, bed/chair alarm and bed rail was completed.
Physician discontinued use of hipster and bed/chair alarm. A signed bed rail consent was obtained.

#21dentlficatlon

The Unit Coordinator will review RD recommendations from 11/10/19 to 1/13/20 to evaluate for timely follow-up process of RD recommendations including but not limited to Glucerna and/or Promod orders as well as documentation accuracy on RD notes in reference to recommended strength per ml with regards to Promod recommendations if applicable.

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(X4) !D 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 21

physicians order for the provision of hipsters, bed/chair alarm and bed rails and 4) failed to accurately document when care was not provided as ordered. This was evident for 2 out of 3 residents (Resident #42 and #17) reviewed for pressure ulcers and 2 of 3 residents (Resident#300 and #23) reviewed for accidents during the survey.
The findings include:

Cross reference to F 692 Nutrition

The findings include:

1a) On 1/6/20, review of Resident **#42's** medical record revealed that the resident had two pressure ulcers on the buttocks. The resident received a regular diet of pureed consistency and was totally dependent on staff for assistance with eating. The resident also had a g-tube for additional nutritional support, Review of a Nutrition Note, written by RD #13 on 1/3/20, revealed the presence of the two pressure ulcers and that the resident was currently receiving Glucerna 1.5 bolus (1 can via g-tube] two times a day. The note also revealed: "RD recommends increasing TF [tube feeding]: Glucerna 1.5 bolus feeds 237 ml (1 can) TIO [three times a day]..." Review of the resident's care plan revealed it had been revised on 1/3/20 and included "Bolus glucerna 1.5 TIO."

Further review of the medical record, during the afternoon of 1/6/20, revealed documentation that the resident had been receiving the Glucerna bolus two times a day since it was ordered in September 2019. No documentation was found that RD #13's recommendation of an increase to three times a day had been ordered or

{F 684}

The Unit Coordinator will conduct observational rounds to identify current residents with orders for hipsters, chair/bed alarms, bed rails to evaluate for use or non-use of hipster, bed/chair alarm and bed rail as well as to assure consent is obtained for bed rail use if appropriate and revision of care plan as needed.

#3 5:ilstemic CorrectionLEducation

The District Director of Clinical Services or Director of Regulatory Compliance has educated the Director of Nursing, Unit Coordinator and Unit Managers on work flow process for completion of Dietary Recommendations. The licensed nurses will be educated on same process by the Director of Nursing to assure timely completion of Registered Dietician's recommendations.

The Registered Dietician will be educated by the Director of Regulatory Compliance on Dietary Recommendation work flow process and to not update the care plan until her recommendation has been approved or an order is given by the attending physician as well as assuring clarity in her documentation including but not limited to Promod strength and calculation of recommended serving.

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{F 684}	Continued From page 22 implemented. On 1/6/20 at 3:50 PM, the Director of Nursing (DON) reported that the dietitian submits recommendations to nursing who will then enter the order after verification with the physician. Surveyor then reviewed the concern that the RD had made a recommendation on 1/3/20 to increase the Glucerna bolus to three times a day, had updated the care plan to reflect this change but that as of this afternoon the order remained for the Glucerna to be administered two times a day. On 1/7/20, review of the medical record revealed an order, dated 1/6/20 at 4:14 PM for the Glucerna 1.5 Give 1 can three times a day at 8 AM, 2 PM and 8 PM. On 1/7/20 at 10:20 AM, RD #13 reported that, if after her assessment, she has a recommendation, she will document this in her note and fill out a dietary recommendation. If the recommendation was for something the nurses would administer, she would write down the recommendation and put it in their box. She went on to clarify that there is a dietary recommendation form that she utilizes to write the orders and that, since she does not have the authority to add the order into the electronic health record, she gives the dietary recommendation form to the unit manager or the DON to input into the electronic health record. The RD went on to report that she attends morning meetings on the days that she is in the facility, which are usually Tuesday/Thursday and Friday. On 1/7/20, the unit nurse manager #12 reported	{F **684}**	The District Director of Clinical Services educated the Unit Managers, Unit Coordinator and Director of Nursing on process for Care Plan Revision to include observational rounding of residents' rooms prior to evaluation of hipsters, chair/bed alarms or bedrails for use or non -use as well as confirming presence of bed rails consent on file if applicable and care plan revision entry as deemed appropriate. The Director of Nursing will educate licensed nurses on same content. **#4 Monitoring** The Director of Nursing will review 50% of RD recommendations to validate for timely follow-up process including but not limited to Glucerna and/or Promod orders as well as documentation accuracy on RD notes in reference to recommended strength per ml with regards to Promod weekly for four weeks then monthly for three months. These audits will be sub mitt ed.t o the QAPI Committee for review and further recommendations as necessary. The Director of Nursing will randomly audit 50 % of current residents with hipsters, chair/bed alarms, bedrails to validate for documentation accuracy of use or non-use	

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(XA) 10 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	!D PREFIX TAG	PROVIDER'S PLAN OF CORHECT!ON (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
{F 684}	Continued From page 23 that the dietary recommendation had been put in her box on Friday evening and that she "should grab it Monday morning." She went on to report that recommendations from the day before are reviewed at the morning meeting, however, she had not attended yesterday's morning meeting due to being assigned to administer medications. She also reported that the DON also had the recommendation, which he had entered into the electronic health record the day before. The unit manager reported that, going forward, they will be asking the RD to hand the recommendations directly to nursing. Review of the plan of correction for F 692 for a survey completed in September 2019 revealed the following: If nourishments are part of the Dietitian Recommendations, they will be reviewed with the MD by the DON, ADON and/or Unit Manager and written as a physician order. This will be further validated during the Clinical Stand-up [morning meeting] as new orders are reviewed and compared to the Dietitian Recommendation Log that has been distributed to nursing management by the Dietitian. On 1/9/20 at 9:02 AM, RD #13 reported that the Dietitian Recommendation Log is a hand written form that she fills out daily for residents that require changes. A copy of the form is given to the unit nurse manager, a copy to the DON and the RD keeps a copy. Upon request, the RD provided a copy of the log titled "Medical Nutritional Therapy Assessment Recommendations", dated 1/3/20, that included a notation for Resident #42 to receive Glucerna 1.5 1 can TIO. The reason documented was: wound healing/poor po [by mouth] intake.	{F 684}	of hipsters/chair/bed alarms, presence of consent, MD order and care plan entry for use of bed rails weekly for four weeks then monthly for three months. These audits will be submitted to the QAPI Committee for review and further recommendations as necessary.	

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{F 684}	Continued From page 24 On1/9/19 atapproximately9:15AM, Nurse#21 confirmed that the log provided by the RD was the log that would be reviewed at the morning meeting. 1 b) On 1/9/20, review of Resident #17's medical record revealed the presence of two pressure ulcers. Review of the 12/18/19 Nutrition note revealed documentation of the existence of the wounds and stated the following: "Protein needs are being met at this time. Will continue to follow; if no improvement in wounds by next review, recommend increasing ProMod to TIO [three times a day]." Review of the 12/27/19 nutrition note revealed that per the wound physician one of the wounds had deteriorated and included the following: "Protein needs are being met with diet and supplements at this time but will increase ProMOD to TIO as there is no progress in wound healing." Review of the "Medical Nutritional Therapy Assessment Recommendations" log, dated 12/27/19, revealed a recommendation for Resident #17 to "increase ProMod 30 cc to TID" and the reason listed was wound healing. Further review of the medical record revealed that the resident's care plan was revised on 12/27/19 to include the ProMod 30 cc TIO. Further review of the medical record revealed a Nutrition Note, dated 1/2/20, which revealed that, per wound physician, both pressure ulcers had shown improvement and that the resident was currently receiving ProMod BIO. This note included the following: "Protein needs are being met with diet and supplements at this time. Will increase ProMOD to TID if there is no progress in	{F 684}		

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{F 684}	Continued From page 25	{F 684}		

wound healing by next review." This note failed to include any documentation regarding the previous week's recommendation to increase the ProMod to three times a day.

Further review of the medical record revealed that, on 1/3/20, the order for the ProMod to be given two times a day was discontinued and a new order was implemented to administer the ProMod three times a day. These orders were implemented a week after the dietitian made the recommendation and updated the care plan on 12/27/19 and were in conflict with the dietitian's 1/2/20 assessment and documented recommendation of keeping the ProMod at two times a day.

2) On 1/6/20, review of Resident #42's medical record revealed an order, originally dated 10/10/19, for Protein Liquid to be administered two times a day. The order failed to include the amount of the Protein Liquid to be administered the resident. Review of the Medication Administration Record (MAR) revealed that the Protein Liquid was due at 9:00 AM and 5:00 PM and there were areas for staff to document the amount that the resident had ingested.

Review of the care plan revealed the following intervention, initiated 1/3/20, "Provide supplements as ordered: ProMod 30 cc BID [two times a day]." Review of the registered dietitian's note, also dated 1/3/20, revealed "Continues on ProMod BID 30 cc to provide additional 30gm/day."

ProMod is the name of a liquid protein supplement. Regarding liquid volume 1 ml is the same as 1 cc,

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{F 684}	Continued From page 26	{F 684}		

On 1/7/20 at 9:43 AM, nurse #1 reported that she had administered 30 ml of the ProMod to Resident #42 that morning. Observation of the bottle located on the medication cart that the nurse reported she had obtained the ProMod from, revealed the strength to be 10 gms/ 30 ml.

Two 30 cc doses of the ProMod at 10 gms/30 ml per day would provide 20 gms of protein per day, not the 30 gms of protein per day as indicated in RD #13's note, dated 1/3/20.

3) Resident #300's record was reviewed on 1/6/20 at 2:50 PM. The record included physicians' orders for:
Encourage hipsters worn at all times as tolerated every shift.
Hipsters on as tolerated every shift for recurrent **falls**
Bed and Chair alarm to remind resident to call for assistance with transfers - Check for placement and function every shift for fall prevention.

A plan of care was in place for high risk for falls. The care plan interventions included, but were not limited to:
Apply hipsters to wear both in bed and when up in wheelchair.
Hipsters as tolerated.
Bed and chair alarm to remind resident to call for assistance with transfers, check for placement and function.
No plan of care was found for Resident #300's use of bed rails, no consent and no physicians orders were found for his/her bed rails.
A Bed Rail Safety Review, dated 12/29/19 , indicated to continue ½ rails on both sides of Resident #300's bed.

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{F 684}	Continued From page 27	{F 684}		

Resident #300 was observed on 1/8/20 at 3:00 PM sitting on the side of their bed putting their socks on. The resident did not appear to be wearing hipsters under their slacks. The resident was interviewed on 1/9/20 at 9:34 AM, again sitting on the side of the bed . Resident #300 was wearing thin slacks. The resident did not appear to be wearing hipsters and when asked, Resident #300 denied having hipsters on and indicated that they wanted the bed rails and used them to reposition themself in the bed. At 11:30 AM on 1 /9/20, the resident was lying on their bed and did not appear to have hipsters on. During each of these observations, no bed/chair alarm was observed and ½ bed rails were observed in the raised position. At 12:05 PM on 1/9/20, the surveyor observed Resident #300 with Staff #4 the District Director of Clinical Services and Staff #5 the Assistant Director of Nursing. The resident was lying on his/her bed. Staff #5 verified that the resident was not wearing hipsters and that the bed alarm was not on the bed or in the resident's wheelchair and both ½ bed rails were up. When asked where the alarm was, Resident #300 stated "I don't think there is one". Staff #4 located the bed alarm and pad dangling over the outside of the bed rail to the resident's left and was turned off. The alarm wires were entangled with the bed control cord and the bed rail.

The Treatment Administration Record (TAR) for January 2020 included the bed/chair alarm and hipster orders and were signed off, by a nurse, each shift from 0700 (7:00 AM) 1/1/20 to 0700 1/9/20 as administered, with documentation that the resident refused hipsters as tolerated on 2 occasions at 1500 (3:00 PM) on 1/1/20 and 1/8/20. Staff #4 and #5 were made aware and

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{F 684}	Continued From page 28	{F 684}		

confirmed that the facility staff failed to accurately document the residents use or non-use of his/her hipsters and bed/chair alarm. They were made aware that the resident had no physician's order, no consent, nor plan of care for the use of bed rails.

4) Resident #23's record was reviewed on 1/6/20 at 1:23 PM. The record contained a current physicians order, originally written on 9/6/19, for bilateral ½ side rails to help with mobility however, a signed consent for the use of bed rails was not found in Resident #23's record.

During an interview on 1/9/20 at 12:30 PM Staff #12, a unit nurse manager, was made aware that Resident #23 did not have a consent for the use of bed rails.

On 1/9/20 at 12:30 PM, Staff#12 indicated that she opened the consent form in the electronic medical record on 10/21/19, but failed to put the information into the consent and have the RP sign the consent form.

Further review of Resident #23's medical record revealed a physician's order for Hipsters to be worn every shift as tolerated. Review of the Resident's January TAR in the Electronic Medical Record (EMR) revealed that the resident's Hipsters were signed off as administered every shift from 1/1/20, up to and including 0700, on 1/9/20. With the only exception of 0700 on 1/6/19 which was coded "see progress note".

During an observation of Resident #23, on 1/9/20 at 12:40 PM, Staff #6 confirmed that Resident #23 was not wearing his/her hipsters. Staff #4 was made aware that the staff documented the

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{F 684}	Continued From page 29 administration of Resident #23's Hipsters when they were not actually provided. Upon review of a printed copy, the January TAR revealed that the space previously initialed by Staff #6 indicating the Hipsters were administered at 0700 on 1/9/20 was blank. Staff #4 was made aware of these findings. During an interview on 1/9/20 at 1:37 PM, Staff #12 indicated that Resident #23 refuses their Hipsters almost every day. Resident #23's Hipsters were signed off as administered every shift from 1/1/20 to 1/9/20 with the exception of 1/6/20 at 0700. Staff #4 was made aware of the above findings at that time.	{F 684}		2/10/20
{F 692}	Nutrition/Hydration Status Maintenance SS::D CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostorny and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care	{F 692}	**#1 Correctiv e Action** Resident# 42's Glucerna and Promod order was clarified with MD. Resident #17's physician was notified and order was received for Promod 30 cc three times a day. **#2 Identification** The Unit Coordinator will review current residents with recommendations from 1l/10/19 to1/13/20 to evaluate for timely follow-up process of RD recommendations including but not limited to Glucerna and/or Promod orders as well as documentation accuracy on RD notes in reference to recommended strength per ml with regards to Promod order.	

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{F 692}	Continued From page 30 provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, it was determined that the facility failed to ensure that recommendations made by the dietitian were addressed and implemented in a timely manner: and failed to ensure that the registered dietitian completed an accurate assessment of the resident's dietary supplements as evidenced by inaccurately assessing the amount of protein a resident was receiving from an ordered liquid protein supplement. This was found to be evident for 2 out of 3 residents (Resident #42 and #17) reviewed for pressure ulcers. Cross reference to F 867 Quality Assessment and Assurance Cross reference to F 684 Quality of Care The findings include: A recertification survey of this facility, completed on 9/10/19, identified a deficient practice in which the facility failed to implement nutritional supplements when recommended by, and added to the care plan, by the dietitian. Review of the statement of deficiencies for the 9/10/19 survey revealed that, on 9/3/19, the dietitian verbalized the process for implementing her recommendations involved writing her order on paper and then either giving the order to the unit manger or just putting the order in the unit manager's mailbox and also in the Director of Nursing's (DON) mailbox. 1a) On 1/6/20, review of Resident #42's medical record revealed the resident currently had two pressure ulcers on the buttocks. The resident	{F 692}	**#3 Systemic Change/Education** The District Director of Clinical Services has educated the Director of Nursing, Unit Coordinator and Unit Managers on work flow process for completion of Dietary Recommendations. The licensed nurses will be educated on same process by the Director of Nursing to assure timely completion of Registered Dietician's recommendations. The Registered Dietician (RD) will be educated by the Director of Regulatory Compliance to not update the care plan until her recommendation has been approved or an order is given by the attending physician as well as assuring clarity or accuracy in her documentation including but not limited to Promod strength and calculation of recommended serving.	

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{F 692}	Continued From page 31 received a regular diet of pureed consistency and was totally dependent on staff for assistance with eating. The resident also had a g-tube for additional nutritional support. Review of a Nutrition Note, written by RD #13 on 1/3/20, revealed the presence of the two pressure ulcers and that the resident was currently receiving Glucerna 1.5 bolus (1 can via g-tube] two times a day. The note also revealed: "RD recommends increasing TF [tube feeding]: Glucerna 1.5 bolus feeds 237 ml (1 can) TIO [three times a day]..." Review of the resident's care plan revealed it had been revised on 1/3/20 and included "Bolus glucerna 1.5 TIO." Further review of the medical record during the afternoon on 1/6/20, revealed documentation that the resident had been receiving the Glucerna bolus two times a day since it was ordered in September 2019. No documentation was found that RD #13's recommendation of an increase to three times a day had been ordered or implemented. On 1/6/20 at 3:50 PM, the Director of Nursing (DON) reported that the dietitian submits recommendations to nursing who will then enter the order after verification with the physician. Surveyor then reviewed the concern that the RD had made a recommendation on 1/3 to increase the Glucerna bolus to three times a day, had updated the care plan to reflect this change, but that as of the afternoon of 1/6/20, the order remained for the Glucerna to be administered two times a day. On 117/20, review of the medical record revealed an order, dated 1/6/20 at 4:14 PM, for the Glucerna 1.5 Give 1 can three times a day at 8	{F 692}	**#4 Monit ring** The Director of Nursing will review 50% of RD recommendations to validate for timely follow-up process including but not limited to Glucerna and/or Promod order as well as transcription and documentation accuracy in reference to RD recommendation matching with RD notes, in reference to recommended strength per ml with regards to Promod order as well as care plan revision entry only post receipt of MD approval for RD recommendations weekly for four weeks then monthly for three months. These audits will be submitted to the QAPI Committee for review and further recommendations as necessary .	

