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

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

Phone: 703-564-7318; email: jdowney@jeffdowney.com

Northwest Healthcare Center

4601 Pall Mall Road
Baltimore, MD 21215

Characteristics:

- For Profit Partnership with 91 beds
- Legal Business Name – Northwest Snf LLC
- Website (https://www.communicarehealth.com)
- Owner – WO Holdings LLC

As of April 2022, Northwest Healthcare Center is rated as a one-star facility on a scale one-to-five, with one being the lowest, according to Medicare.gov

A note by attorney Jeffrey J. Downey about researching nursing homes:

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's Office of Health Care Quality inspects nursing homes and assisted living facilities including Northwest Healthcare Center in Baltimore, Maryland. Periodically they do inspections, as complaint surveys should be public record.

I've provided a link to send an online complaint or for those who prefer the old analog method via letter, use this link. https://app.smartsheet.com/b/publish?EQBCT=07c94438f6714af1bbfe8ff1037b8b74

The address is Maryland Department of Health, Office of Health Care Quality, 7120 Samuel Morse Drive, Second Floor, Columbia, MD 21046-3422 Phone: 410-402-8015; Fax: 410-802-8056.

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

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.

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 NPIs. Some documents may not be accurately copied or some results may have changed upon appeal, which may not be noted here.

Maryland
DEPARTMENT OF HEALTH
Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Dennis R. Schrader, Secretary

Office of Health Care Quality
7120 Samuel Morse Drive
Second Floor
Columbia, MD 21046-3422

November 9, 2021

Mr. Meir Hakimi
Northwest Healthcare Center
4601 Pall Mall Road
Baltimore, MD 21215

PROVIDER #215346

RE: NOTICE OF CURRENT DEFICIENCIES, NOTICE OF IMPOSITION OF A DIRECTED PLAN OF CORRECTION UNDER STATE REGULATIONS, NOTICE OF IMPOSITION OF A CIVIL MONEY PENALTY UNDER STATE REGULATIONS, AND POSSIBLE IMPOSITION OF OTHER REMEDIES

Mr. Hakimi:

An administrative review was conducted by the Office of Health Care Quality (OHCQ) to determine if your facility was in compliance with the State requirements for reporting to CRISP. This review found that your facility was not in compliance with the reporting requirements. See the attached State Form for details of the deficiency.

I. DIRECTED PLAN OF CORRECTION

OHCQ is imposing a Directed Plan of Correction on your facility in accordance with the Code of Maryland Regulations (COMAR) 10.07.02.68A(3). The attached Directed Plan of Correction must be implemented and operational within 24 hours of receipt of this notice. This Directed Plan of Correction is **in lieu of** the requirement that a facility must submit a completed Plan of Correction for all cited deficiencies within ten (10) calendar days after a facility receives the Statement of Deficiencies. **The facility does not need to submit a Plan of Correction.** Failure to implement this Directed Plan of Correction within the above time frames may result in the imposition of additional remedies.

II. IMPOSITION OF A PER INSTANCE CIVIL MONEY PENALTY UNDER CODE OF MARYLAND REGULATIONS

Under Maryland Health General Article Sections 19-1401 *et seq*. and COMAR 10.07.02.70 through .74, the Department of Health has the authority to impose a civil money penalty (CMP) based upon the existence of deficiencies at a comprehensive care facility.

Based upon the deficiencies cited at your facility, I hereby impose a per instance Civil Money Penalty (CMP) of $5,000.00 per instance of failure to comply with the CRISP reporting requirements. The total CMP is $5,000.00. See: COMAR 10.07.02.70; MDH Amended Directive and Order Regarding Nursing Home Matters, No. MDH 2021-08-18-02. The deficiencies upon which the CMP is based are enclosed with this letter on the State Form which is incorporated by reference.

In determining whether to impose a CMP, the Department took into consideration the following factors:

1. The number, nature, and seriousness of the deficiencies;
2. The extent to which the deficiency or deficiencies are part of an ongoing pattern during the preceding 24 months;
3. The degree of risk to the health, life, or safety of the residents of the nursing facility caused by the deficiency or deficiencies;
4. The efforts made by, and the ability of, the nursing facility to correct the deficiency or deficiencies;
5. The nursing facility's prior history of compliance in general and specifically with reference to the cited deficiencies; and
6. Such other factors as justice may require.

In setting the amount of the CMP, the Department considered the following factors in addition to those factors considered in determining whether to impose a CMP:

Current federal guidelines for civil money penalties; and whether the amount of the proposed civil money penalty will jeopardize the financial ability of the nursing facility to continue operating as a nursing facility.

III. INFORMAL DISPUTE RESOLUTION

I am providing you one opportunity to dispute the survey findings 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 the deficiency(ies), to Mark Paugh, Office of Health Care Quality, 7120

Samuel Morse Drive, Second Floor, Columbia, MD 21046-3422, mark.paugh@maryland.gov. This request must be sent within 10 days of receipt of this letter.

Informal dispute resolution for the cited deficiencies will not delay the imposition of the enforcement actions 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 a remedy.

IV. REQUEST FOR A HEARING

The facility may request a hearing on the decision to impose this CMP. Any hearing will be held in accordance with State Government Article, Title 10, Subtitle 2, Annotated Code of Maryland, and COMAR 28.02.01 and 10.01.03. Any request for a hearing must be submitted in writing to Carla Boyd, Office of the Attorney General, 300 West Preston Street, Suite 302, Baltimore, Maryland, 21201, no later than 30 days after receipt of this notice. The request shall include a copy of this letter. If the informal dispute resolution process referenced elsewhere in this letter does not result in settlement of this matter, this matter will be referred to the Office of Administrative Hearings to hold a hearing and issue a proposed decision within 10 working days of the hearing in accordance with COMAR 10.07.02.74C. The aggrieved person may file exceptions as provided in COMAR 10.01.03.18. A final decision by the Secretary shall be issued in accordance with COMAR 10.01.03.18J. If you do not request a hearing within 30 days after the receipt of this notice, the imposition of the CMP will become final at that time.

The CMP payment is due 15 calendar days after the time period for requesting a hearing has expired and a request for a hearing was not received; or 15 calendar days after receipt of a written request from the facility to waive its right to a hearing and reduce the amount of the CMP by 40 percent, provided the written request is received by the Department within 30 calendar days of the Department's order imposing the civil money penalty. COMAR 10.07.02.73A.

If the nursing facility files a timely request for a hearing, the nursing facility shall deposit the amount of the CMP in an interest-bearing escrow account. The nursing facility shall bear any costs associated with establishing the escrow account, and the account shall be titled in the name of the nursing facility and the Department of Health as joint owners. COMAR 10.07.02.73B.

When the Secretary issues the final decision of the Department, the funds in the escrow account, plus accrued interest if applicable, shall be distributed in accordance with COMAR 10.07.02.73C.

If you have any questions concerning the instructions contained in this letter, please contact Mark Paugh, OHCQ Long Term Care Unit, at 667-210-9638 or by email at mark.paugh@maryland.gov.

Sincerely,

Patricia Tomsko Nay, MD

Patricia Tomsko Nay, M.D.
Executive Director
Office of Health Care Quality

Enclosures: State Form
Directed Plan of Correction

cc: Carla Boyd, Esq.
Jane Sacco
Ruby Potter
Ciara Lee
Stevanne Ellis
File II

Northwest Healthcare Center
Directed Plan of Correction
November 9, 2021

1. The facility's failure to report data to CRISP impairs the prompt identification of potential new infectious outbreaks that may require community or state-based responses and interventions and thereby places all residents, staff, and visitors at increased risk for serious harm.

2. On receipt of this Directed Plan of Correction, the facility shall immediately identify and assign one staff (**Primary Reporter**) as accountable for all daily and weekly CRISP reporting requirements. The Primary Reporter may delegate reporting to other staff (**Delegated Reporter**) on any given day, but the Primary Reporter retains accountability for daily and weekly reporting.

3. The facility shall immediately review and confirm that the Primary Reporter and all Delegated Reporters have working access to the CRISP system.

4. The assigned facility staff shall report all required daily data into CRISP by 11:00 am each day and all required weekly data by 11:00 am each Wednesday.

5. The facility shall establish and maintain a paper or electronic **CRISP Reporting Log** that contains the name of the Primary Reporter or Delegated Reporter for each day and all email receipts received from CRISP during the reporting window. The facility shall educate the Primary Reporter and all Delegated Reporters on this process.

6. The Administrator shall immediately notify the Quality Committee and all members of the governing body of the facility's failure to comply with the mandatory reporting requirements to CRISP.

7. The facility shall designate a **QA Reviewer** who reviews the CRISP Reporting Log daily and takes immediate action(s) on any day that reporting is not completed by the deadline. The QA Reviewer shall prepare and present a report at the monthly Quality Committee meeting. This monthly reporting shall continue for as long as CRISP reporting requirements remain in effect.

8. This plan shall be fully implemented and operational within 24 hours of receipt.

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
	215346	A. BUILDING: _____ B. WING _____	C 11/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHWEST HEALTHCARE CENTER	**4601 PALL MALL ROAD BALTIMORE, MD 21215**

(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 11/5/21, the Maryland Office of Health Care Quality (OHCQ) completed an administrative-review survey for this facility. The licensed bed capacity for this facility is 91. Survey activities included review of data reported in the Chesapeake Regional Information System for Our Patients (CRISP) system and follow up email communication. The review identified that the facility was not in compliance with facility Administration requirements.	S 000		
S 100	10.07.02.09 A-B Administration and Resident Care .09 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. B. Delegation to Administrator. (1) The licensee, if not acting as an administrator, shall appoint as administrator a responsible person who is: (a) Qualified by training and experience; and (b) Licensed by the Board of Examiners of Nursing Home Administrators for the State.	S 100		

OHCQ

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 100	Continued From page 1 (2) The administrator shall: (a) Be responsible for the control of the operation on a 24-hour basis; and (b) With the exception of §B(3) of this regulation, serve full-time. (3) With the Department ' s approval, an administrator may serve on a less than full-time basis for a maximum of two nursing facilities, one of which shall have a licensed capacity of 35 beds or fewer. (4) The Department shall consider the following factors when deciding whether to approve an administrator to serve on a less than full-time basis: (a) Geographic location of the facilities; (b) Ownership of the facilities; (c) Organizational structure of the facilities; (d) Size of the facilities; and (e) Background and experience of the administrator. This Regulation is not met as evidenced by: Based on review of required reporting data and follow up communications with the facility by email, the facility failed to submit daily reporting information by the 11:00 AM deadline through the Chesapeake Regional Information System for our	S 100		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 100	Continued From page 2 Patients (CRISP) health information exchange system as required by Governor and Health Secretary Order, during a declared State emergency and healthcare pandemic. This concern was evident in 1/14 days reviewed (10/30/21), in the review period covering 10/19/21 through 11/1/21. The findings include: On March 5, 2020 the Governor of Maryland issued a Declaration of State of Emergency and Existence of Catastrophic Health Emergency - COVID-19. On April 29, 2020 the Governor of Maryland issued an Executive Order stating "The Secretary is hereby ordered to issue directives under this Order requiring each Nursing Home to: ... Regularly report to CRISP and the applicable local health department such information as the Secretary deems necessary to monitor the spread of the COVID-19 in and around Nursing Homes." A series of numerous superseding orders continued facility reporting requirements as follows: Facility Reporting to Health Department: In addition to all current reporting requirements to state and local health departments, all facilities shall report the following information to the Chesapeake Regional Information System for Our Patients (CRISP). On a daily basis, each facility report should include at least the following: i. The census of occupied beds; ii. Number of residents with positive COVID-19 test results; iii. Number of residents with suspected COVID-19; iv. Number of residents with negative COVID-19 test results; v. Number of deaths, by COVID-19 status; vi. Number of staff with positive COVID-19	S 100		

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S 100	Continued From page 3 test results; vii. Number of residents with severe respiratory infection or COVID-19 resulting in hospitalization; viii. Number of staff with severe respiratory infection or COVID-19 resulting in hospitalization; ix. Number of residents or staff with new-onset respiratory symptoms that occur within 72 hours of another resident or staff developing respiratory symptoms; and x. On a weekly basis, each facility report should include the number of days their private PPE stockpile can supply. xi. Any other information required. Review on 11/2/21 of reports submitted to CRISP revealed that data from this facility was missing from the CRISP database on 1/14 days (10/30/21) in the review period of 10/19/21 through 11/1/21. On 11/2/21, the OHCQ surveyor emailed the facility Administrator requesting any clarifying information or credible evidence of reporting on the above noted date, and requested this be provided by close of business 11/4/21. The facility Administrator acknowledged he did not report on this date and provided no information about any potential back-up process or staff who otherwise could have reported to meet the minimum requirement. On 10/8/21, the facility was cited for the same noncompliance concern and a Directed Plan of Correction was issued by the State Survey Agency. The Directed Plan of Correction reemphasized the need to ensure systems and process were followed to report into CRISP daily as required. The facility nonetheless failed to report again on 10/23/21.	S 100		

Office of Health Care Quality

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	215346	A. BUILDING _____ B. WING _____	R-C 08/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHWEST HEALTHCARE CENTER	**4601 PALL MALL ROAD BALTIMORE, MD 21215**

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{F 000}	INITIAL COMMENTS On August 13, 2021 an off-site survey was conducted to review the facility's plan of correction for deficiencies that were cited during the survey ending July 9, 2021. Survey activities included the review of the facility's plan of correction and credible evidence. Effective August 13, 2021, the facility was determined to be in compliance with the requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities.	{F 000}		

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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OHCQ

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

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
	215346	A. BUILDING _____ B. WING _____	R-C 09/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHWEST HEALTHCARE CENTER	**4601 PALL MALL ROAD BALTIMORE, MD 21215**

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

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

D: 11/17/2021
M APPROVED

Maryland
DEPARTMENT OF HEALTH

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Dennis R. Schrader, Secretary

Office of Health Care Quality
7120 Samuel Morse Drive
Second Floor
Columbia, MD 21046-3422

August 25, 2021

Mr. Meir Hakimi, Administrator
Northwest Healthcare Center
4601 Pall Mall Road
Baltimore, MD 21215

RE: Provider # 215346

Notice of Deficiencies, Imposition of Denial of Payments for New Admissions under Federal Regulations and Loss of NATCEP

Dear Mr. Meir:

On July 30, 2021, a Complaint survey conducted at your facility by the Office of Health Care Quality, determined that your facility was not in substantial compliance with Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs.