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{F 692}	Continued From page 32 AM, 2 PM and 8 PM. On 1/7/20 at 10:20 AM, RD #13 reported that, if after her assessment she has a recommendation, she will document this in her note and fill out a dietary recommendation. If the recommendation was for something the nurses would give, she would write down the recommendation and put it in their box. She went on to clarify that they have a dietary recommendation form that she utilizes to write the orders and that, since she does not have the authority to add the order into the electronic health record, she gives the dietary recommendation form to the unit manager or the DON to input into the electronic health record. The RD went on to report that she attends morning meetings on the days that she is in the facility, which are usually Tuesday/Thursday and Friday. On 1/7/20, the unit nurse manager #12 reported that the dietary recommendation had been put in her box on Friday evening and that she "should grab it Monday morning." She went on to report that recommendations from the day before are reviewed at the morning meeting, however, she had not attended yesterday's morning meeting due to being assigned to administer medications. She also reported that the DON also had the recommendation, which he had entered into the electronic health record the day before. The unit manager reported that they will be asking the RD to hand the recommendations directly to nursing. Further review of the plan of correction for F 692 revealed the following: If nourishments are part of the Dietitian Recommendations, they will be reviewed with the MD by the DON, ADON and/or Unit Manager and written as a physician order.	{F 692}		

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{F 692}	Continued From page 33 This will be further validated during the Clinical Stand-up [morning meeting] as new orders are reviewed and compared to the Dietitian Recommendation Log that has been distributed to nursing management by the Dietitian. On 1/9/20 at 9:02 AM , RD #13 reported that the Dietitian Recommendation Log is a hand written form that she fills out daily for residents that require changes in their orders. A copy of the form is given to the unit nurse manager, a copy to the DON and the RD keeps a copy. Upon request, the RD provided a copy of the log titled "Medical Nutritional Therapy Assessment Recommendations," dated 1/3/20, that included a notation for Resident #42 to receive Glucerna 1.5 1 can TIO. The reason documented was: wound healing/poor po [by mouth] intake. On 1/9/19 at approximately 9:15 AM, when asked if a determination had been made of the cause of the missed recommendation that was identified in the 9/10/19 survey, corporate nurse #21 reported that the nurse should have been given the recommendation and then indicated that moving forward that will be the process. Nurse #21 also confirmed that the log provided by the RD was the log that would be reviewed at the morning meeting. On 1/13/20 at 2:00 PM, the Administrator reported that the change that was supposed to have occurred after the September survey, was that the RD was to give the nurses the recommendations. The Administrator was unable to provide an explanation as to why the current RD verbalized a different process, which involved leaving the recommendations in the unit managers box.	{F 692}		

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{F 692}	Continued From page 34	{F 692}		

1 b) On 1/9/20, review of the medical record revealed that Resident #17 had two pressure ulcers. Review of the 12/18/19 Nutrition note revealed documentation of the existence of the wounds and stated the following: "Protein needs are being met at this time. Will continue to follow; if no improvement in wounds by next review, recommend increasing ProMod to TIO [three times a day]." Review of the 12/27/19 nutrition note revealed that, per the wound physician, one of tt,e wounds had deteriorated and included the following: "Protein needs are being met with diet and supplements at this time but will increase ProMOD to TIO as there is no progress in wound healing."

Review of the "Medical Nutritional Therapy Assessment Recommendations" log, dated 12/27/19, revealed a recommendation for Resident #17 to "increase ProMod 30 cc to TIO" with the reason listed for wound healing.

Further review of the medical record revealed the resident's care plan was revised on 12/27/19 to include the ProMod 30 cc TIO.

Further review of the medical record revealed a Nutrition Note, dated 1/2/20, which revealed that per wound physician, both pressure ulcers had shown improvement and that the resident was currently receiving ProMod BID. This note included the following: "Protein needs are being met with diet and supplements at this time. Will increase ProMOD to TIO if there is no progress in wound healing by next review." This note failed to include any documentation regarding the previous week's recommendation to increase the ProMod to three times a day.

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{F 692}	Continued From page 35	{F 692}		

Further review of the medical record revealed that, on 1/3/20, the order for the ProMod to be given two times a day was discontinued, and a new order was implemented to administer the ProMod three times a day. These orders were implemented a week after the dietitian made the recommendation on 12/27/19, and were in conflict with the dietitian's 1/2/20 assessment and documented recommendation of keeping the ProMod at two times a day.

2) On 1/6/20, review of Resident #42's medical record revealed an order, originally dated 10/10/19, for Protein Liquid to be administered two times a day. The order failed to include the amount of the Protein Liquid to be administered the resident. Review of the Medication Administration Record (MAR) revealed that the Protein Liquid was due at 9:00 AM and 5:00 PM, and there were areas for staff to document the amount.

Review of the care plan revealed the following intervention, initiated 1/3/20, "Provide supplements as ordered: ProMod 30 cc BID [two times a day]." Review of the registered dietitian's note, also dated 1/3/20, revealed "Continues on ProMod BID 30 cc to provide additional 30gm/day."

ProMod is the name of a liquid protein supplement. Regarding liquid volume, 1 ml is the same as 1 cc.

On 1/7/20 at 9:43 AM, nurse #1 reported that she had administered 30 ml of the ProMod to Resident #42 this morning. Observation of the bottle located on the medication cart that the

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{F 692}	Continued From page 36 nurse reported she had obtained the ProMod from, revealed the strength to be 10 gms/ 30 ml. Two 30 cc doses of the ProMod at 10 gms/30 ml per day would provide 20 gms of protein per day, not the 30 gms of protein per day as indicated in RD #13's note dated 1/3/20.	{F 692}		
{F 700} SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, it was determined that the facility failed to obtained informed consent for the use of bed rails, failed to address the use of bed rails in	{F 700}	**#1 Identified Residents/ Corrective Action** Residents# 17 and #23 's consents, physician's orders for bed rails were obtained and care plans reflecting bed rail use were completed. Resident #300 no longer resides in the facility. **#2 Identification** The Unit Coordinator will review current residents with orders for bedrails from 11/10/19 to 1/13/20 and conduct observational rounds throughout the facility to evaluate for presence of bed rail, consent, MD orders and care plan reflecting bed rail use.	2/10/20

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{F 700}	Continued From page 37 the resident's comprehensive care plan and failed to obtain a physician order for the use of the bed rails. This was found to be evident for 3 out of 3 residents (Resident #17, #23 and #300) reviewed for the use of bed rails. Cross reference to F 867 Quality Assessment and Assurance The findings include: 1) On 1/9/20, review of Resident #17's medical record revealed the resident had two certifications, signed by physicians in 2005 and 2006, indicating the resident "is not capable of understanding any information about his/her healthcare and is unable to make an informed decision. This resident is also not able to sign any documentation pertaining his/her healthcare needs. The healthcare POA [power of attorney] will sign all documents." Further review of the medical record revealed the resident had current orders for bed rails, dated 12/2/19. On 10/10/20 observation of resident in bed confirmed the presence of one half side rail being in the up position. Further review of the medical record revealed a Bed Rail Safety Review form, completed by unit nurse manager #14 on 12/2/19. Review of this form revealed documentation that the Resident and/or the Resident's Representative had been educated on the use of alternative to bed rail use, and that, based on the assessment they would "continue current alternative measures." The section of the form to indicate the implementation of new bed rails or the continuation of current bed	{F 700}	**#3 Systemic Change** The District Director of Clinical Services educated the Unit Managers, Unit Coordinator and Director of Nursing on process for Bed Rails to include review of bed rail orders and observational rounding of residents' rooms as well as confirming presence of bed rails order and consent from resident or resident's representative (if deemed incapable or lacks capacity) on file as well as care plan entry reflecting use of bed rails. The Director of Nursing will educate the licensed nurses on same content about Bed Rail process. The Clinical team will review and validate all components required for Bed rail order and implementation validation prior, during or after the clinical meetin2. **#4M onltorlng** The Director of Nursing will conduct observational rounds and review 50% of current residents with bedrails to validate for bed rails, physician order and consent from resident or resident's representative (if deemed incapable or lacks capacity) on file as well as care plan entry reflecting use of bed rails weekly for four weeks then mon y for three months. These audits will besubmitted to the QAPI Committee for review and further recommendations as necessary.	

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{F 700}	Continued From page 38	{F 700}		

Further review of the medical record revealed a Consent for Bed Rail Use form that included the following: I understand that my interdisciplinary team has recommended the following bed rails to address my medical needs: 1/2 side rails to each side of the bed to enable improved bed mobility. The consent was signed by the resident. No documentation was found in the medical record that the resident's POA had been educated regarding the use of the bed rails or provided consent for their use.

No documentation was found that use of the bed rails were addressed at a interdisciplinary meeting or addressed in the resident's care plans.

On 1/9/20 at 3:30 PM, surveyor reviewed the concern with corporate nurse #4 that the consent for the bed rails had been obtained from the resident who, according to the medical record, had been certified by two physicians as being not capable to make informed decisions about health care or sign any documents pertaining to healthcare needs.

On 1/10/20 at 10:58 am, surveyor reviewed the concern regarding failure to address the bed rails in the care plan with the unit nurse manager #14, who indicated she would check the care plan. The unit manager also confirmed that the resident had the bed rails prior to the December assessment.

As of time of exit, no documentation was provided to indicate that the bed rails were addressed in the resident's care plan.

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{F 700}	Continued From page 39	{F 700}		

On 1/9/20 at 1:43 PM, the Assistant Director of Nursing (ADON) #5 reported that staff would obtain consents for bed rails from the resident if they are their own responsible party, and if they aren't, then they would obtain consent from the POA. In regard to Resident #17, the ADON reported the resident was their own RP. Surveyor then reviewed with the ADON the two certifications that the resident was not capable to make health care decisions.

Cross Reference to F842 Medical Records .

2) Resident #23's record was reviewed on 1/6/20 at 1:23 PM. The record contained a current physicians' order, originally written 9/6/19, for bilateral (both sides) ½ side rails to help with mobility however, a signed consent for the use of bed rails was not found in Resident #23's record.

During an interview on 1/9/20 at 12:30 PM, Staff #12 a unit manager, was asked about the process for bed rails. She indicated that the resident is assessed for the need for rails and if they are safe to use the rails. The resident or the **resident's responsible party (RP) is provided** education for bed rails use and a consent is signed, a physician's order for the bed rails is obtained and a care plan is put into place. She was made aware that Resident #23 did not have a consent for the use of bed rails.

On 1/9/20 at 12:30 PM, Staff#12 provided the surveyor with a nursing progress note from 10/21/19. The note indicated that the RP signed the resident education for bed rails, that he/she was educated on the risk and benefits of bed rails

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{F 700}	Continued From page 40 and would like the bed rails to help in aiding in mobility. Staff #12 indicated that she opened the consent form in the electronic medical record on that same date, but failed to put the information into the consent and have the RP sign the consent form. This same deficient practice was cited for the same resident during the last annual survey. Cross reference F 867. 3) Resident #300's record was reviewed on 1/6/20 at 2:50 PM. The record contained bed rail safety reviews, dated 10/21/19 at 16:36, (4:36 PM) and another that was signed and dated by Staff #22 on 12/29/19 at 22:09 (10:09 PM) upon the residents return from a hospital stay. Section C included continue current bed rails as indicated and indicated ½ rails both sides. Further review of the record failed to reveal a consent for the use of bed rails, a physician's order for bed rails, nor a plan of care for the use of bed rails for Resident #300. Half bed rails were observed in the raised position on both sides of Resident #300's bed on 1/8/20 at 3:00 PM, on 1/9/20 at 9:34 AM and 11:30 AM. Another observation was made on 1/9/20 at 12:05 with Staff #4 the District Director of Clinical Services and #5 the Assistant Director of Nursing present. Resident #300 was lying in the bed at that time with both ½ rails in the raised position. They were made aware at that time that the resident had no physicians order, no consent nor plan of care for the use of bed rails.	{F 700}		
{F 744} SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the	{F 744}		2/10/20

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appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being.
This REQUIREMENT is not met as evidenced by:
Based on medical record review and interview, it was determined the facility failed to evaluate resident care plan and have achievable care plan goals for a resident with dementia. This was evident for 1 out of 3 residents (Resident #55) reviewed for dementia care during the survey.

Cross reference to F 867 Quality Assessment and Assurance

The findings include:

A care plan is a guide that addresses the unique need of each resident. It is used to plan, assess and evaluate the effectiveness of the resident's care.

A recertification survey of this facility, completed on 9/10/2019, identified a deficient practice in which the facility failed to evaluate resident care plans and have achievable care plan goals for residents with dementia.

On 1/10/20, review of Resident #55's medical record revealed a diagnosis of dementia. Review of the Minimum Data Set assessment, with a reference date of 11/18/19, revealed a BIMS (Brief Interview for Mental Status) score of 0, indicating severe cognitive impairment.

Review of the resident's care plan revealed a plan, with a revision date of 11/14/19, addressing "[name of resident] has impaired cognitive function or impaired thought processes r/t

{F 744}

#1 Corrective Action

Resident #SS's Bl Ms score was completed on 1/B/20 with a score of 3. The residents care plan has been revised to reflect current cognitive status as well as achievable goals for a resident with Dementia.

#2 Identification

The Social Services staff will review current residents with Dementia who have had a care plan meeting from 11/10/19 to 1/13/20 to evaluate for timely care plan evaluation and presence of achievable care plan goals.

#3 Systemic Correction/Education

The District Director of Clinical Services educated the Social Services staff and the Interdisciplinary team on importance of reviewing residents' with Dementia to assure timely care plan evaluation as well as care plans have achievable goals.

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{F 744}	Continued From page 42	{F 744}	**#4 Monitoring**	

Alzheimers." The goal was: "[name of resident] will continue to try to participate in the BIMS and know where their room is in the next 90 days.

Review of the statement of deficiencies for the 9/10/19 survey revealed Resident #55 had a a care plan for "I have impaired cognitive function or impaired thought processes r/t Alzheimer's." The goal was:" I will continue to try to participate in the BIMS and know where [his/her] room is in the next 90 days." Further review of the statement of deficiencies revealed there was no evidence in the medical record that the care plan was evaluated or if current interventions were working. There was no documentation in the medical record if the resident achieved the goal of the care plan.

On 1/10/20, further review of the medical record revealed that a care plan meeting had occurred on 12/3/19. Several care plan notes, dated 12/3/19, were found addressing various care plan goals, but no evaluations were found for the care plan specifically addressing impaired cognitive function. No documentation was found in the medical record to indicate if the resident achieved the stated goal, had made improvements or had a decline.

On 1/13/20 at 11:21 AM, the Administrator reported that every one of them [care plan goals] should have had a note, and that it was an oversight that this care plan goal was not addressed. The Administrator went on to report that the director of the dementia unit has been out on leave since October. The Unit Nurse Manager #12 reported that she was updating the nursing related care plans. When asked who was responsible for the non-nursing related updates,

The Director of Nursing will review 50% of current residents with Dementia who recently had or is scheduled for a care plan meeting to evaluate for timeliness of care plan review as well as presence of· achievable care plan goals weekly for four weeks then monthly for three months.

These audits will be submitted to the QAPI Committee for review and further recommendation as necessary.

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(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 744}	Continued From page 43	{F 744}		

the Administrator reported that Social Services was, but that moving forward, this would be the responsibility of the Director of Activities.

2/10/20

{F 757} SS=D Drug Regimen is Free from Unnecessary Drugs
CFR(s): 483.45(d)(1)-(6)

§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 reduced or discontinued; or

§483.45(d)(6) Any combinations of 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 and interview, it was determined that the facility failed to ensure that the resident's medication regimen was free from unnecessary medication by failing ta indicate the amount of a protein supplement to be given and failing to administer the correct amount of the supplement after the order had been clarified. This was evident for 1 out of 3

{F 757} **#1 Corrective Action**

Resident# 42's Promod order was clarified with MD and transcribed correctly.
Assigned nurse
was immediately educated on importance of documentation accuracy of Promod order by the Unit Coordinator.

#2 Identification

The Unit Coordinator will review current residents with orders for Promod from

11/10/19 to 1/13/10 to evaluate for proper transcription and documentation accuracy by nurses on the eMAR (Electronic Medication Administration Record).

#3 Systemic Correction/Education

The District Director of Clinical Services educated the Unit Coordinator, Unit Managers, Director of Nursing on how to properly transcribe or clarify a Promod order including but not limited to discontinuing previous order, entering a new order as well as assuring current date being entered as "start date" as well as a supplementary prompt documentation being entered such c:1s "ml" or "cc"; etc.