All references to regulatory requirement(s) contained in this letter are found in Title 42, Code of Federal Regulations.

Based on the complaint survey which was conducted at your facility on July 9, 2021, the facility was initiated on an enforcement track. Based on the enclosed findings of the July 30, 2021 survey, the enforcement track continues, with remedy imposition dates based on the survey that initiated the enforcement track on July 9, 2021.

I. IMPOSITION OF REMEDIES

As a result of our finding that your facility is not in substantial compliance, the following remedy (ies) will be imposed:

Imposition of denial of payment for new admissions, effective October 9, 2021.

If substantial compliance is not achieved by January 9, 2022, the CMS Regional Office and/or the State Medicaid Agency may terminate your provider agreement that date.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should CMS determine that termination or any other remedy is warranted, CMS will provide you with a separate formal notification of that determination.

II. AUTOMATIC CONSEQUENCES AS A RESULT OF IMPOSITION OF DENIAL OF PAYMENT FOR NEW ADMISSION

As a result of the imposition of denial of payment for new admissions effective October 9, 2021, your facility is prohibited from operating a nurse aide training program for two years from the last day of the survey. See §483.151

As a result of the survey findings the Center for Medicare and Medicaid Services (CMS) and the Maryland State Medicaid Agency have authorized us to inform you that Medicare and Medicaid payment for all new admissions to your facility will be denied effective October 9, 2021. This action is required by sections 1819 (h)(2)(B)(I), 1819 (h)(2)(D), 1919 (h)(3)(B)(ii), and 1919 (h)(3)(C)(i) of the Social Security Act. In addition, you are advised that, should you remain out of compliance, your provider agreement will be terminated by CMS and the Maryland State Medicaid Agency on . Please note that the denial of payment for new Medicare admissions includes Medicare beneficiaries enrolled in Medicare managed care plans. It is your obligation to inform Medicare managed care plans contracting with your facility of this denial of payments for new admissions.

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 CFR §498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. A copy of the hearing request shall be submitted to:

Chief Counsel
Office of the General Counsel
801 Market Street
Suite 9400
Philadelphia, PA 19107

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a

written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree, 42 CFR §498.40(b)(1). It should also specify the basis for contending that the findings and conclusions are incorrect, 42 CFR §498.40(b)(2). You may be represented by counsel at a hearing, at your own expense.

Should we take action to terminate your participation in the Medicare program, we will advise you of your appeal rights as a result of that action. Please note that those appeal rights are separate and distinct from the appeal rights cited above.

You will be notified separately by the Maryland Medicaid State Agency regarding their application of the remedies in this letter.

III. 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** as noted in the previously provided Resident Roster. 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 the documents are released to the public.

IV. ALLEGATION OF COMPLIANCE

If you believe the deficiencies identified in form CMS 2567 have been corrected, you may contact Jasmine Hayes, Survey Coordinator at the Office of Health Care Quality, 7120 Samuel Morse Drive, Second Floor, 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.

If upon a subsequent revisit or by other means, we verify that the facility is in substantial compliance, we will recommend to CMS that the remedy (ies) be terminated. However, if the seriousness of noncompliance changes from the survey findings, the remedies selected may change. If this occurs, you will be advised of any change.

V. 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. Renee Webster, Deputy Director of Federal Programs, Office of Health Care Quality, 7120 Samuel Morse Drive, Second Floor, Columbia, MD 21046-3422. This request must be sent within 10 days of your receipt of the CMS 2567.

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

VI. 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 Jasmine Hayes at (410) 402-8201 or Jasmine.Hayes@maryland.gov.

Sincerely,

Patricia Tomsko Nay, MD

Patricia Tomsko Nay, M.D.
Executive Director
Office of Health Care Quality

Enclosures: CMS 2567
State Form

cc: Ginger Levesque, CMS RO
Jane Sacco
Jasmine Hayes
Ciara Lee
Stevanne Ellis
File II

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFI CATION NUMBER:	""8IE CONSTRUCTION ABDC; B WG -1	(X3) DATE SURVEY COMPLETED
	215346		C 07/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHWEST HEALTHCARE CENTER	4601 PALL MALL ROAD BALTIMORE, MD 21215

(X4)10 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	**INITIAL COMMENTS** A Complaint survey was conducted at this facility onsite on July 29, and 30, 2021, by the Office of Health Care Quality to investigate the following complaints: MD00169245, MD00169300, MD00169372 and self report MD00169516 and MD00169861. The licensed bed capacity for this facility is 91, and the resident census at the start of the survey was 67, and there were 4 residents included in the sample. Survey activities consisted of a review of medical records, facility documentation, interviews with residents, staff, family members, and observations of resident and staff practices. Administrative reports and facility policies and procedures were also reviewed. This survey did not identify non-compliance with Federal and State requirements that were reviewed in relationship to complaints: MD00169245, MD00169300, MD00169372 and self report MD00169516 and MD00169861.	F 000	CommuniCare Health Services- Northwest is filing this plan of correction for the purpose of regulatory compliance. This Center is submitting this plan of Correction to comply with applicable laws & not an admission or statement of agreement with the alleged deficiencies herein. To remain in compliance with all federal & slate regulations, the Center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the Center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates alleged.	9/24/2021
F 610 SS=D	The following deficiencies are a result of the survey. Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.	F 610	What corrective action will be accomplished for those residents found lo have been affected by the deficient practice? Resident #1 no longer resides at the facility. How will you identify other residents having the potential to be affected by the same deficient practice & what corrective actions will be taken? All residents have the potential to be affected. Regional Director of Clinical Operations will conduct an audit of allegations of abuse in the last 30 *days* to ensure that a proper investigation has been conducted. What measures will be put into place to ensure that the deficient practice does not recur? Staff Development Nurse will re-educate ED on the proper abuse allegation investigation process.	9/24/2021

tyl2Qj)t? Executive Director 9/7/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (XS) 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.

F 610	Continued From page 1 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on administrative record review and interviews with facility staff it was determined the facility failed to complete a thorough investigation when a resident reported abuse allegations. This was found to be evident for 1 (Resident # 1) of 2 residents reviewed for abuse during a complaint investigation conducted at the facility. The findings include: Self-Report# MD00169861 was reviewed on 7/29/21 and 7/30/21 regarding an allegations of abuse involving Resident #1. On 7/29/2021 the facility provided a copy of their investigation to the survey team. A review of the investigation revealed statements from Staff# 7, an LPN (Licensed Practical Nurse), Staff #8, an GNA (Geriatric Nurse Assistant) and Staff #9, an RN (Registered Nurse) Supervisor. There were no other statements from other residents or staff included in the facility's investigation for this allegation. An interview was conducted with the Administrator and the DON on 7/29/21 at 12:30 PM and they were asked if the facility interviewed any other residents or additional staff, and the Administrator stated that	F 61 O	How will the corrective action be monitored to ensure the deficient practice will not recur? ED or DON will audit self reports weekly x4, then monthly x2 for a total of 90 days to ensure abuse allegations are properly investigated	

STATEMENT OF DEFICIENCIES AND Pl.AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	CONSTRUCTION	(XJ) DATE SURVEY COMPLETED
	215346	A 8D4I B w-G	C 07130/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHWEST HEALTHCARE CENTER	4601 PALL MALL ROAD BALTIMORE, MD 21215

(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)	iX5) COMPtEllON DATE
F 610	Continued From page 2 obtained from staff assigned to Resident #1. The administrator was asked to explain the investigation process when abuse allegations are reported by a resident. The Administrator explained that he received an email on 7/21/21 of allegations involving Resident # 1 and based on those allegations, the facility initiated a self-report. He went on to say that It was an abuse allegation that involved Resident #1 and staff (no specific staff), so the facility investigated accordingly. He stated that the Social Worker (SW) assists with interviewing residents and staff and that all staff and residents are interviewed. He added that the SW was recently hired and that he assisted with the investigation. An interview was conducted with the SW, Staff #4, oo 7/30/21 at 9:45 **AM.** He stated that he assists in obtaining statements for abuse investigations. He went on to say that he only interviewed Resident #2 and that no other interviews were conducted with residents or staff. The SW was unable to provide documentation of resident # 2 interview. In an interview conducted with the Administrator on 7/30/21 at 10:45 AM he confirmed that other residents and staff	F 610		
F 732 SS::D	weren't interviewed during the investigation Into the allegations received on 7/21/21 involving staff and Resident #1. The facility unsubstantiated abuse. Posted Nurse Staffing Information CFR(s): 483.35(gX1)-(4) §483.35(9) Nurse Staffing Information. §483.35{g)(1) Data requirements. The	F 732		

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facility must post the following information on a daily basis:

PRINTED: 08/24/2021 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES 0MB NO. 093S.0391

STATEMENT OF DEFICIENCIES AND PIAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	'4ADE CONSTRUCTION A BOC BWG	(X3) DATE SURVEY COMPLETED
	215346		C 07/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHWEST HEALTHCARE CENTER	4601 PALL MALL ROAD BALTIMORE, MD 21215

(X4)ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEOED 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 732	Continued From page 3 (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(9)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(9)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(9)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation it was determined the facility [illegible]	F 732	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The proper posting of the daily staffing schedule was immediately corrected. How will you identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected. What measures will be put into place to ensure that the deficient practice does not recur? Staff Development Nurse will re-educate Unit Managers on the proper posting of the daily staffing schedule. How will the corrective action be monitored to ensure the deficient practice will not recur? Unit managers will conduct a weekly audit ensuring the proper posting of the daily staffing schedule. This audit will be conducted weekly X4 weeks & then monthly X2 months for a total of 90 days. Audits will be forwarded to QAPI for review & recommendations.	9/24/2021

	staffing data on the Daily Staffing Schedule. The facility also failed to post the Daily Staffing Schedule in a prominent place and readily accessible to visitors			

STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER	14,lfJE CONSTRUCTION	(X3l DATE SURVEY COMPLETED
	215346	A aJLN: BWING	C 07130/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHWEST HEALTHCARE CENTER	4601 PALL MALL ROAD BALTIMORE, MD 21215

F 732	Continued From page 4 and residents. This was evident on 2 out of 2 nursing units. The findings included: On 7/29/21 at 8:30 AM upon arrival on the **Main** Hall Unit this surveyor was unable to locate the current staffing assignments for the unit. Interview on 7/29/21 at 10:30 AM with the Administrator revealed the staffing schedule was on an 8 X 10-inch paper and in a book at the nursing station counter. On 7/29/2021 a review of the schedule revealed the document did not include the total number and the actual hours worked by the licensed and unlicensed nursing staff directly responsible for resident care per shift. The schedule was not in a prominent place nor accessible for residents and visitors in wheelchairs. Wheelchair residents or visitors would have to request the schedule. On 7/29/2021 at 10:30 AM Observation also revealed the staffing board on the short hallway unit. The board listed the names of the nurses and geriatric nursing assistants **(GNAs),** however failed to document the total number of nursing hours.	F 732		
F 838 SS=E	The above findings were confirmed with the Administrator and Director of Nursing on 7/29/21 at 10:30 **AM.** Facility Assessment CFR(s): 483.70(e}(1)-(3} §483.70(e} Facility assessment. The facility must conduct and document a	F 838		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1tA1J1: CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215346	A BOO B WG	C 07/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS. CITY, STATE, ZIP CODE
NORTHWEST HEALTHCARE CENTER	4601 PALL MALL ROAD BALTIMORE, MD 21215

(X4) JO 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 838	Continued From page 5 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, {i) Both the number of residents and the facility's resident capacity; {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,	F 838	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Facility assessment has since been updated. How will you identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected. What measures will be put into place to ensure that the defcient practice does not recur? Regional Director of Operations will re• educate the ED on the need to update the facility assessment annually or as needed. How will the corrective action be monitored to ensure the deficient practice will not recur? ED or DON will conduct a weekly audit x4 & then x2 months for a total of 90 days to ensure the facility assessment is up to date. Audit will be forwarded lo QAPI for review & recommendations..	9/24/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDERISUPPLIERICLIA IDENTIFICATION NUMBER	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215346	A BOC B W,G	C 07/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHWEST HEALTHCARE CENTER	4601 PALL MALL ROAD BALTIMORE, MD 21215

(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 838	Continued From page 6 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 community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on staff interview, it was determined that facility failed to 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. This was found to be evident during a complaint survey conducted at the facility. The findings: In an interview with the facility administrator on 7/30/21 at 11:30 AM, the facility administrator stated that a facility	F 838		
F 842 SS=D	assessment has not been completed since 2017. The facility administrator stated that s/he has only been the administrator of the facility for a few months. Resident Records - Identifiable Information	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215346	A BIN: _____ B WG _____	C 07/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHWEST HEALTHCARE CENTER	4601 PALL MALL ROAD BALTIMORE, MD 21215

(X4)10 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLEOON OATE
F 842	Continued From page 7 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 §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	F 842	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #1 no longer resides at the facility. How will you identify other residents having the potential to be affected by the same deficient practice & what corrective actions will be taken? All residents have the potential to be affected. Unit manager will audit all residents noted with discoloration or bruising of the hand & monitoring was recommended in the last 30 days, to ensure monitoring was done as recommended. What measures will be put into place to ensure that the deficient practice does not recur? Staff development nurse will re-educate all licensed nurses on following proper recommendations for residents. How will the corrective action be monitored to ensure the deficient practice will not recur? Unit managers will audit residents with discoloration or bruising of the hand weekly X4 & then monthly x2 for a total of 90 days ensuring that proper recommendations are followed. The audits will be forwarded to OAPI for review & recommendations.	9/24/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215346	A BOC BWG	C 07/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS. CITY, STATE. ZIP CODE
NORTHWEST HEALTHCARE CENTER	4601 PALL MALL ROAD BALTIMORE, MD 21215

(X4) 10 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUll REGULATORY OR LSC IDENTIFYING INFORMATION)	10 PREFIX TAG	PROVIDER'S **PLAN** OF CORRECTION (EACH CORRECTIVE ACTION SHOULD **BE** CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X51 COMPLETION DATE
F 842	Continued From page 8 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 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 administrative record review and interviews with facility staff, it was determined the facility failed to assess and document on a resident when discoloration/bruising of the hand was noted and monitoring was recommended for the resident. This was found to be evident for 1 (Resident# 1) of 5 residents reviewed during a complaint survey conducted at the facility. Findings include:	F 842		

STATEMENT OF DEFICIENCIES AND PI.AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	""81:. CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215346	A IWE B WG	C 07/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY. STATE, ZIP CODE
NORTHWEST HEALTHCARE CENTER	"601 PALL MALL ROAD BALTIMORE, MD 21215

(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 842	Continued From page 9 Intake# MD00169300 was reviewed on 7/29/21 and 7/30/21 for allegations of abuse. The complainant had multiple concerns involving Resident #1, including bruises that was noted to the resident hands. Abuse was unsubstantiated by the facility. A review of Resident #1's medical record on 7/29/21 at 11:00 AM revealed the resident's current diagnosis include, but not limited to: Hemiplegia and Hemiparesis (varying degrees of weakness in the body causing inability to move) affecting right dominant side. A review of a note dated 7/12/21 at 00:53 (12:53 **AM)** revealed Resident #1 had a Skin Grid Non-Pressure Assessment which noted the back of the resident's left had had was positive for a bruise, Bruising: Length 2.0, Width 2.0, Depth 0. Further review of an SBAR (Situation, Background, Assessment, Recommendation) Summary for Providers note, dated 7/12/21 at 13:33 (1:33 PM), listed skin evaluation with discoloration noted. Nurse observations and recommendations: Resident denied pain and discomfort during assessment. Range of Motion (ROM) within normal limits (WNL). Propels wheelchair with left hand. Primary Care Provider feedback, "No new order at this time, will continue to monitor." Further review of the resident's record revalued there was no follow-up skin assessments done on 7/13/21 for Resident #1's hand. A progress note dated 7/14/21 at 14:40 (2:40 PM) indicates Resident #1 had a non-witnessed fall, noted sitting on hand. An x-ray was obtained with a result of non-displaced stress fracture. An interview was conducted with the DON on 7/30/21 at 11:00 AM and she stated that she was	F 842		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	!t,lfll: CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215346	I\ BOC BWG	C 07/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHWEST HEALTHCARE CENTER	4601 PALL MALL ROAD BALTIMORE, MD 21215

(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 PI.AN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION OATE
F 842	Continued From page 10 unable to provide documentation that a follow-up assessment was done for Resident #1 on 7/13/21. She confirmed that monitoring of the resident hand for swelling and bruising should have been documented All concerns were discussed with Administration at the time of exit on 7/30/21 at 12:15 PM.	F 842		

Office of Health Care Qualit

STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	X3) OATE SURVEY COMPLETED
	215346	A. BUILDING _____ _!!_ WING	C 07/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET AOORESS CITY, STATE ZIP CODE
NORTHWEST HEALTHCARE CENTER	4601 PALL MALL ROAD BALTIMORE, MD 21215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	10 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5> COr..FI.ETE OATE
S 0001	Initial Comments A Complaint survey was conducted at this facility onsite on July 29, and 30, 2021, by the Office of Health Care Quality to investigate the following complaints: MD00169245, MD00169300, MD00169372 and self report MD00169516 and MD00169861. The licensed bed capacity for this facility is 91, and the resident census at the start of the survey was 67, and there were 4 residents included in the sample. Survey activities consisted of a review of medical records, facility documentation, interviews with residents, staff, family members, and observations of resident and staff practices. Administrative reports and facility policies and procedures were also reviewed. This survey did not identify non-compliance with Federal and State requirements that were reviewed in relationship to complaints: MD00169245, MD00169300, MD00169372 and self report MD00169516 and MD00169861. The following deficiencies are a result of the survey.	S 000		
S 12	10.07.02.09 F Administration and Resident Care - Staffing .09 Administration and Resident Care. F. Staffing. **(1)** The administrator shall employ sufficient and satisfactory personnel as specified in this chapter to: (a) Provide maintenance, cleaning, and housekeeping;	S 120	Please see POC for F838	

OHCQ
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Mark Hopkins — Executive Director — 9/7/2021

Office of Health Care Qualit

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDERISUPPLIERICLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	XJ) DATE SURVEY COMPLETED
	21534&	A. B_UILDING: B. W!.",!G	C 07/30/2021

NAME OF OVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE. ZIP COOE
NORTHWEST HEALTHCARE CENTER	4601 PALL MALL ROAD BALTIMORE, MD 21215

(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)	(X) COMPLETE DATE
s 120	Continued From page 1 (b) Assist residents with eating; and (c)Give adequate resident care. (2) Voluntary Admissions Ceiling. **(a)A** nursing home may request a voluntary admissions ceiling by submitting a written request to the Department to authorize a temporary restriction on resident admissions based upon anticipated bed usage. (b)When the nursing home wishes to request that the restriction be removed, the request shall include the specific effective date and a statement that personnel staffing is sufficient to meet the State ' s requirements at the designated census level. (c)The Department shall approve the increase in beds within 72 hours following receipt of the nursing home ' s documentation that the required additional staff is in position to serve the increased number of beds. (d)Management of the nursing home may not permit the resident census to exceed the admissions ceiling without prior approval from the Department. This Regulation is not met as evidenced by: Refer to CMS 2567 F 838	S 120		

Office of Health Care Qualit

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	215346	A. BUILDING _ 8. WING	C 07/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHWEST HEALTHCARE CENTER	4601 PALL MALL ROAD BALTIMORE, MD 2121S

(X4)10 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	to PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S137	Continued From page 2	S1370		
S137c	10.07.02.32 A Clinical Records .32 Clinical Records. A. Records for all Residents. Records for all residents shall be maintained in accordance with accepted professional standards and practices. This Regulation is not met as evidenced by: Refer to CMS 2567 Form F-842	S1370	Please see POC for F842	
S3130	10.07.02.67 Posting of Staffing .67 Posting of Staffing. A. A nursing home shall post a notice on each floor or unit of the nursing home, for each shift, a notice that gives the ratio of licensed and unlicensed staff to residents. B. The posting on each floor shall include: (1) Names of the staff members on duty and the room numbers of the residents to whom each is assigned; (2) Name of the charge nurse or person who is in charge of the unit; (3) If the person in charge is not a registered nurse, the name of the registered nurse responsible for the unit; and (4) Name of the medicine aide or person responsible for medication administration. C. The posting shall be on a form provided or approved by the Department.	S3130	Please see POC for F732	

STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIDER/SUF>PLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	215346	A. BUILDING B. WING	C 07/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS. CITY, STATE, ZIP CODE
NORTHWEST HEALTHCARE CENTER	**4601 PALL MALL ROAD** **BALTIMORE, MO 21215**

(X4)1D PREFIX TAG	SUMMARY STATEMENT OF DEFlaENCIES (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) COMPI.ETE DATE
S3130	Continued From page 3 0. A record of the posting shall be retained for 1 year. This Regulation is not met as evidenced by: Refer to CMS 2567 F 732	S3130		
S6350	10.07.09.15 D (1) Investigations;thorough .15 Abuse of Residents. D. Investigations. A nursing facility shall: (1} Thoroughly investigate all allegations ofabuse;and This Regulation is not met as evidenced by: Refer to CMS 2567 Form F-610	S6350	Please see POC for F610	

Office of Hea

Maryland
DEPARTMENT OF HEALTH

Larry Hoga11, Governor · Bo)'d K Ruthe,jord, Lt. Govemor · Robert R. NcaL4 Secretary

Office of Health Care Quality (OHCQ}
7120 Samuel Morse Drive, Second Floor
Columbia, MD 21046-3422

July 23, 2021

Meir Hakimi, Administrator,
Northwest Healthcare Center
4601 Pall Mall Road
Baltimore, MD 21215

PROVIDER# 215346
RE: NOTICE OF CURRENT DEFICIENCIES AND POSSIBLE IMPOSITION OF REMEDIES

Dear Meir Hakimi:

On July 9, 2021, a survey was conducted at your facility by the Office of Health Care Quality to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey was also conducted for the purpose of State licensure. This survey found that your facility was not in substantial compliance with the participation requirements.

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

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 August 23, 2021. 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 October 9, 2021 identifying non-compliance, we must deny payments for new admissions. (§488.417(a)) Also, if the denial of payment for new admissions sanction is imposed, your facility is prohibited from operating a nurse aide training program for two years from the last day of the survey. (§483.151)

If your facility has failed to achieve substantial compliance by January 9, 2022, your Medicare provider agreement will be terminated.

Ill. ALLEGATION OF COMPLIANCE

If you believe that the deficiencies identified in the CMS form 2567 have been corrected, you may contact me at the Office of Health Care Quality, 7120 Samuel Morse Drive, Second Floor, 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 July 9, 2021 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. Renee Webster, Deputy Director of Federal Programs, Office of Health Care Quality, 7120 Samuel Morse Drive Second Floor, Columbia, MD 21046-3422, fax 410-402-8234. This request must be sent during the same IO days you have for submitting a PoC for the cited deficiencies. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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 ofreceipt 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 410-402-8034.

Sincerely,

Jasmine Hayes, MPH
Health Facilities Survey Coordinator II
Long Term Care

Enclosures: CMS 2567
State Form

cc: Stevanne Ellis
Jane Sacco

File II

Meir Hakimi, Administrator,
Northwest Healthcare Center
July 23, 2021

August 1, 2021

Northwest Healthcare Center

4601 Pall **Mall Road**

Baltimore, Maryland 21215

Enclosed please find our plan of correction for the complaint survey that was conducted at our facility on July 8th-9th.

Please contact me with any questions or concerns you may have.

Thank you in advance for your cooperation & assistance in this matter.