Importance of amount consumed or taken

STATE MENT OF DEFICIENCIES AND PLAN OF CORRECTI ON	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMAR Y STATEMENT OF DEFICIENCIS (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)	(X5) COMPLETION DATE
{F 757}	Continued From page 44 resident's (Resident #42) reviewed for unnecessary medications. Cross reference to F 867 Quality Assessment and Assurance The findings include: A recertification survey of this facility, completed on 9/10/2019, identified a deficient practice in which the facility failed to indicate the amount of a protein supplement to be administered to a resident. On 1/6/20, review of Resident #42's medical record revealed an order, originally dated 10/10/19, for Protein Liquid to be administered two times a day. The order failed to include the amount of the Protein Liquid to be administered the resident. Review of the Medication Administration Record (MAR) revealed that the Protein Liquid was due at 9:00 AM and 5:00 PM, and there were areas for staff to document the amount on the MAR. Review of the care plan revealed the following intervention , initiated 1/3/20, "Provide supplements as ordered: ProMod 30 cc BID [two times a day]." Review of the registered dietitian's note, also dated 1/3/20, revealed "Continues on ProMod BID 30 cc to provide additional 30gm/day." ProMod is the name of a liquid protein supplement. Regarding liquid volume 1 ml is the same as 1 cc. Review of the November 2019 MAR revealed documentation that the Protein Liquid had been	{F 757}	by resident in correct units needs to be accurately entered in the eMAR post administration was also discussed, The Director of Nursing will educate licensed nurses on same process to assure proper transcription and accurate administration documentation of Promod orders. **#4 Monitoring** The Director of Nursing will review 50% of current residents with Promod orders to validate proper transcription of order, accurate documentation of amount consumed by resident in appropriate units such as "ml" or "cc", etc. post administration weekly for four weeks then monthly for three months. These audits will be submitted to the QAPI Committee for review and further recommendations as necessary .	

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{F 757} Continued From page 45 {F 757}

administered twice daily. On 38 occasions, staff documented 100 in the area for amount. No documentation of ml, cc or percentage was documented for 37 of these 38 documentations of 100. Review of the December 2019 MAR revealed 26 occasions when 100 was documented and the January 2020 MAR revealed 5 occasions when 100 was documented. On all other occasions, 30 or 30 ml had been documented.

On 1/7/20 at 9:43 AM, nurse #1 reported that she had administered 30 ml of the ProMod to Resident #42 this morning. When asked how she knew the amount to give, the nurse confirmed that the order did not include the amount. Observation of the bottle located on the medication cart, and that the nurse reported she had obtained the ProMod from, revealed the strength to be 10 gms/ 30 ml.

Two 30 cc doses of the ProMod at 10 gms/30 ml **per day would provide 20 gms of protein per day,** not the 30 gms of protein per day as indicated in the RD #13's note dated 1/3/20.

On 1/7/20 at 10:00 AM, the unit nurse manger (Staff#12) reported that the nurse had brought the **issue regarding staff's failure to include an** amount for the ProMod order to her attention, and that she had addressed the issue. The unit manager provided a copy of the modified order which revealed that the order date remained 10/10/19, and in the section for Additional Directions, there was the following notation: PRO MOD 30 cc. In a follow up interview, the unit nurse manager reported that she had entered the original order into the electronic health record, and then gave the order to the Director of

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{F 757}	Continued From page 46 Nursing. On 1/13/20, further review of the medical record revealed that a new order was entered on 1/9/20 for Commercial Supplement two times a day for Wound Healing Pro mod 30 cc. Review of the January MAR revealed an area for the nurse to document ml administered. Review of the nursing documentation revealed that, for the doses due on 1/10/20 and 1/11/20 at 5:00 PM, the nurse documented 100. For the dose due on 1/11/20 at 9:00 AM, the nurse documented "120m", which would be4 times the dose that was ordered. Review of the plan of correction for the F 757 tag cited during the September survey revealed "Licensed staff education will be completed on transcription accuracy and proper identification of the order's components to include dosage, route, frequency and other clinical parameters for the drug by the Director of Nursing or Unit Coordinator. Further review of the MARs revealed that, at least 8 different nurses had administered the Protein Liquid supplement since November, however, no documentation was found that any of these nurses had requested an order clarification.	{F 757}		
{F 759} SS==E	Free of Medication Error Rts 5 Prent or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by:	{F 759}	**#1 Corrective Action** Resident #75's physician was notified about Tamsulosin medication and order was clarified. Re!>iuenl UlO's physician was not1fted about the lmdur medication and order was changed to another medication that can be crushed.	)ll)0

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{F 759} Continued From page 47

Based on medical record review, interview and observation, it was determined that the facility failed to ensure that their observed medication error rate was less than 5% as evidenced by the observation of 2 errors out of 35 opportunities for error resulting in an error rate of 5.7%. These errors were found to be evident for 2 out of the 3 residents (Resident #75 and #10) whose medication preparation and administration was observed.

The findings include :

1) On 1/7/20 at approximately 9:00 AM, surveyor observed nurse #1 prepare and administer medications to Resident #75. The nurse prepared and administered one Tamsulosin 0.4 mg to the resident.

On 1/7/20, after the completion of the medication administration observation, review of the medical record revealed the order for the Tamsulosin included the following: give 1/2 hour prior to breakfast. This order had been in effect since 2017. Review of the medication administration record (MAR) revealed the medication was scheduled to be given at 8:00 AM.

Review of the scheduled meal delivery times documentation revealed that the breakfast carts for Resident #75's unit are scheduled to arrive at 7:10 and 7:17 AM; and breakfast is scheduled to be served in the main dining room at 7:45 AM.

On 1/7/20 at 9:30 AM, Nurse #1 confirmed that Resident #75 had already eaten breakfast when the morning medications had been administered .

On 1/7/20 at 3:00 PM, surveyor reviewed with

{F 759} **#2 Identification**

The Director of Nursing will pull a listing of licensed nurses working in the facility to evaluate for presence of medication pass observation skills check as well conduct preliminary medication pass observation for those nurses identified to be of priority.

#3 Systemic Correction/Education

The Director of Regulatory Compliance will educate the Director of Nursing, Unit Coordinator and Unit Managers on Proper Medication Administration with an emphasis on following physician's orders to prevent a medication error. The Director of Nursing will educate same content with the licensed nurse and will be advised that they will be observed by assigned Nurse leaders with medication pass observation and will need to demonstrate 100% compliance with following through the process.

A list of meds that are listed as "not crushable" were made accessible for the nurses and nurses were advised that if an order is received that seems different from the manufacturer's guideline-to alert the Physicians and/or obtain a r.larifying order and do not administer medication.

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{F 759} Continued From page 48
corporate nurse #4 the medication error of

administering a medication after breakfast that had been ordered to be administered 1/2 hour

before breakfast.

2) On 1/9/20 at 10:16 AM, surveyor observed Nurse #6 prepare medications for Resident #10 by crushing all of the medications. One of the crushed medications was lsosorbide 30 mg. The nurse then attempted to administer the crushed medications to the resident, however, the resident refused all of the medications.

lsosorbide is also known as IMDUR.

At 10:40 AM, surveyor requested al list of do not crush medications from the Administrator . Review of this list revealed that IMDUR should not be crushed, as it is an extended release medication.

On 1/9/20 at 2:00 PM, surveyor **asked** Nurse #6 if IMDUR should be crushed, after looking up the medication the nurse confirmed that the medication should not be crushed.

The concern regarding the medication error rate of greater than 5% was reviewed with the Administrator and the corporate nurse #4 at time of exit on 1/13/20.

F 814 SS=E Dispose Garbage and Refuse Properly
CFR(s) : 483.60(i)(4)

§483.60(i)(4)- Dispose of garbage and refuse properly.
This REQUIREMENT is not met as evidenced

by:
Based on observation during tour of the facility's

{F 759} **#4 M onltorIng**
The Director of Nursing will conduct

medication observation daily for seven

days, weekly for four weeks then monthly for three months to validate licensed nurses competency in medication administration with an emphasis on ability to follow physician orders or obtaining a clarifying order prior to administration if a medication order seems different from manufacturer's guidelines. These audits will be submitted to the QAPI Committee for review and further recommendations as necessary.

F 8141 **#1 Correc ti ve Action**

Garbage was properly disposed of from the area around the dumpsters by the Maintenance Director and the Vice

President of Operations.

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F 814	Continued From page 49 dumpster area, it was determined the facility staff failed to dispose of garbage and refuse properly. This deficient practice has the potential to affect all residents. The findings include: An observation of the facility's dumpster/trash disposal area was conducted on 1/7/2020 at 9:30 AM where dumpster doors were observed open. Multiple pieces of trash and debris were present on the ground including wood pallets and old furniture such as couches and chairs. The findings were reviewed with the Administrator on 1/9/2020 at 2:45 PM.	F 81.t	**#2 Identification** The Director of Regulatory Compliance rounded the outside premises within the facility property to evaluate if there are any other location of the facility in need of garbage needing disposal including wood pallets and old furniture such as couches, chairs etc. **#3 Systemic Correction/Education** The Dietary Manager and Housekeeping Manage was re- educated by the Director of Regulatory Compliance to ensure the dumpster area remains free of clutter.,	2/10/20
{F 842} SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	{F **842}**	debris and trash, properly disposed of in dumpster with doors kept closed. These Managers will educate their staff to assure system remains in place to maintain the . dumpster area being clear of clutter, de ns, trash, old furniture such as couches, chairs, etc. **#4 Monitoring** The Dietary Manager will monitor the dumpster area to validate free of clutt r, debris and trash properly disposed of in dump ter with doors kept closed bi-weekly for one week, then weekly for four weeks then monthly for three months. These audits will be submitted to the QAPI Committee for review and further recommendations as necessary.	

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{F 842}	Continued From page 50	{F 842}	**15, F842 Resident Records**	

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening

#1 Corrective Actions

Resident# 42's Promod order was clarified with MD and properly tr ansc ribed.in the eM AR.

Resident# 17's bed rail consent was obtained from the responsible party.

Resident #17-Name and Rm# added to the physician's note.

Resident #23's hipsters have been discontinued by the MD.

Resident #300 no longer resides in the facility.

#2 Identification

The Unit Coordinator will current residents' Promod orders from 11/10/19 to 1/13/20 to evaluate for medical records kept in accordance with professional standards by assuring that "start" date are properly transcribed and no other modified orders after the original order date resulting in previous month's documentation to include the modification.

The Social Services staff will review current residents' active charts who experienced a significant improvement in cognitive function from 11/10/19 to 1/13/20 to evaluate for updated Physician certifications related to Medical condition, Decision Making and Treatment Limitations being completed.

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{F 842}	Continued From page 51 and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, it was determined that the facility failed to ensure that medical records were kept in accordance with professional standards as evidenced by 1) having an electronic medical record system that allowed orders to be modified after the original order date resulting in previous months MAR documentation to include the modification; 2) failed to ensure updated Physician Certifications Related to Medical Condition , Decision Making , and Treamtent Limitations were completed when a resident had a significant improvement in cognitive function; 3) failed to ensure that resident identifiable information was included on physician progress notes, 4) failed to maintain complete and accurate medical records by failing to accurately document residents care and treatment and 5) failed to ensure the residents wishes for life sustaining treatment was accurately documented throughout the medical record. This was found to be evident for 4 out of the 22 resident's (Residents #42, #17, #300 and #23) medical records reviewed during the survey. The findings include: 1) On 1/6/20, reveiw of Resident **#42's** medical record revealed an order, originally dated 10/10/19, for Protein Liquid to be administered two times a day. The order failed to include the amount of the Protein Liquid to be administered	{F **842}**	The Medical Records designee reviewed current residents' active charts to evaluate for presence of resident name and room number in physician progress notes. The Unit Coordinator reviewed current residents' who have care and treatment such as Promod and Glucerna orders, hipster, chair/bed alarm, bed rail use etc is accurately documented in the eMARs and/or reflected in the plan of care or Kardex. The Social Services Director, Unit Managers and Director of Regulatory Compliance conducted an audit to evaluate for residents' wishes for life sustaining treatment was accurately documented throughout the Medical record. **#3 Systemic Correction/Education** The Director of Nursing educated licensed nurses on importance of proper transcription of Promod orders including but not limited to assuring "start" date is properly transcribed and no other modified orders after original order date resulting in previous months' documentation to include modification to assure medical records kept in c:1crnrdance with protessional standards. The District Director of Clinical Services educated the Social Services staff on importance of evaluating current residents'	

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{F 842} Continued From page 52

to the resident. Review of the Medication Administration Record (MAR) revealed that the Protein Liquid was due at 9:00 AM and 5:00 PM, and there were areas on the MAR for staff to document the amount that was ingested..

On 1/7/20 at 9:43 AM nurse **#1** reported that she had administered 30 ml of the ProMod to Resident #42 this morning. When asked how she knew the amount to give, the nurse confirmed that the order did not include the amount.

Regarding liquid volume, 1 ml is the same as 1 cc.

On 1/7/20 at 10:00 AM, the unit nurse manger #12 reported that a nurse had brought to her attention the issue regarding failure to include an amount for the ProMod order and stated that she had addressed the issue. The unit manager provided a copy of the order which revealed that the order date remained 10/10/19, and in the section for Additional Directions, there was the following notation: PRO MOD 30 cc.

On 1/7/20, upon review of the copies of the MAR for the Protein Liquid administration documentation for November, December and January (which had been printed on 1/7/20 at 12:26 PM) surveyor noted that PRO MOD 30cc appeared in the order section. On 1/9/20 at 8:33 AM , corporate nurse #4 confirmed that the 30 cc had not been in the order prior to 1/7/20. Surveyor then reviewed the concern that the copy of the order provided by the unit manger on 1/7/20 was dated 10/10/19 and included the 30cc notation and that the MARs provided for previous months also included the 30 cc notation.

{F 842}

who are actively experiencing or who have had a significant improvement in cognitive function for updated Physician certifications related to Medical condition, Decision Making and Treatment Limitations being completed, etc. The Director of Nursing will educate same content to the licensed nurses.

The District Director of Clinical Services educated the Medical Records and IDT on importance of assuring current residents' forms in active charts have resident name and room number such as in physician progress notes etc. The Director of Nursing will educate same content to the licensed nurses.

The Director of Nursing will educate licensed nurses on importance of documentation accuracy in the eMARs and/or reflected in the plan of care or Kardex of current residents with orders for care and treatment such as Promod orders, hipster, chair/bed alarm, etc..

#4 MonItorIne

The Director of Nursing will audit 50% of residents with new Promod orders to validate proper transcription to assure medical records are kept in accordance with professional standards weekly for four weeks then monthly for three months.

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{F 842}	Continued From page 53 2 & 3) On 1/9/20, review of Resident #1?'s medical record revealed the resident had two certifications signed by physicins in 2005 and 2006 indicating the resident "is not capable of understanding any information about his/her healthcare and is unable to make an informed decision. This resident is also not able to sign any documentation pertaining his/her healthcare needs. The heatlhcare POA [power of attorney] will sign all documents." Further review of the medical record revealed a Consent for Bed Rail Use revealed the following : I understand that my interdisciplinary team has recommeded the following bed rails to address my medical needs: 1/2 side rails to each side of the bed to enable improved bed mobility. The consent was signed by the resident. No documentation was found in the medical record that the resident's POA had been educated regarding the use of the bed rails or provided consent for their use. On 1/9/20 at 3:30 PM, surveyor reviewed the concern with corporate nurse #4 that the consent for the bed rails had been obtained from the resident who, according to the medical record, had been certified by two physicians as being not capable to make informed decisions about health care or sign any documents pertaining to healthcare needs. On 1/9/20 at 1:43 PM, the ADON #5 reported that staff would obtain consents for bed rails from the resident if they are their own responsible party, if they aren't then they would obtain consent from the POA. In regard to Resident #17, the ADON reported the resident was his/her own RP. Surveyor then reviewed with the ADON the two	{F 842}	The Social Services Director will audit 50 % of current residents who are actively experiencing or who have had a significant improvement in cognitive function to validate for updated Physician certifications related to Medical condition, Decision Making and Treatment Limitations being completed weekly for four weeks then monthly for three months. The Medical Records will review 10% of current residents' active charts to validate medical records are kept in accordance with professional standards such as assuring resident names, room numbers etc. are present in physician progress notes or any forms pertaining to residents' medical records weekly for four weeks then monthly for three months. The Unit Coordinator or Interim Director of Nursing will randomly audit 10% of residents with new orders for care and treatment such as Promod, hipster, chair/bed alarm, etc. to validate proper transcription and accuracy of documentation in the eMARs and/or reflected in the plan of care or Kardex weekly for four weeks then monthly for three month . These audits will be submitted to the QAPI Committee for review and further recommendations as necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215184	A. BUILDING _____ B. WING _____	R-C 01/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 842}	Continued From page 54 certifications that the resident was not capable to make health care decisions. Further review of the medical record revealed that the resident had signed for immunization Consent for the flu shot on 10/1/19. On 1/10/20, the Administrator reported that Resident #17 has had improvement, the resident's BIMS [brief interview for mental status] yesterday was found to be 13 [indicating cognitively intact]. The Administrator went on to report that based on the current BIMS they have asked the physicians to come in today and re-assess the resident. On 1/13/20, review of the medical record revealed a Physician Certification Related to Medical Condition, Decision Making and Treatment Limitations form, signed on 1/10/20, that documented the resident as having "adequate decision making capacity." Further review of the resident's paper chart revealed a physician note, dated 1/10/20, that addressed the re-assessment for the resident's decision making capacity. Review of the copy of this note provided by the facility failed to reveal documentation of the resident's name or other identifying information. 4a) Resident #23's medical record was reviewed on 1/9/20 and revealed a physician's order for Hipsters to be worn every shift as tolerated. Review of the Resident's January TAR in the Electronic Medical Record (EMR) revealed that the resident's Hipsters were signed off as	{F 842}		

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{F 842}	Continued From page 55 administered every shift from 1/1/20 up to and including 0700 on 1/9/20. With the only exception of 0700 on 1/6/19, which was coded "see progress note". During an observation of Resident #23, on 1/9/20 at 12:40 PM, Staff#6 confirmed that Resident #23 was not wearing his/her hipsters. Staff #4 The District Director of Clinical Services was made aware that the staff documented the administration of Resident #23's Hipsters when they were not actually provided. Upon review of a printed copy, the January TAR revealed that the space previously initialed by Staff #6 indicating that the Hipsters were administered at 0700 on 1/9/20 was blank. Staff #4 was made aware of these findings. During an interview, on 1/9/20 at 1:37 PM, Staff #12 indicated that Resident #23 refused his/her Hipsters almost every day. Resident #23's Hipsters were signed off every shift from 1/1/20 to 1/9/20 as administered, with the exception of 1/6/20 at 0700. Staff #4 was made aware of the above findings at that time. 4b) Resident #300's record was reviewed on 1/6/20 at 2:50 PM. The record included physicians' orders for: Encourage hipsters worn at all times as tolerated every shift. Hipsters on as tolerated every shift for recurrent falls. Bed and Chair alarm to remind resident to call for assistance with transfers • Check for placement and function every shift for fall prevention.	{F 842}		

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{F 842}	Continued From page 56	{F 842}		

A plan of care was in place for high risk for falls. The care plan interventions included but were not limited to:
Apply hipsters to wear both in bed and when up in wheelchair.
Hipsters as tolerated.
Bed and chair alarm to remind resident to call for assistance with transfers, check for placement and function.