Sincerely,

Meir Hakimi, LNHA

[redacted]

Executive Director

STATEMENI OF DEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMSER:	(X2) MULTIPI.£ CONSTRUCTION	(X3) DATE' SURVEY COMPLETED
	215346	A. BUILDING _____ __ 8WINGL --------	C 07/09/2021

NME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY. STATE. ZIP CODE
NORTHWEST HEALTHCARE CENTER	4601 PALL MAU.ROAD BALTIMORE, MD 21215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUU REGULATORY **OR** LSC IDENTIfYING **INFORMATION)**	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	()(5) C(M>LE"TI()N DATE
FOOO	INITIAL COMMENTS			
	A Complaint survey was conducted at this facility onsite from July 8, 2021-Juty 9, 2021, by the Office of Health care Quality to investigate the following complaints: MD00168270, MD00166587, MD00164104 and self report MD00159817. The licensed bed capacity for this factlity is 91, and the resident census at the start of the survey was 82. and there were eight (8) residents included in the sample. Survey activities consisted of a review of medical records, *facility* documentation, interviews with residents. staff. family members, and observations of resident and staff practices. Administrative reports and facility policies and procedures were also reviewed. This survey identified non-compliance with Federal and State requirements that were reviewed in relatiOnship to complaint MD00159817 and MD00164104. The following deficiencies are a result of the survey.	FOOO	CommuniGare Health Services- **Northwest** s filing this Plan of Correction for the purposes of regulatory compliance. This Center is submitting this plan of correction o comply with applicable laws & not an dmission or statement of agreement with e alleged deficiencies herein. To remain n compliance with all federal & state "89Ulations, the Center has taken or v.ill Jake the actions set forth in the following plan of correction. The following plan of rrection constitutes the Center's allegation of compliance such that all F1lleged deficiencies cited have been or will be corrected by the date or dates indicated.	8/13/2021
F657 SS=D	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-** (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	F657	What corrective action will be accomplished for those residents found to have been ffected by the deficient practice? esident #1 has since been discharged. J-jow will you identify other residents having the potenbal to be affected by the same eficient practice and what corrective actions will be taken? unit manager or designee will audit all	811312021

LABORATORY OIRE TOR"S OR PR OERISUPPUER REPRESEHTATM.' S SIGNATURE TITLE (X6)0ATI:

Any deficiency statemenl ending with an asterisk *(i* denotes a deficiency which the instit 10n may OO excused from correcting providing it is determined that other safeguards provide MIfficient protection to the patients. (See inslructions.) Except for nur11ing homes, the findings staled 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 col1'8Ction 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) PROVIO£RISUPPLIERICLIA IDENTIFICATION NUMBER	(X2) MULTIPL£ CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215346	A BUILDING _____ 8W-ING _____	C 07/09/2021

NAME Of PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHWEST HEALTHCARE CENTER	**4601 PALI.MAU.ROAD** BALTl""ORE, MD 21215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDEKTIfYING INFORMATION)	ID PREFIX TAG	PROVJDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMP\£"TION CATE
F657	Continued From page **1** 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 detennined 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 medical record review and staff interview, it was detennined that the facility staff failed to update care plans and remain them placed upon the Resident returned to the facility. This was found to be evident for **1** out of the **4** residents reviewed during the investigative portion of the survey (Resident #4) and was identified secondary to an investigation of intake **#MD00164104.** The findings include: **A** care plan is a guide that addresses the needs of each resident. It is used to plan, assess and evaluate the effectiveness of the resident's care. A review of the Resident #4's medical record was conducted on 7/8/21 at 10:12 AM. The review revealed that Resident #4 had been transferred to	F657	Re-admissions within the last 90 days to ensure care plans have been updated and emain in place when the residents return to the facility. What measured will be put into place to ensure that the deficient practice does not ecur? Staff Development nurse will r ducate MOS, Social Services department, etc on the need to update care plans & remain them in place upon the residents return to the facility. How will the corrective action be monitored o ensure the deficient practice will not ecur? Unit manager or designee will audit re-admissions to ensure care plans are updated and in place upon return to the facility. Audit will be conducted weekly X4 weeks then monthly X2 for a total of 90 days. Audits will be forwarded to OAPI for review & recommendations.	

STATE:Mf.NT OF DEFICIENCIES **ANO PLAN** Of CORRECTION	**(X1)** PROVIDER/SUPPUER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215346	**A.** BUILDING _____ __ **B. WING** _____ __	C **07/09/2021**

NAME OF PROVIDER OR SUPPLIER	STREET AD DRESS, CITY, STATE, ZIP CODE
NORTHWEST HEALTHCARE CENTER	4601 PAll MAll ROAD BALTIMORE, MD 21215

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F657	Continued From page 2 I on nd re-admitted on -- However, further **review** of the record revealed that the resident's care plan was closed on 3122/2021. On 4/112021 the facility initiated a new care plan for Resident #4. During·an interview on 7/8/21 at 1:32 PM, the Director of Nursing (DON) was informed that there were no care plans in place for Resident **#4** between 3/23121 to 3/31/21. The DON was asked to provide any documentation to support the Resident's comprehensive care was continuously conducted. During a phone interview with a facility MDS Coordinator (Staff#6) on 7/9/21 at 12:55 **PM,** Staff #6 indicated that the Electronic Health Record (EHR) used by the facility automatically doses a care plan after a resident is discharged. Staff #6 added that if a resident stayed in the hospital more than 24 hours, the EHR system would consider the resident as discharged and close their record. Staff *116* also explained that if the resident returned, the facility staff would need to assess and reset the resident's care plan. During the interview, Staff *116* verified that Resident #4's care plan was not reset for nine (9) days after the resident returned from the hospital, and there was no active care plan for the resident from 3123121 to 3/31/21. As of the end of the survey, no evidence was provided to the survey team to support that Resident #4's had an active care plan during the nine days of their re-admission from the hospital.	F657		
F658 SS::D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	F658		

STATEMENT Of OE.FICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIERICLIA IDENTIFICATION NUMBER:	(JU) MULTIPl£ CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215346	A. BUILDING _____ __ B. 'MNG _____	C 07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS. CITY, STATE, ZIP CODE
NORTHWEST HEALTHCARE CENTER	4601 PAU. MAU. ROAD BALTIMORE, MD 21215

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F658	Continued From page 3 §483.21(b)(3) Comprehensive Care Plans The se.rvices provided or arranged by the facility, as outhned by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on administrative record review and interviews with facility staff it was determined the facility failed to follow professional standards of practice when a proper assessment was not done on a resident after a witnessed fall and the resident was noted to have bleeding present to the elbow later. This was found to be evident for 1 of 4 residents reviewed during a complaint survey conducted at the facility (Resident #2). A review of Resident #2's medical record on 7/912.1 and a progress skin/wound note dated on 5/15/21 at 3:34 PM read as follows: Resident #2 came to the nurse station with blood on the gown and ann and after assessment was found to have skin tears to the left elbow. The resident was unable to recall the incident A *cor,,J* of the Resident #2 falls for May 2020 and was submrtt.ed to the survey team upon request on 7/9(21 at 9:30 AM. The facility provided the survey team with fall investigations for the following dates: 5/15/21 and 5/27121. Review of the fall investigation for the fall that occurred on 5/15/21 at 4:50 **PM** indicated that Resident #2 was placed at the nurse station for close observation related to restlessness. The nurse was in vW!IW of the resident, at a cart at the nurse station passing medications when the resident attempted to stand from sitting position and lost balance. The fall was witnessed by the nurse and	F658	What corrective action will be accomplished ""or those residents found to have been affected by the deficient practice? esident #2 has since been discharged. IHow will you identify other residents having !the potential to be affected by the same k:teficient practice and what corrective !actions will be taken? Unit Manager or designee will audit witnessed falls from last 30 days to ensure that proper assessments were done. What measured will be put into place to lensure that the deficient practice does not ""ecur? Staff development nurse will re-educate icensed nursing on the need to conduct broper assessments after a witnessed fall. How will the corrective action be monitored lo ensure the deficient practice will not ecur? Unit manager or designee will audit falls monthly for the next 90 days. The results Will be forwarded to QAPI for **review** & '"ecommendations.	8/13/2021

STATEMENT Of DEFICIENCIES MID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CIIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(XJ) OA TE: SIJRVEY COMPLETED
	215346	A BUILDING _____ [illegible] STREET ADDRESS, CITY, STATE, ZI	C 07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS. CITY. STATE. ZIP CODE
NORTHWEST HEALTHCARE CENTER	4601 PALL MALL ROAD BALTIMORE, MD 21215

(X4) 10 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUU REGULATORY OR LSC IDENTIFYING INFORMATION)	10 PREFIX TAG	PROVIDER"S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(JC5) COMPLETION DATE
F658	Continued From page 4 the resident was observed to have landed on the buttocks. Interception of the fall was unsuccessful by the nurse. Upon assessment. Resident# 2 was noted with no obvious injury. An interview was conducted with the Corporate Clinical Director (CCD) and the Director of Nursing (DON) on 7/9/21 at 12:19 PM and they were shown the documentation in the resident medical record of the skin/wound note that identified the resident with bleeding noted on the gown. They were asked to provide a copy of the facility's investigation into how the skin tears that were noted to the elbow occurred. During a subsequent interview with the CCD and the DON on the same date at 1:20 PM, they stated that the DON started at the facility in March 2021. They further stated that *they* reviewed the incident and the skin teal'S noted to Resident #2.'s left elbow occurred because of the witnessed fall that occurred on 5/15/21 and that it was not a separate incident The CCD and the DON went on to *say* the nurse who witnessed the fall indicated that there were no injuries, but Resident #2. was noted with Injuries by the oncoming shift nurse Who did an assessment of the resident who found the resident with bleeding on the gown and skin tears to the left elbow. The CCD stated that a follow-up assessment should have been done by the nurse who witnessed Resident #2.'s fall to see if there *were any* further bruises. The DON and Corporate Director stated that the nurse put in for therapy to evaluate the resident All concerns were discussed with the Corporate Administrator, CCD, and the DON at the time of exit.	F658		
F677 SS=O	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F677		

STATEMENT OF DEFICIENCll:S ANO PLAN OF CORRECTION	(X1) PROVIOERISUPPLIER/CIIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRLICTION	(XJ) 01\TE. SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHWEST HEALTHCARE CENTER	4601 PALL MALL ROAD BALTIMORE, MD 21215

(X.CJ 10 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	10 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO TliE APPROPRIA Tl: DEFICIENCY)	()(5) COMPIETION DATE
F677	Continued From page 5 §483.2 ( )(2) **A** resident **who** is unable to carry out actlVmes of dai_ly living receives the necessary services to maintain good nutrition, grooming, and pe:->°nal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on the review of resident medical records and interview with facility staff, it was determined that the fa lity staff failed to assist a dependent res1de t with activities of daily living (AOL). This evident for 1 of 3 residents (Resident #3) investigated for ADLs during the survey. The findings include: The Minimum Data Set **(MOS)** is **a** comprehensive ssessment of the resident completed by the facility staff. The MDS is a multi rsciplinarian tool that allows many facets of the resident's care. One of the sections of the MOS is Activities of Daily LNing (ADLs) which are tasks re to everyday life, (eating, bathing, dressing, toileting and transferring). The AOL score reviews each ADLs, to assess the resident's self-performance and determine the amount of staff support needed to perform each task. A review of Resident #3's medical record was conducted on 7/9/21 at 9:10AM. A.. fa hospital discharge summary dated demonstrated that Resident #3 was treat for fractures to both lower extremities and a left elbow fracture before admission to the facility. Continued record review revealed that Resident #3's order summary indicated the resident was "non-weight bearing" on . Also, the Minimum Data Set (MOS) dated 1/29/21 stated	F677	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #3 has since been discharged. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken? MDS nurse will conduct an audit of the AOL section of the MOS and ensure that staff are following the assistance requirement based off the MOS. What measured will be put into place to ensure that the deficient practice does not recur? Staff development nurse will re-educate clinical staff on the need to follow assistance requirements based off MOS. dditionally, staff will be re-educated to Kiocument property when residents refuse ,:are. How will the corrective action be monitored o ensure the deficient practice will not recur? MOS nurse will audit 25% of charts & contrast it to MOS to ensure clinical staff are following proper requirements. trhis audit will occur monthly for the next days. Results **will be** forwarded to QAPI for review & recommendations.	8/13/2021

F677 Continued From page 6
the resident required two-persons to assist ADLs.

On 7/9/21 at 5:00 PM. a review of Resident#3's ADLs tracking log from 1/23/21 to 2ll/21 was conducted. The ADLs tracking log recorded **44** columns for the task of toilet use. ln 27 of the 44 columns staff documented the resident's self-performance as independent and no support or set-up was provided from staff. In addition, staff documented in five (5) columns that support was provided by one-person physical assist and one column noted as the resident received: "setup help only provided" for the task. The Administrator and Director of Nursing (DON) were made aware of surveyor findings on 7/9/21.

F689 Free of Accident Hazards/Supervision/Devices
SS=D CFR(s): 483.25(d)(1)(2)

§483.25(d) Accidents.
The facility must ensure that -
§483.25(d)(1) The resident environment remains as free of accident ha:z:ards as is possible; and

§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.
This REQUIREMENT is not met as evidenced by:
Based on administrative record review and interviews with facility staff it was determined the facility failed to provide proper supervision for a resident to prevent elopment. This was found to be *evident for* 1 of ***4*** complaints reviewed during a complaint survey conducted at the facility (Resident #1).

Findings include:

F677

F689 What corrective action will be accomplished !for those residents found to have been laffected by the deficient practice? 8/13/2021

Residents #1 has since been discharged.

!How will you identify other residents having the potential to be affected by the same deficient practice and what corrective lactions will be taken?