Resident #300 was observed on 1/8/20 at 3:00 PM sitting on the side of his/her bed putting his/her socks on. The resident did not appear to be wearing hipsters under his/her slacks. The resident was interviewed on 1/9/20 at 9:34 AM. He/she was again sitting on the side of the bed. He/she was wearing thin slacks. The resident did not appear to be wearing hipsters and when asked , Resident #300 denied having hipsters on. At 11:30 AM on 1/9/20, the resident was lying on his/her bed and did not appear to have hipsters on. During each of these observations, no bed/chair alarm was observed. At 12:05 PM on 1/9/20, the surveyor observed Resident #300 with Staff #4 the District Director of Clinical Services and Staff #5 the Assistant Director of Nursing. The resident was lying on his/her bed. Staff #5 verified that the resident was not wearing hipsters and that the bed alarm was not on the bed or in the resident's wheelchair. When asked where the alarm was, Resident #300 stated "I don't think there is one". Staff #4 located the bed alarm and pad dangling over the outside of the bed rail to the resident's left. The alarm wires were entangled with the bed control cord and the bed rail.

The Treatment Administration Record (TAR) for

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{F 842}	Continued From page 57 January 2020 included the bed/chair alarm and hipster orders and were signed off, by a nurse, each shift from 0700 (7:00 AM) 1/1/20 to 0700 1/9/20 as administered, with documentation that the resident refused hipsters as tolerated on 2 occasions at 1500 (3:00 PM) on 1/1/20 and 1/8/20. Staff #4 and #5 were made aware and confirmed that the facility staff failed to accurately document the resident's use or non-use of his/her hipsters and bed/chair alarm. 5) Further review of Resident #300's medical record, on 1/8/20 at 3:00 PM, revealed a MOLST (Maryland Medical Orders for Life-Sustaining Treatment) form dated 12/9/19. The MOLST documented that it was Resident #300's wishes to not receive CPR, but to receive Palliative and Supportive Care in the event of cardiac and/or pulmonary arrest. The physician's orders however, contained a current order, originally written on 10/21/19 for "Full Code". Full Code indicates that, in the event of cardiac and/or pulmonary arrest, any and all medical efforts that are indicated including artificial ventilation and CPR should be attempted. A plan of care was initiated on 10/29/19 for: Resident (#300) chooses to have CPR. The physician's orders and Resident #300's plan of care did not accurately reflect the resident's No Code status per his/her current MOLST dated 12/9/19. Staff #4 the District Director of Clinical Services was made aware and confirmed these findings on 1/8/20 at 3:10 PM.	{F 842}		

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{F 842}	Continued From page 58 During 3 separate interviews, licensed nursing staff identified that they would look at the resident's MOLST form to determine a resident's CPR status if they discovered a resident unresponsive.	{F 842}		
{F 867}	**SOnteyefi-e'tauffer;-lfeffy--** QAPI/QAA Improvement Activities SS=F CFR(s): 483.75(g)(2)(ii) §483.75(9) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on review of medical records and other pertinent documentation and interviews, it was determined that the facility failed to implement an appropriate plan of correction to address identified deficiencies as evidenced by the identification of 13 repeat deficiencies during the follow up survey. This deficient practice has the potential to affect every resident. The findings include: Cross reference F 623 Notice Requirements before Transfer/Discharge	{F 867}	#1 **Corre ctive** Action Issues noted with identified residents were corrected and all cited tags were reviewed at weekly Ad Hoc QAPI Meetings for further review . **#2 Identification** Residents residing at the facility have the potential to be affected by the alleged deficient practice. **#3 S ste mic CorrectionLEducation** The District Director of Clinical Services reviewed with the Leadership Team of the Repeat Citations from the facility's Annual Re-visit survey along ;is with written plan of correction that everyone is expected to adhere to. The Leadership team will be advised of the expectation that any	2)1 £'

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{F 867} Continued From page 59

F 624 Preparation for Safe/Orderly Transfer/Discharge
F 625 Notice of Bed Hold Policy Before/Upon Transfer
F 641 Accuracy of Assessments
F 656 Development of Comprehensive Care Plans
F 657 Care Plan Timing and Revision
F 684 Quality of Care
F 692: Nutrition/Hydration Status
F 700 Bedrails
F 744 Treatment/Services for Dementia Care
F 757 Drug Regimen is Free from Unnecessary Drugs
F 759 Free of Medication Error Rate 5 percent or More
F 842 Resident Records

In addition to identified deficiencies for the same regulations, it was determined that, for the following deficiencies the same or very similar examples were identified to evidence the deficient practice:

F 623 the facility failed to notify resident representative in writing of a transfer/discharge of a resident to an acute care facility and failed to ensure that correct information regarding the the name, address and telephone number of the entity which receives appeal requests was included in the notification documentation.

F 624 the facility failed to document what preparation and orientation was given to residents to ensure an orderly transfer to an acute care facility.

{F 867}

assigned tasks in relation to the plan of correction will be completed thoroughly and accordingly.

#4 Monitoring

The NHA will review facility's status on their submitted plan of correction to determine progress or attainment of substantial compliance for repeat deficiencies weekly for four weeks then monthly for three months to validate assigned staff members' consistent compliance and adherence to the plan of correction. The results of this review will be submitted and presented to the QAPI Committee for review and further recommendations as necessary.

The NHA will present the status of compliance with the current POC to the monthly QAPI Committee Meeting with the District Director of Clinical Services or Designee for corporate oversight for the next three months either in person or via phone to validate facility's compliance with QAPI review.

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{F 867}	Continued From page 60	{F 867}		

F 625 the facility failed to notify the resident representative in writing of the bed-hold policy upon transfer of a resident to an acute care facility.

F 692: the facility failed to implement nutritional supplements when recommended by and added to the care plan by the dietitian.

F 744 the facility failed to evaluate resident care plans and have achievable care plan goals for residents with dementia. Further review of the statement of deficiencies from the September survey revealed that the same issue with Resident #55's care plan that was identified during the revisit survey had been identified during the September survey.

F 757 the facility failed to indicate the amount of a protein supplement to be administered to a resident.

F 700 Bed Rails failed to obtain consent for use of bed rails.

Resident #23's record was reviewed on 1/6/20 at 1:23 PM. The record contained a physician's order that was originally written 9/6/19 for bilateral ½ side rails to help with mobility. A signed consent for the use of bed rails was not found in the resident's record. The same deficient practice was cited for Resident #23 during the last recertification survey. The facility's plan of correction indicated that Resident #23's bed rail consent had been signed by 10/25/19.

Resident #300's record was reviewed on 1/6/20

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{F 867}	Continued From page 61 at 2:50 PM. Bed rail safety reviews, dated 10/21/19 at 16:36 and 12/29/19 at 22:09 (10:09 PM), were in the record. Section C indicated to continue ½ rails both sides. Further review of the record failed to reveal a consent for the use of bed rails, a physician's order for bed rails, nor a plan of care for the use of bed rails. Resident #300 was observed on 1/8/20 at 3:00 PM and 1/9/20 at 9:34 AM, 11:30 AM and 12:05 PM with ½ bed rails in the raised position on each side of his/her bed. The facility's Plan of Correction from the last recertification survey ending 9/10/19 indicated that the facility completed an audit for all residents with bed rails for orders, consents and education sheets; that education was provided to staff on the bed rail policy, that the Director of Nursing and/or Unit Managers would audit new admissions for the need for bed rails including the completion of consent, orders, education and risk/benefit discussion, and that Care Plans would reflect any bed rails utilized. F 641 facility failed to accurately assess the administration of medication. The MOS is a complete assessment of the resident which provides the facility with the **information necessary to develop a plan of care,** provide the appropriate care and services to the resident, and to modify the care plan based on the resident's status. Review of Resident #68's medical record on 1/7/20 revealed that the facility staff failed to accurately code Section N041OG of resident's Quarterly Minimum Data Set (MDS) dated 10/22/19, to reflect that the resident received a diuretic medication on all 7 days of the lookback period. Cross reference F 641.	{F 867}		

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{F 867} Continued From page 62

{F 867}

This same deficient practice was cited during the last recertification survey ending 9/10/19. An interview was conducted on 1/8/20 with Staff #17 the District Director of Case Management and Staff#18 MOS coordinator. The corrective measures that the facility put into place after the last survey, (to prevent the same deficient practice from recurring) were reviewed. Staff #17 indicated that the team was educated on

accurately coding the MOS on 10/15/19. The focus was on medications, overall MOS accuracy was gone over, but they drilled down on the specific areas cited, and audits were done. When asked how the same deficient practice recurred, she initially indicated that she thought there was an issue with the audit. She added that they will now be more diligent with what they are reviewing and that she would be checking behind the MOS coordinator from time to time. They were asked if an attempt was made to determine the root cause ur ll,e MD3 errors. 3taff#17 **stated** [11]i t **w s** missed". When asked if the facility attempted to identify why it was again missed, Staff #18 indicated that many residents stop by the MDS office to "chit chat" with the MOS staff causing the MOS staff to be distracted. She added that they will now keep the MOS office door closed and are planning to relocate the MDS office to an area with less resident traffic. Staff #17 added that the MDS coordinator would be double checking all of the MOS assessments prior to transmitting them.

State Tags

S600 ---------- See POC for F624

S610 ---------- See POC for F759

S820 ---------- See POC for F692

S1380 ---------- See POC for F623, F624, F625, F700, F842

S2900 ---------- See POC for F641

S2910 ---------- See POC for F657

S2940 ---------- See POC for F700

S2950 ---------- See POC for F744

S3000 ---------- See POC for F867

S5095 ---------- See POC for F684

S6038 ---------- See POC for F557

S7090 - See POC for F814

TI Frederick
n.J Health and Rehabilitation Center

May 3, 2019

Patti Melodini

Health Facilities Survey Coordinator

Long Term Care

Office of Health Care Quality

7120 Samuel Morse Dr.

Columbia, Maryland 21046

Dear Ms. Melodini:

Attached you will find our response to the complaint survey conducted at our facility by the Office of Health Care Quality on April 11 and April 12, 2019.

Please let us know if you have additional questions.

Thank you so much.

Henri Carlton LNH*A*--

Frederick Health and Rehabilitation Center

30 North Place

Frederick, Maryland 21701

301695 6618

MARYLAND
Department of Health

Larry Hngan, Governor · Boyd K. Ruther/ind, Lt. Oovemor · Roher/ R. Neall, SecrefOIJ'

Office of Health Care Quality
7120 Samuel Morse Dr.
Columbia, MD 21046

April 24, 2019

Ms. Henri Carlton, Administrator
Frederick Health & Rehabilitation Center
30 North Place
f'rederick, MD 2170 I

PROVIDER# 215184
RE:NOTICE OF CURRENT DEFICIENCIES AND POSSIBLE IMPOSITION OF REMEDIES

Dear Ms. Carlton:

On April 11 and 12, 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 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.

I. PLAN OF 'ORR I CT ION (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 afiected 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;

- 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.

IL IMPOSI ION 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 May 27, 2019. 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.July 12, 2019) identifying non-compliance, we must deny payments for new admissions. (§488.41?(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 October 12, 2019, your Medicare provider agreement will be terminated.

III. ALLEGATION OF C01v1PLIANCE

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 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 April 12, 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.

IV. 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, 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 informal dispute resolution process will not delay the effective date of any enforcement action.

V. 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 oremail at patricia.melodini@maryland.gov.

Sincerely,

Patti Melodini
Health Facilities Survey Coordinator
Long Term Care

Enclosures: CMS 2567
State Form

cc: Stevanne Ellis
Jane Sacco
File JI

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

PRINTED: 04/24/2019
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215184	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED C 04/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICK HEALTH & REHABILITATION CENTER	30 NORTH PLACE FREDERICK, MD 21701

(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)	(X5) COMPLETION DATE
F 000	**INITIAL** COMMENTS On April 11, 2019 through April 12, 2019 an investigation was conducted at this facility by the Office of Health Care Quality of two complaints MD00137345, MD00126763 and one facility reported incident MD00128627. The census was 110 and the licensed bed capacity is 120. Survey activities consisted of a review of residents' medical records, observation, interview of the facility staff, and a review of administrative records. The survey identified non compliance with Federal and State requirements that were reviewed in relationship to complaint MD00137345.	F 000	Preparation and/or execution of this plan of correction do not constitute admission of agreement by the provider as to the validity of the assertions set forth in the statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of Federal and State Laws.	
F 552 SS=D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be *informed, in* advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or	F 552	**F 552/S230/S5095** 1. Administrator and Don reviewed findings of survey on April 26, 2019 2. Administrator and DON reviewed all deaf residents having potential to be affected by findings. Review done through discussions with deaf residents on May 3, 2019 3. Education to all staff by the Staff Development Coordinator and Department Heads to notify Administrator or DON if interpreter is requested by the resident. We are in the process of hiring a full time sign language interpreter to attend assessments, care plans, financial discussions rehabilitation treatments as resident feels	04/26/2019 05/03/2019 05/22/2019

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.