!staff development nurse will audit current residents. Those who are at rtsk for elopement will receive an individualized re plan to reduce the risk of elopement

IWhat measured will be put into place to nsure that the deficient practice does not recur?

lstaff development nurse will re-educate IDT & licensed staff in need to timely &

,ATEMENT OF DEFICIENCIES \ID Pt.AN OF CORRECTION	(x1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	216346	8.IMNG	C 07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET AODRESS, CITY, STATE, ZIP CODE
NORTHWEST HEALTHCARE CENTER	4801 PALL MALL ROAD BALTIMORE, MD 21215

{Xo4) 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

F689 Continued From page 7

Facility self-report #MD00159817 was reviewed on 7/8/21. A review of the facilrty's invest1gabon revealed that on 10/26/20 Resident #1 exited the facility by removing hlSlher wander guard device and removing an air conditioning unit from the window. The resident exited through the window. A review of the facility's investigation on 7/8/21 at 10·00 AM revealed on 10/26/20 at approximately 1340 hour.; (1:40 PM) a GNA was working on the facility's Main Wing and observed that the air conditioner for Resident #1's room had been removed from the window and was lying on the floor and the resident was not in the room. The nurse was notified. and a search was initiated. Resident #1's room was inspected at that time and the resident's wander guard was observed on the floor.

A continued **review** of the facility's investigation, inlcuding **a witness** statement, revealed that prior to the elopement Resident #1 was last seen by staff at approximately 1:15 PM on 10/26/20. According to the investigation, at approximately 1400 hours (2:00PM) on 10126/20 Resident#1 was returned to the facility by staff. The resident was without hann or injury. The resident told staff that he/she went a family memeber's home. The resident was able to state the correct address, although the resident's family memeber no longer lives there. The resident was placed on 1:1 supervision upon return to the facility until being transfered to the hospital for evaluation.

An interview was conducted on 7/8/21 at 12:30 **PM with** Staff #1, the Infection Control Nurse (ICN). Staff #1 gave an account of the incident that occurred with Resident #1 on 10/26/20 to the survey team. She stated that her position in October 2020 was the Quality Assurance Nurse.

F689 accurately update individual care plans in residents at risk for elopement in order to orovrde proper supervision.

How will the corrective action be monitored to ensure the deficient pract:Jee will not -ecur?

Staff development nurse will audit ndividuals who are at risk of elopement to ensure their care plans have been updated timely & that proper supervision is in place. This audit will occur monthly *for* 90 dates. TTle results will be forwarded to QAPI for eview &recommendations.

STATEMENT OF DEFICIENCIES ANO PL.AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IOENTIFICATIO NUMBER:	{X2) MULTIPL.E CONSTRUCTION	(XJJ DATE SURVEY COMPLETED
	215346	A BUILDING _____ __ B.W.ING	C 07/09/2021

NAME OF PR.OV!OER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHWEST HEALTHCARE CENTER	4601 PALL MALL ROAD BALTIMORE, MD 21215

(X-4) 10 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIl!; TAG	PROVIDER'S PIAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO TliE APPROPRIATE DEFICIENCY)	(XSJ COMPLETION DATE

J

F689	Continued From page 8 She went on to say that the social worker told her that Resident #1 had a previous history of elopement prior to coming to the facility. Staff #1 stated that upon being informed of this. a wander guard was immediately placed on the resident. She stated that the social worker no longer worked at the facility. A medical record **review** on 7/8f21 at 1:OO PM of Resident #1's Ouarterty Assessment dated 10/23/20 revealed a Brief Interview for Mental Status {BIMS) Score of 8 out of 15. **A** SIMS is a tool used to get a quick snapshot of how well cognitive function. The wandering observation tool for Resident #1, dated 9/15/20, was reviewed on 7/8/21 at 1:15 PM. The following infromation was listed under section 2. Definitive Risk Factors and question #1 O: Does the resident have Risk FactOJS for Elopement or unsafe wandering? The answer was marked yes. Further record review on 7/812.1 at 1:25 PM of the care plan that was initiated for Resident #1 on 9116/20 revealed resident is at risk for elopement, risk/wanderer AEB (as evidenced by) history of elopement An interview was conducted with the Maintenance Director **(MD)** on 7/9/21 at 10:15AM and he stated that currently all of the air conditioning units (ACU) had a security screw that locks the **window** down to prevent the unit from being removed. He went on to say that ACU's are checked weekly and that rooms are randomly selected. He provided documentation of the maintenance logs to the survey team. On 10/23/20 maintenance was done on all the rooms	F689		

DEPARTMENT OF HEALTH **ANO HUMAN** SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STAH ..-E.NI or DEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVJOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215346	A. BUILDING _____ B. WING _____	C 07/09/2021

NAME OF PROVIDER *OR* SUPPLIER	STREET ADDRESS, CITY. STATE. ZIP CODE
NORTlfWESTHEALTHCARECENTER	**4601 PALL MALL ROAD BALTIMORE, MD 21215**

(X4) 10 PREFIX TAG	SUMMARY STATEMENT OF OEF"ICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUU. 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
F689	Continued From page 9 and they were noted to be in compliance with a result of pass. During an interview with the Corporate Clinical Director (CCD) on 7/9/21 at 1:30 PM he stated that Resident #1 had never tried to elope from the facility prior to this incident and the facility put measures in place to prevent an elopement. He went on to say that the facility had no way of knowing that the resident would remove the ACU from the window. He further stated that education was provided to staff on wandering.elopement and missing person drill and all resident rooms were checked to ensure that the ACU's were secured. Documentation was provided to the survey team. The facility is responsible for ensuring that all residents are accounted for and are kept safe. All concerns were discussed with the Corporate Administrator, Corporate Clinical Director and DON at the time of exit on 7/9/21 at 5:05 PM.	F689		

Offic:e of H€' 1th C Qu.ahty

s1.-.n MtN7' or DU 1c1r NCIES AND PI.AN Of CORRECTION	(X1) rROVIOERISUrrt IF:RICLIA IOF.NTIFICAI ION NUMBE.R	()(2) MUlTIPl(CONSTRUCTION	(JC\) OATF SURVEY COMPLETED
	2153-46	A BUILDING. _____ 8 WING_	C 07(()912021

NME OF PROVIDER SUPPLIER	STRF.FT ADORFSS, CITY. STATE, ZIP CODE
NORTIM'ESTHEALTHCARECENTER	4601 PALL MALL ROAD BALTIMORE, MO 21215

(X.O.i 10 PRHIX TAG	SUMMARY STATEMENT OF O!TICIENCIES (EAO! DEFICIENCY MUST BE. PRECEDED RY FULL REGULATORY OR LSC IDENlIFYING INFORMA110N)	10 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (fACH CORP.F.CTIVE ACTION SHOULD B£ CROSS-REFERENCF.O TO THE Af'PROf'RIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	tnmal Comments A Complaint Survey was conducted at this facility onsrte on July 8. and 9, 2021, by the Office of Health Care Quality to investigate the following complaints: MD00168270, MD00166587, MD00164104 and self report MD00159817. The licensed bed capacity for this facility is 91, and the resident census at the start of the survey was 82. and there were 8 residents induded in the sample. Survey activities consisted of a review of medical records, facility documentation, interviews with residents, staff, family members, and observations of resident and staff practices. Administrative reports and facility policies and procedures were also reviewed. This survey identified non-Olmpliance with Federal and State requirements that were reviewed in relationship to complaint MD00159817 and MD00164104. The following deficiencies are a result of the survey.	S000	CommuniCare Health Services- Northwest s filing this Plan of Correction for the purposes of regulatory compliance. This Center is submitting this plan of correctJon ,o comply with applicable laws & not an admission or statement of agreement with the alleged deficiencies herein. To remain n compliance with all federal & state r-egulc:1tions. the Center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the Center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated_	8/13/2021
S619	10.07.02.18 F Nursing Services-Charge Nurses' Datly .18 Nursing Services. F. Charge Nurses· Daily Rounds. The charge nurse or nurses shall make daily rounds on all nursing units for which they are responsible, performing such functJons as: (1) Visiting each resident; (2) Reviewing clinical records, medication orders, resident care plans, and staff assignments; and (3) To the degree possible, accompanying	S610	Please see POC for F658 & F689	8/13/2021

OHCQ
LABORATORY O!RECTOR'S OR PROVIDER/SUPPLIER REPRESENT.ATM'S SIGNATURE — TITLE — (X6) DATE

Executive Director — 8/1/2021

STATE FORM 6899 ti1UG11 If continuation sheet 1 of4

)ffice of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ ft. WING	C 07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH STAR HEALTHCARE CENTER	1601 PALL MALL ROAD BALTIMORE, MD 21215

A. 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
S 610	Continued From *page* 1 ys.,oans when visiting residents. This Regulaoon is not met as evidenced by: Refer to CMS 2567 F 6-.'"8 F6S9 Refer to CMS 2567 F6TT	S610		
S 7	10 07 02.20 E Nursing Services - Responsibilities of DON , .20 Nursing Services - Director of Nursing. E. Respcns1b1hties of the Director of Nursing. The respons1brlitles of the director of nursing shall include: (1) Assisting in the development and updating of statements of nursing philosophy and objectiVes to oefme the type of nursing care the nursing home shall provide; (2) Preparation *of* written job descfiptions for nursmg service personnel; (3) Planning to meet the total nursing needs of residents to be met and recommending the assignment of a sufficient number of supervisory and support personnel for each *tour* of duty; **(4)** Development and maintenance of nursing sel"Vlce policies and procedures to implement the program of care;	S 740	Please see POC for F658 & F689	8/13/2021

Office of He..alth Care Qualit-.

STA1TMOIIT Of DHICICNCIES ANO PLAN OF CORRECTION	(X1) PROVIDER/SUPPUERICLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215346	A.. BUILDING: _____ B. WING _____	C 07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS. CITY. STATE, ZIP CODE
NORTHWEST HEALTHCARE CENTER	4601 PALL MALL ROAD BALTIMORE, MD 21215

()(4) ID PREFIX TAG	SUMMARY STATEMENT Of DEfICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUU. 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) COMPLETI:. DATE
S 740	Continued From page 2 (5) Participation in the coordination of resident services through appropriate staff committee meetings on issues relating to: (a) Pharmacy; (b) Infection control; (c) Resident care policies; (d) Quality assurance programs; and (e) Departmental meetings; (6) Cooperation with administration in planning the orientation program and the staff development program to upgrade the competency of personnel; (7) Ensuring that nursing personnel understand the philosophy and meet the objectives; (8) Participation in planning and budgeting for nursing servaces; (9) Establishment of a procedure to ensure that nursing service personnel, including private duty nurses, have valid and current Maryland licenses; (1O) Execution of resident care policies unless delegated to the principal physician or medical director; (11) Participation in the selection of prospective admissions to ensure that the nursing home ' s staff is capable of meebng the needs of all residents admitted; (12) Coordination of the interdisciplinary resident	S740		

Off, or Health Care Quality

STII.THJltN1 Of OffICll:NCIES AND PLAN Of CORRECTION	()(1) PROV!DER.'SUPPllERICLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSmUCTION	(X:l) DI\TE SURVEY COMPLETED
	2153-46	A BUILDING _____ 8 WING _____	C 07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHWEST HEALTHCARE CENTER	4601 PALL MALL ROAD BALTIMORE, MO 21215

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S 740	Continued From page 3 care management efforts; and (13) Supervision of certified medicine aides to ensure that the aides act within the limitations and restrictions placed on them. This Regulation is not met as evidenced by: Refer to CMS 2567 F658 F689	S 740		
110.07.02.60 E	Care Planning-Timing of Updates .60 care Planning. E. Disciplines shall update the care plans as the resident's assessment warrants, but not less than quarterty. This Regulation is not met as evidenced by: Refer to CMS 2567 F657	S2950	Please see POC for F657	8/13/2021

MARYLAND DEPARTMENT OF HEALTH
OFFICE OF HEALTH CARE QUALITY

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

License No. 30033

Issued to: Northwest Healthcare Center .
460 I Pall M ll Road
Baltimore, MD 21215

Type of Facility and Number of Beds:
Comprehensive Care Facility - 9I Beds

Date Issued: Julyl,2018

This license has been granted to: Northwest SNF, LLC

Authority to operate in thisState is granted to the above entity pursuant to The 1-kalth-Gcneml Article. Title 19 Section 318. Annotated Code of Maryland. 1982 Edition. and subseqw:nt supplements and is subject to any and all statutory provisions. including all applicable rules and regulations promulgated there under. This document is not transli:rablc.

Expiration Date: NON - EXPIRING

Patricia Tomcko May, MD

Director

Falsification of a license shall subjecr the perpetrator to criminal prosecution and the i111positio11 of civil fines.

al MARYLAND
'1i? Department of Health
Larry Hogan, Governor • Boyd K. Rutheiford, Lt. Govemor · Robert R. Neall, SecretalJ'

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

September 12, 2018

Attn: Meir Preis, Administrator
Northwest Healthcare Center
460l Pall Mall Road
Baltimore, MD 21215

Dear Mr. Preis:

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. Thus, beginning on **July** I, **2018,** the effective date of this new law, you are no longer required to submit a license renewal application or submit a licensing tee. 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 91 beds under the provision of 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 requirements. If your insurance company has questions, they may contact me, at 410-402-8101.