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F 552	Continued From page 1 option he or she prefers. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff, resident and family interview, it was determined the facility failed to consistently provide interpreters to sensory impaired residents upon request and during physician visits to ensure that the resident was fully informed, in a language thats/he could understand, of his/her medical condition. This was evident for 3 of 5 (Residents #1, #5 and #8) residents reviewed for resident's rights during this complaint survey. The findings include: 1) Medical record review on 4/11/19 revealed resident #1 was a long-term care resident who was noted to be sensory impaired, non-verbal. Surveyor review of complaint# MD00137345 revealed a concern that the facility failed to consistently provide interpreters for sensory impaired residents for onsite physician visits and to discuss changes in treatment and changes in their condition. During an interview with the surveyor on 4/11/19 at approximately 10:30 AM resident #1 confirmed that s/he expressed concerns to an interpreter that s/he was confused about a change in appointments s/he had scheduled several months ago and about symptoms s/he was experiencing. 1n interview with the surveyor on 4/19/19 at 3:13 PM, Interpreter #2 who visits the facility regularly, reported that sensory impaired residents complain that they do not receive health information in a language that they can understand. Interpreter #2 stated that English	F 552	necessary, mentonng staff in sign language, attending resident council, participation in activities by June 30 2019. Our second sign la nguage is scheduled for May 7 for additional 8 staff members to learn basic sign language. This class is taught by a certified ASL instructor from oµr School for the Deaf in Frederick. 4. Newly hired Deaf Program Director and Administrator will interview all Deaf residents over one month period using a satisfaction tool to be developed with the Director. Administrator and Director report to QAPI monthly on concerns, action plans and progress.	05/0:J,Ja-off ongoing

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

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F 552	Continued From page 2 was not necessarily the first language for sensory impaired residents, therefore, communicating with a boogie board (writing tablet) or by writing may not be effective. 2) Medical record review on 4/12/19 revealed that resident #5 **was a** long-term care resident who was noted to be sensory impaired, non-speaking. During an interview with resident #5 on 4/12/19 at 11:29 AM, s/he stated that, although s/he could read lips and communicate in writing and by texting, s/he would prefer that an interpreter be available when s/he sees the physician. 3) Medical record review on 4/12/19 revealed that resident #8 was a long-term care resident who was noted to be sensory impaired, non-speaking. During an interview with the surveyor on 4/12/19 at 12:25 PM, resident #8's responsible party stated that resident #8 would better understand what is said if s/he could have an interpreter. The responsible party stated that all individuals who are sensory impaired do not write well or may tire of writing their responses (during an assessment or interview). During an interview with the surveyor on 4/12/19 at 11:40 AM, LPN #2 stated that it was not routine to schedule an interpreter for assessments or physicians visits, but if the resident does not understand what is written, the facility will request an interpreter. The findings were discussed with the Administrator and Director of Nursing on 4/12/19 at 3:30 PM.	F 552		

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	F 558 Continued From page 3 F558 Reasonable Accommodations Needs/Preferences SS=E **CFR(s): 483.10(e)(3)** §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on staff, resident, and resident representative interviews, it was determined the facility failed to: 1) ensure consistent access to functional video relay service equipment for sensory impaired residents; 2) ensure that sensory impaired residents had an opportunity to fully participate in the resident council meetings; and 3) consistently provide a program of individualized activities of interest for the sensory impaired population. This was evident for 8 (#1, #4, #5, #6, #7, #8, #9, #10) of 8 residents reviewed for accommodation of needs during this complaint survey. Video Relay Service (VRS) is a form of Telecommunications Relay Service (TRS) that enables persons with hearing disabilities who use American Sign Language (ASL) to communicate with voice telephone users through video equipment, rather than through typed text. Video equipment links the VRS user with a TRS operator - called a "communications assistant" (CA). www.fcc.gov The findings include: 1) Surveyor review of complaint #MD00137345 revealed a concern that access to video relay services for sensory residents was inconsistent	F 558 F SSS	**F558/S5090/S5093/S5095** 1. Findings reviewed by Administrator and DON on April 26, 2019. 2. Administrator and DON reviewed all deaf residents having potential to be affected by findings. Review done through discussions with deaf residents on May 3, 2019 3. New Director will form deaf resident council as well as participate in Resident Council to provide interpretive services for inclusive discussions. Activities Calendar will be updated to identify activities with interpretive services. The Director will participate in calendar development with input from the Deaf residents. SMART TVs have been ordered to accommodate the Activity Connection games for closed caption and onscreen BINGO for the main dining room and for North dining room.	04/26/2019 05/03/2019 05/27/2019

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F 558	Continued From page 4 due to poor internet connectivtiy. During an interview with the suiveyor, with an interpreter, on 4/11/19 at 2:00 PM resident #1 stated the facility has 2 video phones but the signals are very weak, and they do not work. During an interview with the suiveyor on 4/11/19 at 3:15 PM the Administrator stated that the bandwidth (the more bandwidth a data connection has, the more data it can send and receive at one time) is currently not adequate to support use of the video relay services. The Administrator stated the facility plans to address this issue. In interview with the suiveyor on 4/12/19 at 11:40 AM, LPN #2 reported the facility has a videophone on a cart but the lag times are pronounced. The residents and facility identified this as an issue, but did not have a timeline or plan for resolving the Issue at the time of the survey. 2) The facility failed to demonstrate the implementation of a process to ensure that the sensory impaired population is included in the resident council to ensure that they have an opportunity to express their concerns and receive information about facility policies, rules and residents' rights. A resident or family group (council)" is defined as a group of residents or residents' family members that meets regularly to discuss and offer suggestions about facility policies and procedures affecting residents' care, treatment, and quality of life, support each other, plan resident and family	F 558	rr wrn oe contacung our internet service provider to do an internet bandwidth upgraded to increase the allotted bandwidth for the guest Wi-Fi network. IT will create a special firewall rule on facility network router to give the Sorenson Video device " priority" and dedicated bandwidth on the network to reduce delay with video transmissions. 4. Administrator and Director will interview all deaf residents _. monthly using satisfaction tool. Administrator and Director will report monthly to QAPI results, action plans, and progress.	

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F 558	Continued From page 5 activities, participate in educational activities or for any other purpose. During an interview with the surveyor, on 4/11/19 at 3:15 PM, the Administrator stated that the facility was in the process of trying to formulate a family council to provide an opportunity for families to express concerns and offer suggestions for improving care for the sensory impaired residents. It was confirmed during this interview that the facility does not routinely schedule an interpreter for the monthly resident council meetings to accommodate the sensory impaired residents. During an interview with the surveyor, on 4/19/19 at 3:13 PM, Interpreter#2 stated that sensory impaired residents reported feeling isolated from other residents and anxious due to the communication barriers. 3) The facility failed to demonstrate the implementation of a program of activities that meets the individualized needs of the sensory impaired population. During an interview with the surveyor, on 4/11/19 at 12:50 PM, the Activity Director stated that a volunteer from the Maryland School for the Sensory impaired comes to the facility Monday-Friday from 9:30 AM-11:30 AM. The volunteer plays cards with several residents. The Activity Director stated that the volunteer will start coming to the facility in the afternoons on 4/18/19. In addition, the Activities Director stated they show movies with closed caption and some residents play word games. During an interview with the surveyor, on 4/11/19	F 558		

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F 558	Continued From page 6 at approximately 10:30 AM, Resident #1 communicated that s/he wanted to leave the facility because s/he was bored and wished there was more to do. Resident #5 stated during an interview with the surveyor, on 4/12/19 at 11:29 AM, thats/he would like more activities to keep her/him busy. In interview with the surveyor on 4/19/19 at 3:13 PM, Interpreter #2 (who visits the facility at least weekly) discussed concerns that sensory impaired residents reported they feel isolated and want to be included in more activities. The findings were discussed with the Administrator and Director of Nursing on 4/12/19 at 3:30 **PM.**	F 558	**F838/S265** I. Findings reviewed by Administrator and DON on April 26, 2019. 2. Administrator and DON reviewed all deaf esidents having potential to be affected by findings. Review done through discussions with deaf residents on May 3, 2019 along with current emergency instructional sheets identifying actions to be taken by resident and staff 3. Newly created position for Program Development for Deaf residents will be facilitate assessments by Medical Providers, nursing, social service assessments , dietary assessments, activities assessments , care plans, financial discussions, rehab assessments, treatments discussions as needed, resident council, deaf resident council, activity programs, and mentor staff who have completed basic ASL class.	
F 838 SS=E	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, A. Both the number of residents and the facility's resident capacity;	F 838		

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F 838	Continued From page 7 (ii} The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract}, and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and	F 838	Training syuaous wrn oe created with input from newly created position on approach for the deaf residents, review of binder infonnation already available as resource to staff. This will be rolled out to all staff and incorporated in General Orientation for new hires. 4. Adniinistrator and Director will interview deaf residents monthly using satisfaction tool. Administrator and Director to report monthly to QAPI on results, actions plans and progress.	Ongoing

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F 838	Continued From page 8 community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on a review of the Facility Assessment, staff and resident interview, it was determined that the facility failed to update the Facility Assessment to ensure that the individualized needs of the sensory impaired population were fully addressed. This had the potential to affect 8 (#1, #4, #5, #6, #7, #8, #9, #10) of 8 sensory impaired residents. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include the care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; the staff competencies that are necessary to provide the level and types of care needed for the resident population; the physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition	F 838		

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F 838	Continued From page 9 services. The findings include: 1) The facility failed to establish protocols to ensure that residents have an interpreter for initial assessments to establish a baseline for communication needs. Surveyor review of complaint# MD00137345 revealed concerns that the facility failed to provide interpreters for sensory impaired residents for onsite physician visits and to discuss changes in treatment and changes in their condition. On 4/11/19 at 12:50 PM, the surveyor asked the Activity Director how s/he conducts the initial activity assessments. S/he stated s/he hands the assessment form to the resident to answer the questions. In interview with the surveyor on 4/12/19 at 11:05 AM, the Medical Director stated that most of the communication during physician visits is accomplished with pen and paper, that some residents use a laptop or an IPAD, but if someone requests an interpreter, one would be provided. During an interview with the surveyor on 4/12/19 at 11:40 AM, LPN #2 stated that it is not routine to schedule an interpreter for assessments or physicians visits, but if the resident does not understand what is written, the facility will request an interpreter. In interview with the surveyor on 4/12/19 at approximately 1:00 PM, the Occupational Therapist #1 was asked how s/he conducts initial assessments and communicates with sensory	F 838		

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F 838	Continued From page 10 impaired residents who require therapy services. S/he stated s/he has had some experience with signing and has a reference manual with sign language illustrations. The Occupational Therapist denied the need for an interpreter, despite not being cerified in American Sign Language. The resource binder noted that 8 facility staff have completed a basic sign language class, however, they are not certified sign language interpreters. Review of facility resource material and interviews with staff and residents, revealed no structured approach to determine the sensory impaired resident's communication abilities and needs in order to ensure they are able to receive information relative to their care and needs in a language they fully understand. 2) Review of the Facility Assessment, updated on March 19, 2019, revealed the facility failed to include the training needs related to the care of the sensory impaired population. Review of five employee records revealed that 5 of 5 employees did not receive education during orientation regarding care and needs of the sensory impaired population. During an interview with the surveyor on 4/11/19 at 2:17 PM, the Director of Nursing stated that there are binders on each unit with information regarding care of sensory impaired residents. Review of the binder, on 4/12/19 at 11:45 AM, revealed information that included but was not limited to, communicating information to persons with sensory and manual impairments,	F 838		

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F 838	Continued From page 11 information on the language line services and sign language illustrations. The manuals contained a signature sheet for staff to acknowledge the presence of the resource book. The signature sheets were dated 4/11/19, the day the survey started. Review of the facility's resource material and staff interview revealed there were some resources in place but not a structured staff development plan to address the care needs of the sensory impaired residents. 3) The facility assessment failed to address emergency procedures for sensory impaired residents. The resource binder that was placed on the units contained signs that state, there is an emergency, you are safe, stay in your room or please follow me. Staff are to show the signs to the residents during an emergency. There were no other alert systems noted. It is not clear if or when information regarding emergency procedures was presented to the sensory impaired residents to ensure that the most effective alert methods are available and in place in the event of an emergency. The findings were discussed with the Administrator and Director of Nursing on 4/12/19 at 3:30 **PM.**	F 838		

Office of Health Care Quality

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG
S 000	Initial comments On April 11, 2019 through April 12, 2019 an investigation was conducted at this facility by the Office of Health Care Quality of two complaints MD00137345, MD00126763 and one facility reported incident MD00128627. The census was 110 and the licensed bed capacity is 120. Survey activities consisted of a review of residents' medical records, observation, interview of the facility staff, and a review of administrative records. The survey identified non-compliance with Federal and State requirements that were reviewed in relationship to complaint MD00137345.	S 000
S 230	10.07.02.07 AAdministration and Resident Care .07 Administration and Resident Care. A Responsibility. (1) The licensee shall be responsible for the overall conduct of the comprehensive care facility or extended care facility and for compliance with applicable laws and regulations. (2) The administrator shall be responsible for the implementation and enforcement of all provisions of the Patient's Bill of Rights Regulations under **COMAR** 10.07.09. This Regulation is not met as evidenced by: Refer to CMS 2567 F552	S 230

	(X5) COMPLETE DATE
1. Administrator and Don reviewed findings of survey on April 26, 2019	05/03/2019
2. Administrator and DON reviewed all deaf residents having potential to be affected by findings. Review done through discussions with deaf residents on May 3, 2019	05/27/2019
3. Education to all staff by the Staff Development Coordinator and Department Heads to notify Administrator or DON if interpreter is requested by the resident. We are in the process of hiring a full time sign language interpreter to attend assessments, care plans, financial discussions, rehabilitation treatments as resident feels necessary, mentoring staff in sign language, attending resident council, participation in activities by June 30 2019. Our second sign language is scheduled for May 7 for additional 8 staff members to learn basic sign language. This class is taught by a certified ASL instructor from our School for the Deaf in Frederick.	05/30/2019
4. Newly hired Deaf Program-Director and Administrator will interview all Deaf residents over one month penod usmg a satisfaction tool to be developed with the Director. Administrator	

OI·ICO

LABO TORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S S GNATURE

Henri Carlton L/D H->1

05/03/2019

(X6) DATE

STATE FORM

nd Director report to QAPI monthly on concerns, action plans and progress.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	{X2) MULTIPLE CONSTRUCTION	(X3} DATE SURVEY COMPLETED
	215184	A. BUILDING: _____ B . WING _____	C 04/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICK HEALTH & REHABILITATION CEN	30 NORTH PLACE FREDERICK, MD 21701

{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)	(X5) COMPLETE DATE
S 230	Continued From page 1 F838	S230	**F838 /S265** I. Findings reviewed by Administrator and DON on April 26, 2019. 2. Administrator and DON reviewed all deaf residents having potential to be affected by findings. Review done through discussions with deaf residents on May 3, 2019 along with current emergency instructional sheets identifying actions to be taken by resident and staff. 3. Newly created position for Program Development for Deaf residents will be facilitate assessments by Medical Providers, nursing, social service assessments, dietary assessments, activities assessments, care plans, financial discussions, rehab assessments, treatments discussions as needed, resident council, deaf resident council, activity programs, and mentor staff who have completed basic ASL class. Training syllabus will be created with input from newly created position on approach for the deaf residents, review of bmder information already available as resource to staff. This will be rolled out to all staff and incorporated in	'-t \c}bIJ011 05/o JlJo/ o4 ui1
S265	10.07.02.07 H Admin/Res care educ pgm .07 Administration and Resident Care H. Educational Program. An ongoing educational program shall be planned and conducted for the development and improvement of skills of all the facility's personnel, including training related to problems and needs of the aged, ill, and disabled. Records shall be maintained reflecting attendance, by name and title, and training content. In-service training shall include at least: {1) Prevention and control of infections; {2) Fire prevention programs and patient related safety procedures in emergency situations or conditions; (3) Accident prevention; (4} Confidentiality of patient information; (5) Preservation of patient dignity, including protection of the patient's privacy and personal and property rights; (6) Psychophysical and psychosocial needs of the aged ill; (7) Receipt by each employee of appropriate orientation to the facility and its policies, and to the employee's position and duties; {8) Approval by the Department of the orientation and training programs. This Regulation is not met as evidenced by: Refer to CMS 2567 F838	S 265		

General Orientation for new hires.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215184	A B UILDING: _ _ _ _ _ _ _ _ B. WING _ _ _ _ _ _ _ _ _	C 04/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICK HEALTH & REHABILITATION CEN	30 NORTH PLACE FREDERICK, MD 21701

(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)	(X5) COMPLETE DATE
S509 0	10.07.09.08 A Res Rights/Svcs;general .08 Resident's Rights and Services. A A nursing facility shall provide care for residents in a manner and In an environment that maintains or enhances each resident's dignity and respect, and in full recognition of the resident's individuality. This Regulation is not met as evidenced by: Refer to CMS 2567 F558	S5090	**F838/S265** 4. Administrator and Director will interview deaf residents monthly using satisfaction tool. Administrator and Director to report monthly to QAPI on results, actions plans and progress. **FSS8/S5090/S5093/S5095** 1. findings reviewed by Administrator and DON on April 26, 2019. 2. Administrator and DON reviewed all deaf residents having potential to be affected by findings. Review done through discussions with deaf residents on May 3, 2019 3• New Director will form deaf resident council as well as participate in Resident Council to provide interpretive services for inclusive discussions. Activities Calendar will be updated to identify activities with interpretive services. The Director will participate in calendar development with input from the Deaf residents. SMART TVs have been ordered to accommodate the Activity Connection games for closed caption and onscreen BINGO for the main dining room and for North dining room.	ngoing 5/26/2019 5/03/2019 05/27/2019
S5093	10.07.09.08 C (1) Right to reasonable accommodation .oa Resident's Rights and Services. C. A resident has the right to: (1) Reside and receive services in a nursing facility with reasonable accommodations of individual needs and preferences, except when accommodations would endanger the health or safety of the resident or other residents; This Regulation is not met as evidenced by: Refer to CMS 2567 F558	S5093		
S5095	10 .07.09.08 C (2) Right to receive care in qual environ .08 Resident's Rights and Services. C. A resident has the right to:	S5095		

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215184	A. BUILDING: _____ B. WING _____	C 04/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICK HEALTH & REHABILITATION CEN	30 NORTH PLACE FREDERICK, MD 21701

(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)	(X5) COMPLETE DATE
S5095	Continued From page 3 (2) Receive treatment, care, and services that are in an environment that promotes maintenance or enhancement of each resident's quality of life; This Regulation is not met as evidenced by: Refer to CMS 2567 F5095	S5090 S5093	IT will be contacting our internet service provider to do an internet bandwidth upgraded to increase the allotted bandwidth for the guest Wi-Fi network. IT will create a special firewall rule on facility network router to give the Sorenson Video device "priority" and dedicated bandwidth on the network to reduce delay with video transmissions. 4. Administrator and Director will interview all deaf residents 5. monthly using satisfaction tool. Administrator and Director will report monthly to QAPI results, action plans, and progress.	ongoing
		S5095	1. Findings reviewed by Administrator and Don on April 26, 2019 2. Administrator and DON reviewed with Deaf Residents findings on May 3, 2019 3. Newly created Director, fluent in ASL and with family members who are deaf, will assist with training, interpretation of assessments, treatments, careplans, financial discussion, activities to include deaf residents 4. Administrator and newly created Director will interview deaf residents monthly reporting to QAPI on findings, action plans and progress	04/26/2019 05/03/2019 05/27/2019 ongoing

Frederick
Health and Rehabilitation Center

March 29, 2019

Patti Melodini

Health Facilities Survey Coordinator

Long Term Care

7120 Samuel Morse Drive
Second Floor
Columbia, Maryland 21046-3422

Dear Patti,

Enclosed you will find our 2567 response to our RFMS survey on March 4, 2019.

Please let me know if you have questions or changes to the document.

Thank you.

Sincerely,

Henri Carlton NHA

Henri Carlton NHA

Frederick Health and Rehabilitation Center

30 North Place

Frederick, Maryland 21701

301 695 6618

Enclosures

MARYLAND
Department of Health

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

Office of Health Care Quality
7120 Samuel Morse Dr.
Columbia, MD 21046

March 7, 2019

Ms. Henri Carlton, Administrator
Frederick Health & Rehabilitation Center
30 North Place
Frederick, MD 21701

PROVIDER #:215184
RE: NOTICE OF CURRENT DEFICIENCIES

Dear Ms. Carlton:

On March 4, 2019, 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. The survey was also conducted for the purposes of State licensure. As documented in the attached CMS form 2567, this survey found that your facility was in substantial compliance but deficiencies were identified that posed no actual harm with potential for minimal harm.

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

I. PLAN OF CORRECTION (PoC)

A PoC for the deficiencies identified in the attached CMS 2567 must be submitted within 10 days of your receipt of this notice. Failure to submit an acceptable PoC by this date may result in the imposition of remedies.

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;

- How the corrective action 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 unacceptable to include a resident(s) name in these documents since these the PoC is released to the public.

II. ALLEGATION OF COMPLIANCE

If you believe that the deficiency identified in the CMS 2567 form have been corrected, you may contact me at the Office of Health Care Quality, Spring Grove Center, 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 by other means.

If upon a subsequent revisit or by other means, we verify that the facility has not corrected the deficiencies or if the seriousness of non compliance changes from the original survey findings, remedies may be imposed. If this occurs, you will be advised of any change.

III. 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 being disputed, and an explanation of why you are disputing the deficiency, to Ms. Margie Heald, Deputy Director, Office of Health Care Quality, Spring Grove Center, 55 Wade Avenue, Catonsville, Maryland 21228. This request must be sent within 10 days of your receipt of the CMS form 2567.

IV. LICENSURE ACTION

As you are aware, the cited Federal deficiencies have a counter part in State regulations. These deficiencies are cited on the enclosed in the State Form. Please provide us with your plan of correction for these deficiencies within 10 days of receipt of this letter. In the event a revisit determines that 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 by email at patricia.melodini@maryland.gov.

Sincerely,

Patti Melodini
Health Facilities Survey Coordinator
Long Term Care

Enclosures: CMS Form 2567
State Form

cc: File II

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215184	A. BUILDING _____ B. WING _____	C 03/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICK HEALTH & REHABILITATION CENTER	30 NORTH PLACE FREDERICK, MD 21701

(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)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 3/4/19, a survey was conducted at this facility by the Office of Health Care Quality to investigate complaint #MD00137480. Activities included the audit of the residents' personal funds records maintained by this facility. The specific complaint was unsubstantiated. This survey did not identify noncompliance with Federal requirements that were reviewed in relationship to the specific complaint. This survey did identify noncompliance with Federal requirements that were reviewed pertaining to the management of residents' personal funds. (SEE F568)	F 000	Preparation and/or execution of this plan of correction do not constitute admission of agreement by the provider as to the validity of the assertions set forth in the statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of Federal and State Laws.	
F 568 SS=B	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced by: Based on the review, on 3/4/19, of the residents' personal funds records, including residents' account statements, transaction reports, and trial balances, this facility failed to maintain a system	F 568		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nurse Case Mgr NHA | TITLE | (X6) DATE: 3/29/19

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215184	A. BUILDING _____ B. WING _____	C 03/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICK HEALTH & REHABILITATION CENTER	30 NORTH PLACE FREDERICK, MD 21701

(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)	(X5) COMPLETION DATE
F 568	Continued From page 1 that ensures a full and complete accounting of the residents' personal monies entrusted to this facility. Findings include: 1. As of 3/4/19, there was no evidence that statements of each resident's personal fund account had been appropriately furnished for the quarters ending 3/31/18 and 12/31/18.	F 568	F 568 1. Business Office Director and Administrator reviewed all personal fund accounts for quarter ending 3/31/18 and 12/21/18 on 3/5/19 2. Business Office Director reviewed the state process for documentation regarding furnishing each resident, the resident's agent or interested family member with a quarterly statement of the resident's individual account not later than 30 days after the end of each quarter on 3/5/19. 3. Audit tool developed by the Business Office Director to account for each resident fund review per quarter on 3/5/19. (see attachment A) 4. Business Office Director will audit each quarterly statement for completion of process and reviewed by the Administrator. Audit will be presented to QAPI by Business Office Director quarterly. If 100% compliance over four consecutive quarters, audits will be done randomly of 30% of resident accounts for completion of process. This is an ongoing action item.	3/5/19 3/5/19 3/5/19 ongoing

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215184	A. BUILDING _____ B. WING _____	C 03/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICK HEALTH & REHABILITATION CEN	30 NORTH PLACE FREDERICK, MD 21701

(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)	(X5) COMPLETE DATE
S 000	Initial comments On 3/4/19, a survey was conducted at this facility by the Office of Health Care Quality to investigate complaint #MD00137480. Activities included the audit of the residents' personal funds records maintained by this facility. The specific complaint was unsubstantiated. This survey did not identify noncompliance with State requirements that were reviewed in relationship to the specific complaint. This survey did identify noncompliance with State requirements that were reviewed pertaining to the management of residents' personal funds. (SEE S6505)	S 000	F 568/S6505 1. Business Office Director and Administrator reviewed all personal fund accounts for quarter ending 3/31/18 and 12/21/18 on 3/5/19 2. Business Office Director reviewed the state process for documentation regarding furnishing each resident, the resident's agent or interested family member with a quarterly statement of the resident's individual account not later than 30 days after the end of each quarter on 3/5/19. 3. Audit tool developed by the Business Office Director to account for each resident fund review per quarter on 3/5/19. (see attachment A) 4. Business Office Director will audit each quarterly statement for completion of process and reviewed by the Administrator. Audit will be presented to QAPI by Business Office Director quarterly. If 100% compliance over four consecutive quarters, audits will be done randomly of 30% of resident accounts for completion of process. This is an ongoing action item.	3/5/19 3/5/19 3/5/19 ongoing
S6505	10.07.09.19 A (3) Recs pers Funds;qtrly statement .19 Records of Resident Personal Funds. A. Records. For all resident funds entrusted to a nursing facility, the facility shall: (3) Furnish each resident or, when applicable, the resident's agent or interested family member, with a quarterly statement of the resident's individual account not later than 30 days after the end of each quarter; This Regulation is not met as evidenced by: SEE F568	S6505		

OHCQ
LABORATORY DIRECTOR OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Denise Carlton NHA

(X6) DATE
3/29/19

STATE FORM 6899 W9R711 If continuation sheet 1 of 1

ATTACHMENT A

Quarterly Statements

Date: **Quarter:**

	Delivered to		
Name	**Resident**	**Other**	**Additional Information**

FREDERICK HEALH AND RHABILITATION

'Y'C'Frederick
Health and Rehabilitation Center

February 22, 2018

Pattie Melodini

Office Surveyor

Office of Health Care Quality

Spring Grove Center

Bland Bryant Building

55 Wade Avenue

Catonsville, MD 21228

Dear Patti,

Attached is our responseon the 2567 for the survey on January 26 2018. Should you need additional information, please call me at 301 695 6618.

Thank you.

Carlton NHA

Frederick Health and RehabilitationCenter

30 North Place

Frederick, Maryland 21701

301695 6618

"1 MARYLAND
Department of Health
Larry /logo11, Govemor · Boyd K. R11the,fo 1rl. Lt. Governor · Rober/ R. Neall. Secmtmy

February 9, 2018

Ms Henri Carlton
Administrator
Frederick Health & Rehabilitation Center
30 North Place
Frederick, MD 21701

Provider #215184

RE:NOTICE OF COMPLIANCE WITH FEDERAL HEALTH COMPONENT REQUIREMENTS with STATE DEFICIENCY

Dear Ms. Carlton:

On January 26, 2018, a survey was conducted at your facility by the Office of Health Care Quality to determine if your facility was compliant with Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. The survey was also conducted for State licensure.

This survey found that your facility is compliant with the health component of the requirements of 42 CFR Part 483, Subpart B, Requirements for LongTerm Care Facilities. The survey did find a State deficiency under COMAR 10 .07.02, Comprehensive Care Facilities and Extended Care Facilities.

Please sign and date the enclosed CMS form 2567 and.return it to me, along with a plan of correction for the State deficiency cited on the enclosed State Form.

I. PLAN OF CORRECTION (Poe)

A PoC for the deficiency must be submitted within 10 days after the facility receives its State Form. Failure to submit an acceptable PoC within the above time frame may result in administrative action against your State license.

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 efficient 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;

How the corrective actlon(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 Poe as well as any attachments to the PoC. It is unacceptable to include a resident(s) name in these documents since these documents are released to the public.

Ill. ALLEGATION OF COMPLIANCE

If you believe the deficiency identified in State Form has been corrected, you may contact me at the Office of Health Care Quality, Bland Bryant Building, Spring Grove Center, 55 Wade Avenue, Catonsville, Maryland 21228 with your written credible evidence (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 until substantiated by a revisit or other means. Please provide a plan of correction and credible evidence of compliance for this deficiency within 10 days of receipt of this letter.

IV.INFORMAL DISPUTE RESOLUTION

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 being disputed, and an explanation of why you are disputing the deficiency, to Vanessa Leuthold, Acting Deputy Director, Office of Health Care Quality, Spring Grove Center, Bland Bryant Building, 55 Wade Avenue, Catonsville, Maryland 21228. This request must be sent within 10 days of your receipt of the State Form.

Informal dispute resolution for the cited deficiencies will not delay the imposition of any enforcement action.

In the event a revisit determines that compliance has not been achieved, appropriate administrative action may be taken against your State license.

If you have any questions, please call me at 410-402-8201 or by email @patricia.melodini@maryland.gov.

Sincerely,

Patti Melodini
Health Facilities Survey Coordinator
Long Term Care
Office of Health Care Quality

Enclosure: CMS 2567
State Form
cc: File II

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215184	A. BUILDING _____ B. WING	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICK HEALTH & REHABILITATION CENTER	30 NORTH PLACE FREDERICK, MD 21701

(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)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 1/26/18, a survey was conducted at this facility by the Office of Health Care Quality to investigate complaint #MD00122615. Activities included the interview of the facility's business office personnel and an audit of the residents' personal funds records maintained by this facility. The specific complaint was unsubstantiated. This survey did not identify noncompliance with Federal requirements that were reviewed in relationship to the specific complaint	F000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Denise Carlton NHA

TITLE

(X6) DATE: 2/27/18

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.

Office of Health Care Qualit,

STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOER/SUPPUER/CLIA IQENTIFICATIONNUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATESURVEY COMPLETED
	215184	A BUILDING: _____ B.WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREETADDRESS, CITY, STATE, ZIP CODE
FREDERICK HEALTH & REHAB ILITATION CEN	30 NORTH PLACE FREDERICK, MD 21701

(X4) 10 PREFIX TAG	SUMMARY STATEMENTOFDEFICIENCIES (EACH DEFICIENCY MUSTBE PRECEDED BY FULL REGULATORY ORLSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLANOFCORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TOTHEAPPROPRIATE	(XS) COMPLETE DATE
S 000	Initial comments	S 000	Preparation and/or cxecutio"n of this planof correction do not constitute admission of agreement by the provider as to the validity of the assertions set forth in the statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by theprovision of Federal and State Laws.	

On 1/26/18, a survey was conducted at this facility by the Office of Health Care Quality to investigate complaint #MD00122615. Activities included the interview of the facility's business office personnel and an audit of the residents' personal funds records maintained by this facility.

The specific complaint was unsubstantiated. This survey did not identify noncompliance with State requirements that were reviewedin relationshipto the specific complaint

This survey did identify noncompliance with State requirements that were reviewedpertaining to the management of residents' personal funds. (SEE S6569)

S6569 10.07.09.19 E (3) Recs Pers Funds;Release to estate

.19 Records of Resident Personal Funds.

E. Death of a Residenl Upon the death of a resident for whom a nursing facility is holding tunas, tne nursing facility shall notify the resident's agent or interested family member and:

~~(3) Release the resident's funds only to an~~ individual who presents certified letters of administrationthat designate the person as "Representative of the Estate of

; and

This Regulation is not met as evidenced by:
Based on the review, on 1/26/18, of the personal funds records of deceased residents, including individual resident's account summaries, closes

S6569

For S6569

I. Business Office Director and Administrator reviewed regulation I0.07.09.19E on 1/26/2018 — 1/26/2018
2. Business Office Director reviewed deceased residents for past six months. No deficient practice found. Completed on 1/30/2018. — 1/30/2018
3. Business Office and Administrator to review all deceased resident's documentation related to disbursement for evidence of a letter of administration for disbursement to the aooropriate party. — 2/28/2018
4. Business Office Director to report to QAQI each month on proper authorization for disbursement of funds. If I 00%compliant for three consecutive months, then quarterly audits to be done by the Business Office Director reporting to the QAQI committee. — 4/28/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215184	A. BUILDING: _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICK HEALTH & REHABILITATION CEN	30 NORTH PLACE FREDERICK, MD 21701

(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)	(X5) COMPLETE DATE
S6569	Continued From page 1 account summaries, and on the interview of the facility's business office personnel. 1. Resident 1A expired on [redacted]. This facility closed the resident's personal fund account on 12/21/17, without appropriate authorization. The facility released the resident's $951.55 closing balance without evidence of a letter of administration being obtained and presented.	S6569		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215184	A. BUILDING _____ B. WING	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS. CITY, STATE. ZIP CODE
FREDERICK HEALTH & REHABILITATION CENTER	30 NORTH PLACE FREDERICK, MD 21701

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F 000	INITIAL COMMENTS On 1/26/18, a survey was conducted at this facility by the Office of Health Care Quality to investigate complaint #MD00122615. Activities included the interview of the facility's business office personnel and an audit of the residents' personal funds records maintained by this facility. The specific complaint was unsubstantiated. This survey did not identify noncompliance with Federal requirements that were reviewed in relationship to the specific complaint.	F 000	Preparation and/or execution of this plan of correction do not constitute admission of agreement by the provider as to the validity of the assertions set forth in the statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of Federal and State Laws. For S6569 1. Business Office Director and Administrator reviewed regulation 10.07.09.19E 2. Business Office Director reviewed deceased residents for past six. months. No deficient practice found. 3. Business Office and Administrator to review all deceased resident's documentation related to disbursement for evidence of a letter of administration for disbursement to the appropriate party. 4. Business Office Director to report to QAQI each month on proper authorization for disbursement of funds. If 100% compliant for three consecutive months, then quarterly audits to be done by the Business Office Director reporting to the QAQI committee.	(X6) DATE 2/22/18

U,..B0,RifTORY DIRECTQ.R'S ?'f PROVID'tj!SUPPUER REPRESENTATI S NATURE
f|-..lf2./v\. A A { jJJ t7 J/(.i ..<'"\.,, -.,. fØTM

Any deficiency statement ending with an asterisk c•) denotes a deficiency which the instillf ing it Is **de.l6nnine,** that

other safeguards provide sufficient protection to the patients. {See instructions.) Except fo _ _ _ _ _ are disctosable 90 days following the date of survey whether or not a planof cor"rection 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.

Office of Health Care Qualih

STATEMENT OFDEFICIENCIES ANDPLAN OF CORRECTION	(X1) PROVIOER/SUPPUER/CLIA IDENTIFICATIONNUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATESURVEY COMPLETED
	215184	A BUILDING:_____ B. WING_____	C 01/26/2018

NAMEOF PROVIDER ORSUPPLIER	STREETADDRESS, CfTY, STATE, ZIPCODE
FREDERICK HEALTH & REHABILITATIONCEN	30 NORTH PLACE FREDERICK, MD 21701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES {EACHDEFICIENCY MUSTBEPRECEDED BYFULL REGULATORY ORLSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCEDTOTHEAPPROPRIATE DEFICIENCY)	(XS) COMPLETE DATE
S 000	S 000[1] Initial comments On 1/26/18, a survey was conducted at this facility by the Office of Health Care Quality to investigate complaint#MD00122615, Activities included the interview of the facility's business office personnel and an audit of the residents' personal funds records maintained by this facility. The specific complaint was unsubstantiated. This survey did not identify noncompliance with State requirements that were reviewed in relationship to the specific complaint. This survey did identify noncompliance with State requirements that were reviewed pertaining to the management of residents' personal funds. (SEE S6569)	S 000		
S6569	10.07.09.19 E (3) Recs Pers Funds;Release to estate .19 Records of Resident Personal Funds. E. Death of a Resident. Upon the. death of a resident for whom a nursing facility is holdino. runas, the nursing facility shall notify the resident's agent or interested family member and: (3) Release the resident's funds only to an individual who preserits certified letters of administration that designate the person as "Representative of the Estate of ; and This Regulation is not met as evidenced by: Based on the review, on 1/26/18, of the personal funds records of deceased residents, including individual resident's account summaries, closes	S6569		

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215184	A. BUILDING: _____ B. WING _____	C 01/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICK HEALTH & REHABILITATION CEN	30 NORTH PLACE FREDERICK, MD 21701

(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)	(X5) COMPLETE DATE
S6569	Continued From page 1 account summaries, and on the interview of the facility's business office personnel: 1. Resident 1A expired on [redacted] This facility closed the resident's personal fund account on 12/21/17, without appropriate authorization. The facility released the resident's $951.55 closing balance without evidence of a letter of administration being obtained and presented.	S6569		

TI Frederick
Cl.LJ Health and Rehabilitation Center

October 20, 2017

Patti Melodini
Health Facility Survey Coordinator
Office of Health Care Quality
Spring Grove Center
Bland Bryant Building
55 Wade Avenue
Catonsville, MD 21228

Dear Patti,

Attached is the 2567 response to the August 18, 2017 survey. Also attached are copies of our credible allegation of compliance as requested. If you have questions, please contact me at 301695 6618 or on my cell at 410 925 0191. I will beat HFAM conference week of October 23, 2017, however, Dion Davis RN, Director of Nursing, will be available to assist. His number is 301695 6618.