Sincerely,

Margie Heald
Deputy Director of Federal Programs
Office of Health Care Quality

Room and bed breakdown:

CATEGORY	LOCATION	TOTAL
Comprehensive Care Facility	**Main Hall**	
	Duplex Rooms: I, 2, 3, 4, 5, 6, 7, 8, 9, 10, 12, 14, 15, 16,20,22,24, 26	36 beds
	Triple Rooms: 18	03 beds
	Quad Rooms: l I	04 beds
	Total Main Hall	**43 beds**
	New Wing	
	Single Rooms: 46	01 beds
	Duplex Rooms: 40, 47, 48, 49	08 beds
	Triple Rooms: 41, 42, 43, 44, 45	15 beds
	Quad Rooms: 50	04 beds
	Total New Wing	**28 beds**
	Terrace Unit	
	Single Rooms: 36	01 bed
	Duplex Rooms: 31, 32, 33, 34, 35, 37	12 beds
	Triple Rooms: 38	03 beds
	Quad Rooms: 39	04 beds
	Total Terrace Unit	**20 beds**
	Total Overall	**91 beds**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215346	A. BUILDING _____ B. WING _____	R 03/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHWEST HEALTHCARE CENTER	**4601 PALL MALL ROAD BALTIMORE, MD 21215**

(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
{E 000}	Initial Comments An onsite Revisit Survey was conducted at this facility on March 5, 2021 and March 8, 2021, by the Office of Health Care Quality to determine the facility's compliance with the plan of correction submitted for deficiencies cited during a COVID-19 Focused Infection Control Survey that concluded on December 2, 2020. The licensed bed capacity for this facility is 91 and the resident census at the start of the survey was 64, and there were 7 residents included in the sample. Survey activities consisted of a review of medical records, facility documentation, and interviews with residents, staff, family members, and observations of resident and staff practices . Administrative reports and facility policies and procedures were also reviewed. Effective January 29, 2021, the facility was determined to be in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities.	{E 000}		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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OHCQ

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

t'I MARYLAND
Department of Health
Larry Hoga11, Goi•emo,• • Boyd K. R111he,:fi11-d, Lt. G,wen1or • Robert II. Net1ll. Secretory

July 8, 2019

Meir Preis, Administrator
Northwest Healthcare Center
4601 Pall Mall Road
Baltimore, MD 21215

Provider# 215346
Re: Notice of Deficiencies, Imposition of Denial of Payments for New Admissions under Federal Regulations, Loss **ofNATCIIP**

Dear Mr. Preis:

On June 23 through June 26, 2019, a annual survey conducted at your facility by the Office of Health Care Quality, determined that your facility was not in substantial compliance with Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs.

All references to regulatozy requirement(s) contained in this Jetter are found in Title 42, Code of Federal Regulations.

Based on the complaint survey which was conducted at your facility on May 24, 2019, the facility was initiated on an enforcement track. Based on the enclosed findings of June 26, 2019 annual sun,ey, the enforcement track continues, with remedy imposition dates based on the survey that initiated the enforcement track on May 24, 2019.

I. IMPOSITION OF REMEDIES

As a result of our finding that your facility is not in substantial compliance, the following remedy (ies) will be imposed:

Imposition of denial of payment for new admissions, effective August 24, 2019.

If substantial compliance is not achieved by November 24, 2019, the CMS Regional Office and/or the State Medicaid Agency may terminate your provider agreement that date.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should CMS determine that termination or any other remedy is warranted, CMS will provide you with a separate formal notification of that determination.

11. AUTOMATIC CONSEQUENCES AS A RESULT OF IMPOsn·1ON OF DENIAL OF PAYMENT FOR NEW ADMISSION

As a result of the imposition of denial of payment for new admissions effective August 24, 2019, your facility is prohibited from operating a nurse aide training program for two years from the last day of the survey. See §483.151

As a result of the survey findings the Center for Medicare and Medicaid Services (CMS) and the Maryland State Medicaid Agency have authorized us to infonn you that Medicare and Medicaid payment for all new admissions to your facility will be denied effective August 24, 2019. This action is required by sections 1819 (h)(2)(B)(i), 1819 (h)(2)(D), 1919 (h)(3)(B)(ii), and 1919 (h)(3)(C)(i) of the Social Security Act. In addition, you are advised that, should you remain out of compliance, your provider agreement will be terminated by CMS and the Maryland State Medicaid Agency on November 24, 2019. Please note that the denial of payment for new Medicare admissions includes Medicare beneficiaries enrolled in Medicare managed care plans. It is your obligation to inform Medicare managed care plans contracting with your facility of this denial of payments for new admissions.

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 CFR §498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DABE-File) at hups://dab.elile.hhs.gov no later than sixty (60} days after recciviнu thisfollcr. A copy of the hearing request shall be submitted to:

Chief Counsel
Office of the General Counsel
801 Market Street
Suite 9400
Philadelphia, PA 19107

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building - Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree, 42 CFR §498.40(b)(I). It should also specify the basis for contending that the findings and conclusions are incorrect, 42 CFR §498.40(b)(2). You may be represented by counsel at a hearing, at your own expense.

Should we take action to tenninate your participation in the Medicare program, we will advise you of your appeal rights as a result of that action. Please note that those appeal rights arc separate and distinct from the appeal rights cited above.

You will be notified separately by the Maryland Medicaid State Agency regarding their application of the remedies in this letter.

Ill. PLAN OF CORRECTION {POC)

A Poe for the deficiencies identified in the attached CMS 2567 must be submitted within IO 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;

Whal 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 as noted in the previously provided Resident Roster. 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 the documents are released to the public.

IV. ALLEGATION OF COMPLIANCE.

If you believe the deficiencies identified in form CMS 2567 have been corrected, you may contact Laura Norman, Survey Coordinator 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.

If upon a subsequent revisit or by other means, we verify that the facility is in substantial compliance, we will recommend to CMS that the remedy (ics) be terminated. However, if the seriousness of noncompliance changes from the survey findings, the remedies selected may change. If this occurs, you will be advised of any change.

V. 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 Margie Heald, Deputy Director, Office of Health Care Quality, 7120 Samuel Morse Drive, Columbia, MD 21046-3422. This request must be sent within 10 days of your receipt of the CMS 2567.

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

VI. LICENSURE ACTION

As you are aware, the cited Federal deficiencies have a counter part in State regulations. These deficiencies arc 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 Laura Norman at (410) 402-8003.

S . *1 ,tdk-* *J Y/tef)-*

Patricia Tomsko Nay, M.D.
Executive Director
Office of Health Care Quality

Enclosures: CMS 2567
State Form

cc: Ginger Levesque, CMS RO
Jane Sacco
Laura Norman
Ronda Washington
Stevanne Ellis
File II

Nanhwest Healthcare Center

Maryland Department of Health and Mental Hygiene
Office of Health Care Quality
7120 Samuel Morse Drive, Second Floor
Columbia, Maryland 21046-3422

Provider Number 215346

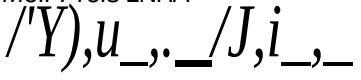
Dear Laura Norman•

Enclosed you wlll find Nanhwest Healthcare Center's Plan of Correction penaining ta the deficiencies obtained during the recent survey that was conducted June, 26 2019.

This Plan of Correction constitutes our allegation of compliance with the federal and state requirements panicipation in the Medicare and Medicaid program.

Sincerely

Meir Preis LNHA



4601Pall Mall Rd, Baltimore MD 21215

STATEMENT OF DEFICIENCIES AND PLANOFCCAAECTION	CX1) PROVIDERISUPPLIERICLIA IDENTIFICATIONNUMBER:	(IOIIWRE A ---. CONSTRUCTION	x"I) DATE SURVEY COMPLETED
	215346	a w·--	C 06/26/2019

NAME CF PROVIDER CA SUPPLIER	STREET ADDRESS. CITY, STATE, ZIP CODE
NORTHWESTHEALTHCARECENTER	4601PALL MALL ROAD BALTIMORE, MD 21215

(X4)1D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU1.L REGULATORY CR LSC IDENTIFYING IHFORMATION)	ID PREFIX TAG	PROVIDER'S PLANOF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS,REFERENCEOTO THE APPROPRIATE DEFICIENCY)	COLl'L E TIIIH
F 0DD	INITIAL COMMENTS On June 23, 2019 lhrough June 26, 2019, an annual Medicare/Medicaid Recertlftcation Sun,ey was conducled by lhe Office of Heallh Cara Quality. The facility's licensed bed capacity Is 91 and lhe census was 86 al the Ume of lhe survey. Survey activities consisted of a review of medical records. interviews wilh residents, famUles, facility staff and lhe Ombudsman, as well as observations of residents and staff practices. Administrative reports and facility policies and procedures wera reviewed as well. An investigation of seven facility reported incidents: MD00125126, MD00125541, MD00131256. MD00133427. MD00135093, MD00135226, MD00141529 and MD00141262 was also conducted. The following deficiencies are a result or lhls survey:	FOOC	Ibis plan of correction is being prepared and executed isbeing prepared and executed because ii is required by the provisions or the state and federal law, and not because !>lorthwesl Healthcare Center admits or denies he validity or the allegations or citations listed on the pages or the suuement or deficiencies. !,lorthwesl Healthcare Center maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character a.s 10 limit our capacity to render adequate care.	7/30/19
F 550 SS=D	Resident Rlghls/Exercise of Rights CFR(sJ: 483.10(aX1K2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-detennination. and · communication wilh and access to persons and services inside and outside the facility, including those specified In lhis section. §litl:J:10(aK1) A facility musttreal each resident with respect and dignity and care ror each resident in a manner and in an environment lhal promotes maintenance or enhancement of his or her quality or life, recognizing each resident's	F 551		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE ,1 .- J-l, | (X6) DATE 7/12/19

Any deflClency Slalemenl enda,g v.i1h an asterisk (") denolas a delldency which Iha lnsaullon may **be** excused r""" c:anecting Plll'mling *U* ISdetennlnecl lhal alher saleguanSs provide sufficient r,,oleclian la lhe palienls, (See Ins--.)Except ror musing homes, lhe rmcfings slated **above are** disdasallle 911daysrallawi1g lhe date al survey whether *01* nala plan al COffl!Cllon Ispravlded. Far nlllSlng homes, lheabave fim!lngs and plans or canectian an, disclasable 14 days falloY,;ng lhe date lhese documents aoe made avallallfo taIlleradiiy, 11deflclcncies areciled, an a planal COffl!Cllan is n,qulsiteIOconlinued pn,gram palliClpalian.

STATEMENT CF DEFICIENCIES ANDPLAN OF CORRECTION	(X1)PRDVIDERISUPPLIER/CLIA IDENTIFICATIONNUMBER:	IGJ,WRE CONSTRUCTION	bal DATE SURVEY CDMI'I.ETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE. ZJP CODE
NORTHWEST HEALTHCARE CENTER	4801 PALL MALL ROAD BALTIMORE, MD 21215.

IX4110 PREFIX TAG	SUMI.tARY StATEMENT OF DEFfCIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INF0Rt.1ATIQN)	ID PREFIX TAG	PROVIDER'S PINI OF CORRECTION !EACH CORRECTIVE ACTION SHOULD BE CROss-REFERENCEDTO THE APPROPRIATE DEFICIENCV)	C X S J CQIAETIQN
F 550	ConUnued From page 1 Individuality. The facility must protect and promote the rights al the resident. §483.10(aX2) The facility must provide equal access to quality care regardless of diagnosis, severity al condition, ar payment source. A facility must establish and maintain idenUcal paHcles and pracUces regarding transfer, discharge, and the provision al services under the Slate plan for all residents regardless of payment source. §483.10(b) Exercise al Rights. The resident has the right ta exercise his ar her rights as a resident al the facility and as a citizen ar resident of the United Slates. §483.10{bX1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right lo be free of interference, coercion, discrimination, and reprisal from the facility In exercising his or her rights and to be supported by the facility in the exercise of his ar her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on medical record review, interview and observation, ii was determined the facillty staff failed to promote care for residents in an environment that maintains or enhances each resident's dignity and respect in lull recognition or his or her individuality by labeling residents as "feeders· on pasted staffing boards. This occurred on 1 ol 3 nursing units' staffing boards. The findings included:	F55I	Corrective ocllon: The S1affing lisl was com,c1ed and the verbiage removed. Identiry others with potential ID be affected: The adminis1ra1or audi1ed 1he facility nursing s1affing boards 10 ensure that there is no inforrnalion on the boards thal would be undignified or disrespectful of the residents. Measures to prevent reoccurrence: The S1affing Development Educalor reeduca1ed 1he nursing s1alf on protecting the dignity and respecl of a residenlS individW1li1y by no1using undignified labels of residents by proper assignmenl 1itles. Monilorlng of corrective actions for residents affected residents: An audit will be comple1ed by nursing supervisor 10 ensure 1he nursing siaffing boards do not have any undignified labels and pro1ec11he dignily and respect of the residenLs. The audi1 will be compleled weekly X4 1hen mon1hly X2. The results of the audits will be reviewed by lhe QAPI Commiuee for **review and comment.**	7/30/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	CXI) PRDVIDERISUPPLIER/CLIA IDENTIFICATION NUMBER:	IGI',WR.E A -•-e CONSIRUCTION	X31DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	SIREET ADDRESS. CITY. STATE, ZIP CODE
NORTHWEST HEALTHCARE CENTI:R	C&OI PAU. MAil. ROAD BALTIMORE, MD 21215

CX4)1D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREl'IX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD SE CRQSS.REFERENCEDTD THE APPROPRIATE DEFICIENCY)	I)CSJ COIA.E110N DATE
F 550	Continued Fram page 2 On 6-23-19 al8:40AM it was observed on Iha Main floor nursing unll's slaffing board lhe slaff had wrillen on Iha lower righlhand comer Iha word "Feeders.• Undemealh feeders was written [name of slafl) 68 and [name of slafl) 10A. The lwo residents were Identified by lheir room number and lhe name of lhe slaff who was lo assist withlheir meal. "Feeder" is an undignified label meaning a resident is Incapable of ealing by themselves and is dependent onIha nursing slaff to feed lhem. Labeling residents in an undignified manner on staffing boards was confirmed by lh8 Director or Nursing on 6-23-19 al 8:40 AM and Iha Admlnlslralor on 6-23-19 al **8:45** AM.	F 551		7/30/19
F 582 SS=O	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(gK17)(1B)(IHv) §4B3.10(gK17) The facility must- . (ii Inform eaeh Medicaid-eligible residenl, in wriUng. at lhe Ume of admission lo the nursing facility and when the residenl becomes eligible for Medicaid of- (A) The items and services that are inciuded in nursing facility sel'llices under the Slale plan and ror which lhe residenl may nolbe charged; (B) Those olher ilems and services lhat the racilily offers and for which lhe resident may be charged. and lhe amount of charges for lhose sel'llices; and (ii) Inform eachMedicaid-eligible resident when changes are made to lheItems and sel'llices specified in §4B3.1O(g)(17)(1)(A) and **(B)** of lhis seclion.	F582	Corrective action: The resident represenuuive of 1he residen1 #*SO* was con1ac1ed and infonned lllllllhe facility failed 10 provide The Nolice of Non-Medicare Coverage. Identify others wllh potential to be affected: The current residenLs who have used lht:ir Medicare benelil over lhe lasl 60 days will be audi1ed by lhe MDS coordinalor 10 see if anyone w_as idenlilied as requiring a NOMNC and if no nolice was provided lhe re.sidenl or residcnl represenlalive will be no1ilied.	

STATEMENT OF DEFICIENCIES AND Pl.AN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	CONSTRUCTION	IX3) DATE SURVEY COMPLETED
	215348	A -·-a & W1Nn	C 08/28/2019

NAM& 0F PROVIDER OR SUPPLIER	STREET ADIIRESS. CITY, STATE, ZIP CODE
NORTHWEST HEALTHCARE CENTER	4601PALL MALL ROAD BALTIMORE, MD 21215

(X4)10 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PIANOF CORRECTION !EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPL.- DATE
F582	Continued From page 3 §483.10(g){18) The facility must infann each resident before, or at the time or admission, and periodically during Iha residenrs stay, al seivices avallable in the facility and or charges for those services, including any charges for seivlces not covered under Medicare/ Medicaid or by the laclllty's per diem rate. (l) Where changes In coverage ara made ID items and services covered by Medicare and/or by the Medicaid State plan, Iha faclDty must provide notice ID residents ol lhe change as soon asis reasonably possible. (ii) Where changes are made locharges for other items and services that the facility otfers, the facility must inlann the resident inwriting al least 60 days prior ID implementation of Iha change. (iii) If a resident dies orIshospitalized orIs transferred and does nalreturn lo the facility, the facility must refund ta the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the laci6ty's per diem rate. ror Iha days the resident actually resided or reseNed or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv)The faciUty must refund lo theresident or resident representative any and all relUnds due the resident within 30 days from the resident's dale ol discharge from the facility. (v) The lenns or an admission contract by or on behalf ol an Individual seeking admission to Iha facility must not connicl with the requirel!lenls of lhese regulations. This REQUIREMENT Is not met as evidenced by: Based on a review or the facility's Bene ciary Prolecllon Notifications and staff interview It was determined that Iha facility staff laHed lo ensure residents received a nolification or an end ID	FSB:	I\lensures 10 prevent reoccurrence: The Regional Reimbursement Care Coordinator will reeducate the Social Services Director, MOS coordinator and Business office manager on providing the NOMNC a.s per regulatory guidance. Weekly the list of residents withpotential change of coverage or ending of coverage will be reviewed lo monilor if the NOMNC needs to be provided. I\lonltorlng or corrective aetians far residents affected residents: The adminismuor will perfonn a monthly audit ror the next three months of residents who have been using their Medicare benefit, **who are having a cllllnge in coverage, to** monitor for proper no1ifica1ion. The findings or the audits will be presented at QAPI ror **review and commen1.**	7/30/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1J PROVIDER/SUI'PI.IER/CLIA IDENTIFICATION NUMBER:	ItlJ,4IIRE CONSTRUCTION	tx:,1DATE SURVEY CCMPLET'ED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CCDE
NORTHWEST HEALTHCARE CENTER	'601 PALL MALL ROAD BALTIMORE, MD 21215

(X4JID PREFIX TAG	SUMMARY STATEMENT 0F DEFICIENCIES (EACH DEFICIENCY MUSTBE PRECEDED BYFULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S Pl.AN OP CORRECTION (EACH CORRECTIVE ACTION SHDUl.11BE CR0SS-REFERENCEDTO THE APPROPRIATE DEFICIENCY)	I X 5 1 COLA.ETIOJI
F 582	Continued From page 4 Medicare part A coverage (#50). This was evldenl fer 1 cut of the 3 residents reviewed for lha SUJVey's Beneficiary Protection NcUficaUon Review. The findings are: **A** review of Resident #SO's beneficiary p,olecUon notificaUon revealed lhallhe resident's start dale for Medicare Part A services was en August 16, 2018and would end en Oclcber 1, 2018. The review also noted that no ncUfication was provided lo the resident or a representative party (RP). The AdmlnlslraIor was interviewed on 6/26/19 al 8:35 AM. He said they did not give the Notice of Non-Medicare Coverage (NOMNC) la Iha resident The resident did not use up the 100 days of Medicare Part A coverage. The resident went to the hospital prior to this date and the 100 days reset and were available. Administrator said he would call the RP to inform him of lhls lnformaUon.	F58:		7/30/19
F 584 SS=E	Safe/Clean/Comfortable/Homelike Envlronmenl CFR(s): 483.10(1)(1H7) §483.1O(i) Safe Envlronmenl. The residenl has a right lo a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports fer daily IMng safely. The facility must provide• §4B3.10(iX1) A safe, dean, comfortable, and homelike environmenl, allowing the resident to use his or her personal belongings 10 lhe extent possible.	F 58'		

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	215346	B WING	C 06/26/2019

NAME OF PROVIDER OR SUPPUER	STREET ADDRESS. CITY. STATE. ZIP CODE
NORTHWEST EALTHCARECENTER	41D1 PALL MALL ROAD BALTIMORE, MD21215

IX4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROS5-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 5 (ii This Includes ensuring lhat the resident can receive care and services salaly and that the physical layout of the facility maximizes resident independence and does not pose a safely risk. (ii) The facility shall exercise reasonable care !or the protecllon of lhe resident's property from loss or lhefl. §483.10(1K21 Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior, §483.10(i)(3) Clean bed and bath linens lhat are ingood condiUon; §483.10(i)(4) Private closet space Ineach resident room, as specified In §483.90 (el(21(iv); §483.10(il(S) Adequate and comfortable lighting levels in all areas; §483.1O(i)(6) Comfortable and sale temperalure levels. Facililies inilially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(11(7) For lhe maintenance of comfortable sound levels. This REQUIREMENT isnot met esevidenced by: Based on surveyor observaUon and residenl Interviews, It was determfned that lhe facility failed to provide a safe, clean, comfortable and homelike environmenL This deficienl practice has lhe potential ta affect all residants. The findings Include:	F 58<	Corrective octlon: - The debris and food remnanlS in room 3!1 ere immediately cleaned up; the shower room "2 wns scrubbed and the excessive mold-like j)uild up was removed and the hale an the Wllll as patched. - The bathroom in room 12 wa.• cleaned up and ales repaired c. The floors in bolh bathrooms have been •°"placed, cleaned and die pest vendor has onspecced the balhroams. The melal vent an the oor wns repaired. - The dried up liquid an the floor of room 4 \Vlls mopped clean. - The scoined sheelS in room 38 were removed nd senl 10 laundry. And the food remnants on he floor were cleaned. r. The wheelchairs far rooms 3 and 4 have been checked ond fixed. - The !rash an lhe floor of room 20 was picked up. 1. The shower room #2 and roam 38 were bolh leaned and *the* feces were cleaned up. •• The room for resident #4 was thoroughly cleaned.	7/30/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XII PROVIDERISUPPUERICLIA IDENTIFICATION NUMBER.	CONSTRUCTION	X3)DATE SURVEY COMPI.EIED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIPCODE
NORTHWEST HEALTHCARE CENTER	4601PALL MALL ROAD BALTIMORE, MO 21215

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F584	Continued From page 6 inleiviews the following obseivations were made: Al8:42 AM Room 39 bed C was obse,ved to have opened, crumbled cookies and a soft drink cup lidon the noor. The sink in Room 39 had multiple crumbs and dried brown liquid stains on ii. Inspection or downstairs Shower Room #2 revealed excessive mold buildup in the shower and grey cloth bins used lo store wet towels. A hole was obse,ved In the back wall or the Shower and 2 drain mes were seen hovering in lhe shower. Al8:44 AM Room 12 was obseived with holes In the wall. The bathroom in this room had toilet paper and trash discarded on the lloor. Al8:46 AM the two balhrooms adjacent to Shower Room #2 were inspected. The left balhroom was obseived to have loose, wooden noorboards. The toilet In this bathroom was clogged with toHet paper, a Styrofoam **cup and** an orange Juice container. The toilet seat had mulUple dried reces stains. The right bathroom next to Shower Room #2 halbored multiple drain Dies and a strong odor or urine. The white, melal air venl on this door was in disrepair and was **obseived** jutting out an inch from the **door** In one comer. Obseivation or Room 4 *at* 8:48 AM revealed a wheelchair with'tom armrests, a floor with dried liquid spills and dressers that were worn and scraped in mulliple places. lnspecUon of Room 38 at 8:50 AM revealed brown stains on the sheets or bed A, with food crumbs and a half eaten sandwich In an open bag below the bed. Bed C in Room 38 had an	FSS.	Idenlify 0ll1ers wllll polenlial lo be affected: In,e MainIenance supen•isors will complete an l1udil or facility wheelchairs 10 ensure dte anns and leg rest ore in good condilion and function. R.egional EVS direclor will conduct an audit of he buildings, il's walls, Doors, I0ile1S and bowers 10 ensure 1hal: I. No Irash is left behind on the Doors. 2. Toilets are clean J. Showers ore free from excessive mold-like build up. 4. Linens are clean and free from stains *S.* Floors ore mopped and clean and "rec of debris and spills. I\lensures 10 pre,·ent reoccurrence: The slarreducalor will reeducate dte nursing staff, housekeeping and mainlenance s111ff on the process for auditing and reponing equipmeni and snnila1ion issues lhroughoul dte facilily. In oddilion the depanment heads will be provided education on completing leadership round that aids in routine **monitoring or safe and sanitary environment,** facility repair items that may need repair and overall homelike presentation of the facility. Rouline Prevenlalive Mainlenanee tasks will **be** reviewed and completed SX/week by dte Maintenance Direcl0r. Slaff may repon safety and ilems needing repair via our TELS syslem. Random Leadership rounds will be completed weekdays by the IDT 10 monitor for safe, sanitary and home-like environment	7/30/19

STATEMENT OF DEFICIENCIES AND Pl.AN OF CORRECTION	CX1) PROVIOERISUPPIJER/CLIA IDENTIFICATION NUMBER:	ltf>WRE A -•--:: B WING	CONSTRUCTION	II3)0ATE SURVEY CCMPLETEO
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS. CIIY. STATE. ZIP CODE
NORTHWEST HEALTHCARE CENTER	4601PALL MALL ROAD BALTIMORE, MD 21215

IX4)10 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH OEFICIENCV MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	10 PREFIX TAG	PROVIDER,; PIAN OF CORRECTION CEACH CORRECTIVE AC110N SHOULD BE CROSS•REFERENCEO TOIHE APPROPRIATE DEFICIENCY)	CXOI CQWI.ETIDN DATE
F 584	Continued From page 7 uneaten open sandwich on the Roor along wilh drink lids and plastic trash. At 9:03 AM Room 3 bed A's wheelchair was observed with tom foot supports. lnspecUon ofRoom 20 al 11:16 AM revealed lrash on the floor and a rip in the room's Chair. On 6/26/2019 at 8:21 AM the right side balhroom, in between Shower Room #2 and Room 38, was observed to have multiple feces stains on the toilet seal The toilet was backed up with toilet paper and approximately 15 drain flies were hovering and landing on the feces found on the toilet. The Adminis!rator and Director of Nuising were made awan, of lhese findings on 6/2612019 during lhe axil conference. 2. On 6-24-19 at 9:53 AM It was observed that Resident #4's bedroom an,a of the three peison room had dirty clolhes piled on the floor on lhe left side of the bed. The dolhes had used plastic spoons on top as well as used straws and food wrappers. The bedside Chesl had abroken drawer wilh assorted ilems duttered on lop. The bed had a large brown stain on lhe bedpad, wadded up sheets and lhe smell of ammonia. The smell bolhen,d Resident #72, who also resided inlhe room and the third resident was unable to verbally communicate. The observation was confirmed by the Director of Nursing on 06/24/19 12:03 PM.		Monitoring of corrective nclions for residents nffected residents: The Preven1alive Maintenance nudits by the lvlaintenance Director as well ns n1erdisciplinlll}'Team leadeiship round udits will be reviewed biweekly x 2 then Monthly x2 by the Quality assUl"llllce nurse for ,,rends and areas of opponunily. The findings)of the audiL• will be presented al QAPI for the tnext 90 days for review and commenL)!.egional EVS Direclor will conduct an audit bi !weekly x2 nnd then a monthly audit x 2 of one µnil per audit to audit the walls, Doors, toilets jmd shower rooms in order lo ensure that these re clean, free of debris, and are in a home-like-nvironment slate. The resuhs of these audits ovill be presented at QAPI for review and omment.	7/30/19
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1)	F60		