Thank you for your assistance.

LrJAA

Henri Carlton LNHA

Frederick Health and RehabilitationCenter

30 North Place

Frederick, Maryland 21701

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

STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION	(X1} PROVIDER/SUPPLIER/CUA IDENTIFICATIONNUMBER:	(X2}MULTIPLE CONSTRUCTION	C DATESURVEY COMPLETED
	215184	A BUILDING _____ B. WING _____	C 08/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE ZIP CODE
FREDERICK HEALTH & REHABILITATION CENTER	30 NORTH PLACE FREDERICK, MD 21701

(X4} ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUSTBE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PI3EF[X TAG	PROVIDER'S el.AN OF CORRECTION • (EACH CORRECTIVE ACTION SHOULD !}E ROPRIATE	(X5) COMPLETION OATE
F 000	INITIAL COMMENTS On August 18, 2017 a complaint investigation survey was conducted at this facility by the Office of Health Care Quality. Anonymous complaint MD00115823 was investigated. Investigative activ ities included a tour of the facility and observations in the facility kitchen, interviews with residents and the staff, and reviews of residents' medical records, and observations of residents' and staff practices, This survey did id ntify noncompdiancewith Federal and State requirements that were reviewed in relationship to anonymous complaint MD00115823 .	FOOO	Preparation and/or execution of this plan of correction do not · constitute admission of agreement bythe provider as to the validityof the assertions set forth in thestatement of Deficiencies. The Planof Correction is prepared and/or executed solely because it is required by theprovision of Federal and State Laws.	
F 371 SS=D	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) Th is may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handlingpractices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F 371	For F tag 371/S6647 Dietary **Manager and NHA** reviewed policy on August 18, 2017. Employee education done by dietary manager on August 18, 2017 to staff. Dietary Manager reviewed with. allstaff about the need to wear both head and beard covering. This isalso in the education for new hires. Completion date: September 18,2017 Audits by the Dining Manager or designec for proper covering of head/beard to bedone randomly each week, four times per week for a time period ofone month. Completion date: October 2, 2017 Report to QA/QI results by Dietary Manager/designcc monthly. If 100% compliance for twoconsecutive months, then random audits as detennined by the QA/QI committee. Completion date: ongoing	

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

Nena Cullon October 20 2017

(X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATESURVEY COMPLETED
	215184	A BUILDING _ _ _ _ _ _ _ _ B. WING	C 08/18/2017

NAME OF PROVIDER *OR* SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICK HEALTH & **REHABILITATION**CENTER	30 NORTH PLACE FREDERICK, MD 21701

(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 0/\IE
F 371	ContinuedFrom page 1 (i){3) Have a poliCY, regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, it was determined that the facility staff failed to prepare and serve food in a sanitary condition. This was observed during a tour of the facility kitchen. The findings include: During the a tour of the facility kitchen, on 08/18/2017 at 12:20 PM, the surveyor observed a dietary aide #1 preparing food during the lunch meal tray line and then serving residents in the dinning room without a facial hair covering. The facility kitchen staff must take steps to serve resident meals in a sanitary condition.	F 371	F43I/S 926 Reviewed with Nursing staff on August 18,2017 and drugs destroyed. Reviewed with Nursing Staff Leadership importance ofsecuring all medications. Completed by the DON on August 18, 2017 to include educational plan. General education to Nursing staff toon securing medications tobecompleted by September 26 2017 by theStaff Development/designee. Review of securing of medications included in newhire orientation by September 22, 2017 by Staff Development as onongoing action plan. Audit to bedone by DON and/or deslgnee randomly five times per week for two months to monitor compliance to securing medications. Completion date: October 02, 20I7 Report to QA/QI monthly by Nursing Leadership. If 100% compliance for two consecutive months, then random audits as detennined by the QA/QI committee. Completion date: ongoing	
F 431 SS=D	483.45(b)(2)(3)(g)(h)DRUG RECORDS, LABEUSTORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicalsto its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if Slate law permits, but only under the general supervision of a lic nsed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215184	A. BUILDING _____ B. WING _____	C 08/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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)	(X5) COMPLETION DATE
F 431	Continued From page 2 (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, it was determined that the facility nursing staff failed to store medications safely. This was observed one time during a complaint survey. The findings include:	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215184	A BUILDING _____ B. WING _____	C 08/18/2017

NAMEOF PROVIDER OR SUPPLIER	STREETADDRESS, CITY, STATE, ZIP CODE
FREDERICK HEALTH & REHABILITATION CENTER	30 NORTH PLACE FREDERICK, MD 21701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR SC 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 431	Continued From page 3 During an observational tour of the facility, on 08/18/2017 at 12:10 PM, the surveyor observed 2 doses of the antihypertensive medication, hydrochlorathizide; sitting on the nursing station desk. The were no nursing staff members at the desk at the time. The surveyor brought this to the attention of the nurse manager at the time of the observation. The facility nursing staff must secure all medications in locked compartments.	F 431		

Office of Health Care Quali '

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215184	A. BUILDING: __ _____ B. WING	C 08/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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)	(X5) COMPLETE DATE
S 000	10.07.02 Initial comments On August 18, 2017 a complaint investigation survey was conducted at this facility by the Office of Health Care Quality. Anonymous complaint MD00115823 was investigated Investigative activities included a tour of the facility and observations in the facility kitchen, interviews with residents and the staff, and reviews of residents' medical records, and observations of residents' and staff practices. This survey did identify noncompliance with Federal and State requirements that were reviewed in relationship to anonymous complaint MD00115823.	SOOO		
S 926	10.07 .02.15 C(1)(i) Pharm Svcs;Med storage .15 Pharmaceutical Services. C. Duties of Pharmaceutical Services Committee. Unless the Department decides that semiannual meetings are appropriate, the committee shall meet at least quarterly to: (1) Establish policies and procedures which shall includ e, at **lea5t, 5tatements** which assure that: (i) Medications shall be stored in a locked medfcation storage area provided at, or convenient to, the nurses' station, which: (i) Is well lighted; (ii) is located where personnel preparing drugs for administration will *riot* be interrupted; (iii) Is sufficiently sp acious to allow storage of external medications separately from internal medications; (iv) Is kept in a clean, orderly and uncluttered manner; and (v) Contains a refrigerator if medications are to be maintained in it.	S 926	F431/S 926 Reviewed with Nursing staff on August *18,* 2017 and drugs destroyed. Reviewed with Nursing Staff Leadership importance of securing all medications. Completed by the DON on August 18, 2017 to include educational plan. General education to Nursing staff to on securing medications to be completed by September 26 2017 by the Staff Development/designee. Review of securing of medications included in new hireorientation by September 22, 2017 by Staff Development as on ongoing action plan. Audit to be done by DON and/or designee randomly five times per week for two months to monitor compliance to securing medications. Completion date: October 02, 2017 Report to QA/QI monthly by Nursing Leadership. If 100% compliance for two consecutive months, then random audits as detemiined by the QA/QI committee. Completion date: ongoing	

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

TITLE (X6) DATE
October 20, 2017

STATE FORM G4KX11 If continuation sheet 1 of 3

S:rATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOERJSUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215184	A BU LDING : _____ B. WING	C 08/18/2017

NAME OF PROV!DER OR SUPPLiER	STREETADDRESS, CITY, STATE. ZIPCODE
FREDERICK HEALTH & REHABILITATION CEN	30 NORTH PLACE FREDERICK, MD 21701

(X4) 10 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUSTBE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVEACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE OATE
S 926	Continued From page 1 This Regulation is not met as evidenced by: Please refer to CMS 2567 F 431	S926	- ForF tag 371/S6647	
S6647	10 .15.03 .06 A Food Protection During Storage, Service and T .06 Food Protection During Storage, Service, and Transport. The person-in-charge shall ensure that: A. At all times: (1) Food is: (a) Not adulterated; and (b) Protected from contamination during storage, preparation, display, service, and transportation; (2) The internal temperature of a food is maintained according to the requirements of this chapter to preclude the growth of pathogenic bacteria and other microorganisms that could cause spoilage; (3) Except during n cessary periods of preparation and service, a potentially hazardous food is refrigerated or held hot as set forth in §6(7) of this regulation; This Regulation is not met as evidenced by: Please refer to CMS 2567	S6647	Dietary Manager and NHA reviewed policy on August 18, 2017. Employee education done bydietary manager on August 18, 2017 to staff. Dietary Manager reviewed with all staffabout theneed to wear both he!ld and beard covering. This is also inthe education for new hires. Completion date: September 18,2017 Audits by theDining Manager or designee for proper covering of head/beard to be done randomly each week, four times per week for a time period of one month. Completion date: October 2, 2017 Report toQA/QI results by Dietary Manager/designee monthly. If 100% compliance for two consecutive months, then random audits as determined by the QA/QI committee. Completion date: ongoing	

Office of Health Care Quality

STATEMENT OF DEFICIENCIES ANOPLAN OF CORRECTION	(Xt) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215 184	A SUILOING: _ _ _ _ _ _ _ B. WING	C 08/18/2017

NAMEOF PROVIDER OR SUPPLIER	STREETADDRESS, CITY, STATE. ZIP CODE
FREDERICK HEALTH & REH BILITATION CEN	30 NORTH PLACE FREDERICK, MD 21701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES {EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	JO PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S6647	Continued From page 2 F 371	S6647		

MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
OFFICE OF HEALTH CARE QUALITY

SPRING GROVE CENTER
BLAND BRYANT BUILDING
55 WADE AVENUE
CATONSV ILLE, MARYLAND 21228

Lice nse No. 10012

Iss ued to: Frederick Hea lth & Rehabilitation Cente r
30 North Place
Frederic k, MD 2170 I

Type of Facility and Number of Beds:
Comprehens ive Care Facility - 120 Beds

Date Iss ued: September **1,** 20I 7

This license has been granted to: No rth Place Operating Company, LLC

Autho rity 10 operate in this State is grant.:d to th.: above entity pursuant to The Healt h-General Article. Tith: 19 Section 318. Annotated Code of Mary land. 1982 Edition. and subsequen t supplement s and is subject to any and all statuto ry provisions: includii1g all :ipplicabh: rules and regulations promulgat.:d th.:re ,' .. .!er. This document is not transli:rablc.

Expiratio n Date: March I, 2019

Patricia Tomsko May, MD

Direc tor

Falsificatin11 of n li ce n se shall subject rhe pe rpetraror to criminal prosec11tio11 a11d th e i111posiri o 11 of civ il Jines .

STATE Of' M A R Y L A N D

Maryland Departme nt of Health and Mental Hygie ne
O ff ice o f Heal th Ca re Qualit y
Sprin g Grove Center • Bland Bryan t Buildin g
55 Wade Aven ue • Calo nsv illc, Ma ryla nd 21 228-4663
Lan:r Hoga 11, Gowmwr - Boyd K. /?111/, er ford, Lt. Co 1·e n 10r - Dem1is R. Sclmule1; Sec relw y

October 05, 2017

Attn: Henri Carlton , Adminis trator
Frederick Hea lth and Rehabilitati on Center
30 North Place
Frederick, MD 2170 1-6200

Dear Mr. Ca rlton:

There was a change of ownership and e ffec tive March I, 2017 , and a provisional license was issue d.

The enclosed license is for the remaining portio n of your facility' s two year licensure period and will be in effec t until Marc h I, 2019 unless revo ked. It is your authority to maintain a comprehensive care facili ty with a licensed capacity of 120 beds under the provis ion s of COMAR I0.12.02.

This license is to be disp layed in a consp.ic uous place, at or near the front entrance, plain ly visible and easily read by the public.

Sincerely,

Margie eald, Deputy Director
Office of Hea lth Ca re Quality

MH/cjc
Enclosure: License No. I0-0 12
cc: Frederick County Health Office r
Maryland Hea lth Care Commissio n
Medical Care Operations Administratio n
Medical Care Policy Administration
Myers and Stauffer
Cynthia Hickman
Patti Melodini, Survey Coordinator
License File

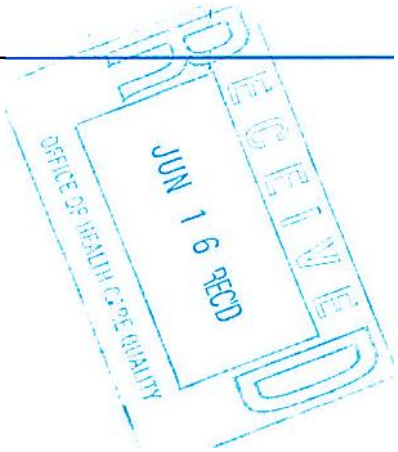
Room and bed breakdown:

CATEGORY	LOCATION	TOTAL
Comprehensive Care Facility		
	ACU	
	Single Rooms: 402 , 403	02 beds
	Duplex Rooms: 3 17 , 3 18 , 3 19, 320 , 32 1, 322 , 323 , 324, 325 , 326 , 327, 400 , 40 1, 404	28 beds
	Total ACU	**30 beds**
	1 North	
	Single Rooms: I00, IOI	02 beds
	Duplex Rooms: I02 , I03 , I04 , I05 , I 06 , I07 , I08, I09	16 beds
	Total 1 North	**18 beds**
	2 North	
	Single Rooms: 202 , 203, 204, 205	04 beds
	Duplex Rooms: 110, 111 , 112, 113, 1 14, 115 , 200 , 20 1	16 beds
	Total 2 North	**20 beds**
	3 North	
	Single Rooms: 123, 124	02 beds
	Duplex Rooms: 116, 1 17, 118 , 119, 120 , 121, 122, 125 , 126. 127	20 beds
	Total 3 North	**22 beds**

Room and bed breakdown:

CATEGORY	LOCATION	TOTAL
Comprehensive Care Facility	**South**	
	Single Rooms: 306, 307	02 beds
	Duplex Rooms: 300, 301, 302, 303, 304, 305, 308, 309. 310, 311,' 312, 313, 314, 315	28 beds
	Total South	**30 beds**
	Overall Total	**120 beds**

Frederick
CL,JHealthand Rehabilitation Center



June 15, 2017

Patti Melodini

HealthFacilities SurveyCoordinator

Long Term Care

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

Dear Ms. Melodini:

Attached is Frederick Health and Rehabilitation's response to the 2567 sent on June 5, 2017 and received in the facility on June 9, 2017 for the complaint survey conducted at our facility on May 25 and 31, 2017.

Please let me know of any changes needed or questions.

Thank you.

Henri Carlton LNHA

Henri Carlton LNHA

Administrator

Frederick Health and RehabilitationCenter

30 North Place

Frederick, Maryland 21701

301695 6618

STATE OF MARYLAND

Maryland Department of Health and Mental Hygiene
Office of Health Care Quality
Spring Grove Center • Bland Bryant Building
55 Wade Avenue • Catons ville, Maryland 21228-4663
Lan)' 1/ogan, Gol'<mwr - Boyd K. Rutlu:1:ford. Lr. GO\'C!rl/Or - Dennis R. Sdm1de1: Secr<'tm :1·

June 5, 2017

Ms. Henri Ca:lton, Administrator
Frederick Health & Rehabilitation Center
30 North Place
Frederick, MD 2170I

PROVIDER# 215184
RE:NOTICE OF CURRENT DEFICIENCIES AND POSSIBLE IMPOSITION OF REMEDIES

Dear Ms. Carlton:

On May 25 and 31, 2017, 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 the purpose 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.

I. 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;

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.

II. IMPOSITION OF REMEDIES

The following remedies will be recommended for imposition by the Center for Medicare and Medicaid Services (CMS) Regional Office if your facility has failed to achieve substantial compliance by July 15,2017. Informal dispute resolution for the cited deficiencies will not delay the imposition of the enforcement actions recommended on this date. A change in the seriousness of the noncompliance may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

If you do not achieve substantial compliance within 3 months after the last day of the survey (i.e.September 29, 2017) 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 November 30, 2017, your Medicare provider agreement will be terminated.

III. 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 Poe 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 May 31, 2017 and will continue until

substantial compliance is achieved. Additionally, we may impose a revised remedy(s), based on changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

IV. INFORMAL DISPUTE RESOLUTION

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

V. 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 Fonn. 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 ar.ainst 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,

(mt-LtuL

Patti Melodini
Health Facilities Survey Coordinator
Long Term Care

Enclosures: CMS 2567
State Form

cc: Stevanne Ellis
Jane Sacco
File II

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDERISUPPLIERICLIA IDENTIFICATION NUMBER;	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215184	A. BUILDING _____ H. WING _____	C 05/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS. CITY. STATE. ZIP CODE
FREDERICK HEALTH & REHABILITATIONCENTER	30 NORTH PL ACE FREDERICK, MD 21701

(X4) ID PREI'IX TAG	SUMMARY STATEMENT OF DEFICIENCIC:S (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)	{X I ' CO MPLE TION 0/\TE
I			Preparation and/or execution of	
F 000'	INITIAL COMMENTS	F 000	this plan of correction do not constituteadmission of agreement by the provider as to the validity of the assertions set forth in the statement of Deficiencies. The Plan of Correction is prepared and/or executed sole ly because it is required by the provision of Federal and State Laws.	may 31,2017
	On May 25 and 31, 2017 a complaint investigation survey was conducted at this facility by the Office of Health Care Quality. Nine intakes were investigated; complaint MD00109830 and facility reported incidents MD00109775, MD00109971, MD00110336, MD00110335, MD00110730, MD00111103, MD00111085 and MD00112907. Investigative activities included a tour of the facility, interviews with residents and the staff, and reviews of residents' active and closed medical records and the facility investigations, and observations of residents' and staff practices. This survey did not identify noncompliance with Federal or State requirements that were reviewed in relationship to complaint MD00109830. This survey did not identify noncompliance with Federal or State requirements that were reviewed in relationship to facility reported incidents MD00109775, MD00110336, MD00110335, MD00110730, MD00111103, and MD00111085. 1his survey d1d 1dent1fy noncompliance with Federal and State requirements that were reviewed in relationship to facility reported incidents MD00109971 and MD00112907.			
F 155 SS=D	483.10(c)(6)(8)(g)(12), 483.24(a)(3) RIGHT TO RE FUSE; FORMULATE ADVANCE DIRECTIVES 483.10 (c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.	F 155	F15 5 I. For Record #I, resident's Moist Fom1 and monthly physician order reconciled to match Moist by the Unit Manager and confirmed by the ADON. NHA reviewed and confim1ed. For Record #9, resident's physician cc rt ificnti ou for incapacity was correct by two Medical physicians who assessed the resident for incapacity and documented resident's incapability of understanding information and/or making informed consent. This was confirmed by Social Service a d Nursing. NHA reviewed and confirmed.	June 6, 2017

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Nurse Educator NHA 6/13/17

(XGJOAI !:

Any deficiency statement ending wilh an asterisk (") denoles a deficier cy w ch the institution may be excused from correcting providing it is detem1ined 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 whelher or not a plan of correction is provided. For nursing hOmes. the above findings and plans of correction arc discrosa ble 14 days following the date these documents are made available to the facility. If delrciencies are cited. an approved plan of correction is requisite to continued program participation.

PRINTED: 06/05/2017

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

STAH : MENT OF DEFICIENCIES ANOPt.AN OF CORRE C TION	(X1) PROVIDER/SUPPLIERICLIA IDENTIFICA TION NUMBER:	CX2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215184	A BUILDING _____ R WING _____	C 05/31/2017

NAME OF PROVJDER OR SUPPLIER	STREET ADDRESS. CITY. STATE. ZIP CODE
FREDERICK HEALTH & REHABILITATION CENTER	30 NORTH PLACE FREDERIC,KMD 21701

(X4i 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 ACI ION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(XS\ co;\PI ETION 0 /\TE
F 155	Continued From page 1 c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate . (g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the fa c ilit y's policies to implement advance directives and appl icable State law. (iii) Faci li ties are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (IV) II an adult 1na1vidua1 is incapacitated at tne time of admission and is unable to receive information *or* articulate whether or not he or she has exe cuted an adva nce direct ive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Fo ll ow- up pro c edures m ust b e in pla c e to p r o v ide the information to the individual direct y at the	F 155	2. House wide audit done on in-houseresidents starting on May 31" by Social Service to include Moist to order verification and two MD signatures on the incapacity certifications. ADON and Unit Managers participated in audit and for each variance, reconciled the MOLST to orders and obtained the proper MD signature for incapacity certifications. 3. Education to all nurses, facility based Department Heads, credentialed physicians on record for facility, Med Options psychiatrist by the N HA , Staff Developmen,t Socia l Workers,and the ADON. Staff Development i3 including education in our orientation agenda for new hires. Education includes the physician to write an order "See Moist" when a Moist is changed to alert nursing staff to transcribe changes to the proper documentation. This order will be reviewed during Clinical Start-Up by Nursing M anagementand Social Work daily.	1 13,a DI t r '30, 0

Office of Health Care Qualih

STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION	(XI) PROVIOER/SUPPLIER/CLIA IDENTIFICATIONNUM0ER:	(X2J MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS. CITY. STATE, ZIP CODE
FREDERICK HEALTH & REHABILITATION CEN	30 NORTH PLACE FREDERICK, MD 21701

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	S 000 10.07.02 Initial comments	S000	S6006 and S 6070	

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This survey did not identify noncompliance with Federal or State requirements that were reviewed in relationship to facility reported incidents MD00109775, MO00110336, MD00110335, MD00110730, MD00111103, and MD00111085.

This survey did identify noncomplioncc with Federal and State requirements that were reviewed in relationship to facility reported incidents MD00109971 and MD00112907.

S6006 10.07.09.08 C (8) Right to be fully informed in advance — S6006

.08 Resident's Rights and Services.

C. A resident has the right to:

(8) Be fully informed in advance about care and treatment, and of proposed changes in that care or treatment;

I. For Record#I, resident's Moist Fonn and monthly physician order reconciled to match Moist by the Unit Manager and confinned by the ADON. NHA reviewed and confirmed.

For Record #9, resident's physician certification for incapacity was correct by two Medical physicians who assessed the resident for incapacity and documented resident's incapability of understanding information and/or making infonned consent. This was confinned by Social St:rvict: um.I Nursing. NHA reviewed and confinned.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY. STATE, ZIP CODE
FREDERICK HEALTH & REHABILITATIONCEN	30 NORTH PLACE FREDERICK, MD 21701

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(X) ID TAG	SUMMARY STATEMENTOF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDEN TIFYING INFORMATION)	10 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE Q[' F f(: IF NI' .Y \	(XS) COMPLETE DATE
S6006	Cont inued From page 1	S6006		

This Regulation is not met as evidenced by:
Please refer to CMS 2567
; F 155

S6070 | 10.07.09 .09 A Res Bill of Rights; Implement facil. S6070

ensure

.09 Implementation of Residents' Bill of Rights.

A nursing facility shall:
A. Ensure that:
(1) The rights of residents as set forth in the , Residents' Bill of Rights are protected, including ' but not limited to informing each resident of the resident's right to select a physician and pharmacy of the resident's choice;
(2) Employees of the nursing facility are trained to:
{a) Respect and enforce the Residents' Bill of Rights and the nursing facility's policies and procedures that implement the Residents' Bill of Rights. and
(b) Protect the rights of residents;
{3) The nursing facility's policies and procedures implement all rights of the residents as set forth in:
(a) Health-General Article, 19-343 ---- 19-347 and 19-349-----19-352 , Annotated Code of Maryland,
(b) Title XIX of the Social Security Act.
(c) 42 CFR §483.10 et seq., and
(d) The regulations of this chapter; and
(4) The nursing facility's policies comply with the requirements of federal and State law concerning advance directives, including but not limited to:
{a) If an applicant is incapacitated or is incapable of informing the nursing facility whether the applicant has executed an advance directive, the

2. House wide audit done on in-house residents starting on May 3 I st by Social Service to include Moist to order verification and two MD signatures on the incapacity certifications. ADON and Unit Managers participatedin audit and for each variance, reconciled the MOLST to orders and obtained the proper MD signature for incapacity certifications.
3. Education to all nurses, facility based Department Heads, credentialed physicians on record for facility, Med Options psychiatrist by the NHA, Staff Development, Social Workers, and the ADON. Staff Development is includingeducation in our orientation agenda for new hires. Education includes the physicianto write an order "See Moist" when a Moist is changed to alert nursing staff to transcribe changes to the proper documentation. This order will be reviewed during Clinical Stait-Up by Nursing Management and Social Work daily.

Cj(P)

STATEMENT OF DEFICIENCIES ANO PLANOF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IOENTJFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215184	A. BUILDING _____ B. WING _____	C 05/31 /2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS. CITY, STATE. ZIP CODE
FREDERICK HEALTH & REHABILITATION CEN	30 NORTH PLACE FREDERICK, MD 21701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR ISC IDENTIFYING INFORMATON)	10 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPETE DATE
S6070	Continued From page 2 facility may provide advance directive information to the resident's health care representative, and {b) Once the resident is no longer incapacitated, the facility shall provide the advance directive information to the resident directly at the appropriate time: This Regulation is not met as evidenced by: Plea se refer to CMS 2567 F 155	S6070	4. Social Service and Nursing under the direction of the DON will audit all new admissions for matching MOLST to orders. All orders will be tracked daily alerting staff to MOLST changes. Weekly audit to be conductedrandomly of 20% of residents in-house. Report all audits to Quality Assurance/Quality Improvement monthly times3 months. If I 00% compliance, then random audits by Social Work and Nursing as detennined by the QA/QI committee.	

STATEMI:NT OF DEFICIENCIES AND PLAN*OF* CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATIONNUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215184	A BUILDING _____ 8. WING _____	C 05/31/2017

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FREDERICK HEALTH & REHAB ILI TATION CE NTER	30 NORTH PLACE **FREDERICK, MD 21701**

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F 155	Continued From page 2 appropria te time. **483 .24** (a)(3) Personnel provide basic life suppor,t including CPR, to a resident requiring such eme rgency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on record review, it was determined that the facility staff failed to 1) identify the incongruence between a resident's MOLST form and the resident's monthly physician orders, and 2) fai led to follow State Law and obtain cer tifications from two physicians when determin ing incapacity on a resident. This was evident for 2 (Resident #1 and Resident #9) of 9 residents reviewed during a complaint survey. The findings include: 1) Review of Resident #1's medical record on 05/25/2017 revealed a Maryland MOLST (Medical Orders for Life-Sustaining Treatment) form, dated 04 /0G/20 17 , which indicated that Re idenl1;1 wanted the following treatments: No CP'R, Option A-2 DNI (Do Not Intubate) : Comprehensive efforts may include limited ventilator support by CPAP or BiPAP, but do not intubate, Do not use any ventilation (no intubation, CPAP or BiPAP), Do not give any blood products, May transfer to a hospital for any situation requiring hospital-level care, May perform any medical tests indicated to diagnose and treat a medical condition, May use antibiotics (oral, intravenous, or intramuscular) as medically indicated, May give fluids or artificial hydration as a therapeutic trail, but do not give artific ially adm inistered nutr ition, Do not provide	F 155	4. Social Service and Nursing under the direction of the DON will audit all new admissions for matching MOLST to orders. All orders will be tracked daily ale1ing staff to MOLST changes. Weekly audit to be conducted randomly of 20% ofresidents in-house. Report all audits to Quality Assurane/Quali ty Improvement monthly times 3 months. If I 00% compli ance,then random audits by Social Work and Nursing as detennined by the QA/QI committee.	

STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION	(XI) PROVIOER/SUPPLIA IDENTIFICATIONNUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3j DATE SURVEY COMPLETED
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F 155	. Continued From page 3	F 155		

acute or chronic dialysis.

Review of Resident #1's May 2017 monthly physician orders revealed the following orders in regards to Resident #1's life sustaining treatments: Resident is a Full Code, Attempt CPR if cardiac or pulmonary arrest occurs. This will include any and all medical efforts that are indicated during arrest, including artificial ventilation and efforts to restore cardio-pulmonary function.

Resident #1's May 2017 physician order form is incongruent with Resident #1's MOLST form by indicating Resident #1 is to be a Full Code and to attempt CPR including artificial ventilation and efforts to restore cardio-pulmonary function. This incongruence could lead to staff performing life sustaining treatments that Resident *tt1* did not want performed in the event Resident #1 was found without respirations and pulseless.

2) Review of Resident #9's medical record, on 05/25/2017, revealed a Physician's Certification of a Resident's Health Care Decision Making torm which revealed two signatures ine11ca11ng that Resident #9 was Incapable of understanding in formation; Incapable of making an informed health care decision and was not able to sign any documents. The Proxy will sign documents pertinent to this certification.

On 11123/2016, a clinical psychologist (PhD} was one of two signatures determining Resident #9 incapable of understanding information, incapable of making an informed health care decision, and **was** not able to sign any documents.

A Review of the Maryland Health Care Decisions

STATEI,1ENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIERICLIA IDENTIFICATIONNUMBER:	(X2j MULTIPLE CONSrn UCTION	(X3) DATE SURVEY COMPLETED
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F 155	Continued From page 4	155		

Act revealed the following:

§ 5-606.

(a) (1) Prior to providing, withholding, or withdrawing treatment for which authorization has been obtained or will be sought under this subtitle, the attending physician and a second physician, one of whom shall have examined the patient within 2 hours before making the certification, shall certify in writing that the patient is incapable of making an informed decision regarding the treatment. The certification shall be based on a personal examination of the patient.

The facility staff failed to obtain a second certification of incapacity from a second physician and not a clinical psychologist (PhD).

MARYLAND DEPARTMENT OF HEALTH
OFFICE OF HEALTH CARE QUALITY

SPRING GROVE CENTER
BLAND BRYANT BUILDING
55 WADE AVENUE
CATONSVILLE,MARYLAND 21228

License No. 10012

Issued to: Frederick Health and Rehabilitation Center
30 North Place
Frederick, MD 21701

Type of Facility and Number of Beds:
Comprehensive Care Facility - 120 Beds

Date Issued: July 1, 2018

This license has been granted to: North Place Operating Company, LLC

Authority to operate in this State is granted to the above entity pursuant to The Health General Article. Title 19 Section 318. Annotated Code of Maryland. 1982 Edition. and subsequent supplements and is subject to any and all statutory provisions. including all applicable rules and regulations promulgated there under. This document is not transfornblc.

Expiration Date: NON-EXPIRING

Patricia Tomasko May, MD
Director

Falsification of a license shall subject the perpetrator to criminal prosecution and the imposition of civil fines.

MARYLAND
Department of Health

Larry Hogan Governor · Boyd K. Rutheiford, Lt. Govemor · Rohal R. Neall, Secretary

Office of Health Care Quality
55 Wade Avenue - Bland Bryant Building
Catonsville, **MD** 21228

July19,2018

Attn: Henri Carlton , Administrator
Frederick Health and Rehabilitation Center
30 North Place
Frederick, MD 21701-6200

Dear Mr. Carlton:

The Maryland General Assembly recently passed Senate Bill 108, which the Governor has signed into law. This new law authorizes the Secretary of Health to eliminate license renewal requirements and licensing fees. Tims, beginning on **July 1, 2018,** the effective date of this new law, you are no longer required to submit a license renewal application or submit a licensing fee. Rather, you are being issued the enclosed non-expiring license.

Although there are no longer any license renewal requirements, you are still required to comply with all statutory and regulatory requirements, and are subject to discipline, including license revocation, for any violations of these requirements.

It is your authority to maintain a comprehensive care facility with a licensed capacity of 120 beds under the provisionof COMAR 10.07.02.

This license is to be displayed in a conspicuous place , at or near the entrance of your facility, plainly visible and easily read by the public.

The bed and room breakdown are attached.

Some insurance companies require proof of license renewal. Because the Department is no longer issuing renewal licenses, you may forward this letter to your insurance company as proof of your compliance with the Department's licensure requirement.s If your insurance company has questions, they may contact me, at 410-402-810I.

Sincerely,

Margie Heald
Deputy Director of Federal Programs
Office of HealthCare Quality

Room and bed breakdown:

CATEGORY	LOCATION	TOTAL
Comprehensive Care Facility		
	ACU	
	Single Rooms:402, 403	02 beds
	Duplex Rooms:317, 318, 319, 320, 321, 322 , 323, 324 , 325, 326, 327 , 400, 401 , 404	28 beds
	Total ACU	**30 beds**
	1 North	
	Single Rooms:100, 101	02 beds
	Duplex Rooms:102, l 03, 104, l 05, l06, 107, 108, l09	16 beds
	Total 1 North	**18 beds**
	2 North	
	Single Rooms:202, 203, 204, 205	04 beds
	Duplex Rooms:110, 111, 112, 113, 114, 115, 200, 20 1	16 beds
	Total 2 North	**20 beds**
	3 North	
	Single Rooms:123, 124	02 beds
	Duplex Rooms:116, 117, l 18, I 19, 120, 121, 122, 125, 126, 127	20 beds
	Total 3 North	**22 beds**
	South	
	Single Rooms:306, 307	02 beds
	Duplex Rooms:300, 301, 302, 303, 304, 305, 308, 309, 310, 311, 312, 313, 314, 315	28 beds
	Total South	**30 beds**
	Overall Total	**120 beds**