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NORTHWl!STHEALTHCARECENTER	4I01 PALL MALL **ROAD** BALTIMORE, MD 21215

()C,4)1D PREFIX TAG	SUMl,tARY STATEMENT 01' DI!I'ICIENCIES IEACH DEFICQ:NCV UUST **Bl! f'ft!C!OI!D** BV FUU. REGULATORY OR l.SC IDENTIFYING INFCRMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORAECTDl IEACH CCRRECnYE ACTION SHCUID BE CIUJss-AEfER£NCEDTO THE APPROPRIATE DEFICIENCY)	IQJ **COWl.lffl0N** Dan!
F 600	Continued From page 8 §483.12 Freedom from Abuse, Neglect, and ExploitaUon The resident has the right to be rree from abuse, neglect, misappRJprlallon of resident property, and exploitation as derined In this subpart. This iu:ludes but is not limited to freedom from corporal punishment, lnvcluntary seclusion and Btly physical or chemical restraint not required IO ltealOle resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, menlal, sexual, or physical abuse, corporal punishment, or involuntary seclusion: This REQUIREMENT Isnot met **asevidenced** by: Based on facility invesllgaUon, medical recant review, and facility slaff end resident Interviews. it was detennined !hat the facility failed toprevent enincident or verbal abuse. This was evident for 1 *ol* 1 residenlS (Resident #72) reviewed for verbal abuse during annual survey. The findings Include: Resident #72 was admitted to lhe facibly **orllllllll** Resident #72 had a history orusing prafanlly and was can, planned for vmbally abusing the Facility staff. On 6-5-19, Stalf#J requested Resident #72 move r,orp another resident's doorway as lhe resident was sleeping. Resident #72, who was facelimlng on hl!lher phone, was speaking loudly and had the phone's volume on high, The person on lhe phone wilh Resident #72 overheard Staff#3's request and began shouting at Staff #3 and then Resident #72 **began shoulrlg** at Staff #3. Staff #3lhen stated to	F60(]	Corrective ortion: The verbal abuse to Resident 11-72 had alrendy occum.-d. The Social Worker evaluated re!lident and detennine no adverse effect to the n:sidenL S1aff # J no longer is employed 111 facilily. ldcmtiry olllen ,vlth potenrial 10 **11ffectl'd:** Current n:sident11 h:ive the potentinl to be alTecled. The current residents deemed interviewable ae intenicwed related to possibility ofabuse. Identified is.11ues will be investig111ed nnd n:poned as necessary. Non lntel'•iewable residenLo; while have their RP:Guardian con1actcd to validate if there an: any poten1ial concerns related 10 abuse. **1eiisarestupttventreoecurrenre:** Staff development coordina1or will provide education 10 current staff on 1he definition :ind prevention ofabuse. New Hin:s will have their background checked for potential previous :ibuse complainlll. Annually and upon hire slllfT arc provided education on the abuse reponing, in\'CStigation and monitoring systems. Monthly during leadenihip roundll intmiewabJe midents will be in1erviewed as to any repons of abuse nnd staff will remind them orlhe nei:d to repon to stDff, should lhey feel they may h;we been abused. During the nexl Residem Council meeting the residents will be reminded that The Ombudsman, OHCQ and complaint line phone numbers are posted rhroughout the faci1i1y. Weekdays 1hc Social Service Director will review grievance log for potential arens of abuse. ldenlified areas will immediately be reponed to the Slate :is required.	7/30/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1)PROVIDER/SUPPLIER/ClIA IDENTIFICATION NUMBER:	CONSTRUCTION A •• r.	) DATE SURVEY COMPLETED
	215348	B WING	C 08/28/2019

NAME OF PROVIDER OR SUPPL[ER	STREET ADDRESS, CITY, STATE. ZIPCDDE
NORTHWEST HEALTHCARE CENTER	4601PALL MALL **ROAD** **BALTIMORE, MD** 21215

IX4)ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFIOENCY MUST BE PRECEDED BY FULL REGU1.ATOAY OR LSCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCEDTD THE APPROPRIATE DEFICIENCY»	(JC$) CGIFll!110N DATE
F600	Continued From page 9 the person on the phone "we can meet out onlha slreet" and retumed the verbal alten:alion yelUng at both the person onlhe phone and Resident #72. The other facility Slaff present removed Slaff #3 and while slartfng anInvestigation;Resident #72 called lhe police. When lhe polial arrivedlha officer told Resident #72 lo lake his/her concerns 10 racilily managemenl. Slaff #3 left and has never relumed to lha facilily. Interview wllh Resldenl #72 on 6-24-19 at 9:50 AM revealed, "I had words with Slaff #3 and ii is laken care of now.• When asked howlt was taken care of Resident #72 staled [Slaff#3] is no longer here. I have no more concerns wllh lhe facilily. The lacilily investigated the Incident prompUy, police notified, Office of Health Care Qualily notified and Slaff #3 was reported to lhelr respective licensing board. Slaff #3 never returned to lhe facifity. The above verbal abuse by facilily staff was confirmed by lhe AdmlnislraloronG-24-19 at **10:00AM.**	**F 601**	**Monitoring or corrective nclions ror residents nrrecred residents:** The social worker will complete a biweekly x2 and !hen monthly x2 oudir of grievance logs and selheports ofalleged abuse lo ensure thal lhc facility is following up on possible incidenlS of abuse. The findings of lhe audil will be prcsenled nt QAPI for review and comment.	**•/30/19**
F 697 55=0	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility musl ensure that pain management is provided lo residents who require such services, consislent with professional slandards of practice, the comprehensive person-centered care plan, and lha residenls' goals and preferences. This REQUIREMENT is nol met as **evidenced by:** **Based** on a review or lhe clinical records and	**F697**	**Corrective oellon:** Residenl # 52 was assessed for pain management and the Record will be provided a lale enlry for adminisll'lltion of lhe Oxycodone on 6111/19 and 6/20/19. The Nurse could no1recall !he pain score assessment so documentation could nol be enlercd as a lale entry.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDERISUPPI.IER/CLIA IDENTIFICATIONNUMBER:	eo,.t.lJR.E A –-–, CONSTRUCTION	IX3)DATE SURVEY COMPLETED
	215348	B WIN"'	C 08/26/1019

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NORTHWEST HEALTHCARE CENTER	4&01 PALL MALL ROAD BALTIMORE, MD 21215

(X4)1D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED aVFULL REGULATORY' OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS Pl.AN OF CORRECTION (EACH CORRECTNE ACTION SHOULD BE CROss.REFERENCEDTDTHEAPPROPRIATE DEFICIENCY)	(ICS) CO'"'"'·EIIDN DATE
F697	Continued Fram page 10 slaff Interview it was detennlned lhat lhe facility slaff failed to document lhe administered of pain medication and monllor lhe effectiveness. This was true for 1 out of lhe 31 reslden ls (Resident #52) reviewed for pain management during lhe annual recertification survey. The findings Include: Medical record review of Resident #52's clinical record revealed on 06/24/19 lhe resident's primary physician ordered: Oxycodone IR 10 mg tablets 2 mg by moulh every 4 hours as needed for pain. Oxycodone is an **opioid** medication used to treat moderate lo severe pain. Medical record review revealed lhe facility staff failed to document the administration of Oxycodone. Review of the Individual Naraillc Record revealed that Oxycodone was removed from the supply box on 06/11/19 and 06/20/19. Interview with lhe Director of Nursing on 6124/19 al 11:DD AM confinned lhe facility staff faHed to thoroughly assess lhe need for pain medication for Resident #52 and document lhe administration of a strong narcotic.	F691	Identify orhers wllh porenllnl to be nffecred: An audir \Viii be completed by the nllllling supervisor of current residenlS receiving pain medications 10 ensure the adminisrrntion of the medication and assess the need for the medications are being documented. Interventions and Core plans updated os needed. Measures to prevent reoeeurrenee: Charge nurses ,viii be provided education by the Siaff Development Director on the documenlation of administrnrion ond evaluation of Pain. Director of Nursing \Viii monitor pain management via the *S* V\Yeek clinical meeting and follo\Y up as needed. ResidenlS **will hilve a pain evaluation on admission,** readmission ond change of condition i\lonlloring ofcorreclive actions for residents offecled residenls: The Din:ctor of Nursing will audit *S* residenlS narcotic administration records for documentation of pain medication administration ond monitoring of effectiveness. This audit will be compleled doily x5 for 4 weeks and monthly x 2• The lindings of lhe audits \Viii be presented or QAPI for the next 90 days for review and **comment**	7/30/19
F 761 SScE	LabeUStore Drugs and Biologicals CFR(s): 483.45(gXh)(1K2) §483.45(9) Labeling of Drugs and Biologicals Drugs and biologicals used in lhe facility must be labeled in accordance with currently accepted professional principles, and include lhe appropriate accessory and cautionary instructions, andlhe expiration date when applicable.	F761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1)PROVIDERISUPP&.IERICLIA IDENTIFICATION NUMBER:	CONSTRUCTION	X3) DAI& SURVEY COMPLETED
	215346	A ---- B WING	C 06126/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE.ZIP CODE
NORTHWEST HEALTHCARE CENTER	4601 PALL MALL ROAD BALTIMORE, MD 21215

(X4)1D PREFIX TAG	SUt.11.tARV STATEI.(ENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATIQN)	ID PREFIX TAG	PROVIDER'S PLAN CF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROS5-REFEAENCEDTO THE APPROPRIATE DEFICIENCY)	tll5) COMPLETION DATE
f 761	Continued From page 11 §4B3.45(h) Storage of DNgs and Blologlcals §483.45(hM1) In accordance wilh State and Federal laws, lhe facility must slore all dNgs and biologicals in locked compartments under proper lemperalure controls, and pennil only authorized personnel lo have access lo lhe keys. §483.45(hX2) The facility must provide separately locked, permanenUy aff,xed compartmenls for storage of conlrolled dNgs listed in Schedule II of lhe Comprehensive DNg Abuse Pl8venlion and Conlrol Act of 1976 and olherdNgs subject lo abuse, except when the facillly usas single unit package dNg distribution systems in which lhe quantily stored is minimal **and a** missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and slalf Interview ii was delennined that lhe facility failed lo ensure medication carts were kepi secure, and medications thoroughly labeled wilh residents' name, and dated when lhe medication was open. This was evidenl during 1 of 2 medication administration reviews and for 2 of 4 medication carts observed during lhe aMual survey process. The findings are: 1)Surveyor observed a medication administration on 6/24119. Aller Slalf#6 administered mecficalion ii was observed at 8:32 AM that lite drawer conlalning controlled subslances was partially out rrom lhe medication cart.The drawer was pulled and lite staff member shown lhal even !hough lhe cart was locked, lhe drawer could still be pulled out. Slaff #6 acknowledged lhat ii should have been dosed and pushed Iha drawer	F761	**Corrective action:** The Cans were secured once ideniified. The unlabeled, undated medications were discarded. lden1lry olhers with polenllol 10 be offected: The Director or Nursing will audit the **medication carts to ensure for proper secure** capabili1y, medications labeled properly and proper handling for opening dates or medications or biologicals reflected when **necessary.** Measures to prevent reoccurrence: StulT Development Educa1or will provide reeducation 10 the licensed nurses related to their responsibility ror the securing or the medication and 1rea1men1 cans. The policy ror proper dating and labeling or medications will also be reviewed with the licensed nurses. Monitoring of corrective octlons for r.-sidenlS affected residents: Weekly the Unit Monagersldesignee will **audit the medication cons for security,** medications being labeled appropriately with residents name and dated os appropriate. This audit will be completed biweekly x 2 then monthly xl. The lindings ohhe audits will be brought 10 QAPI ror review ond comment.	7/30/19

STATEMENT OF DEFICIENCIcS AND PLAN OF CORRECTION	(XI) PROVIDERISIJPPI.IERJCI.IA IDENTIFICATIONNUMBER:	icr,wRE A a,...., CONSTRUCTION	I)CI) DATE SURVEY C01,IPLE1E0
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NAME OF PROVIDER OR 5UPPLIEA	SIREET ADDRESS. CITY, STATE. ZIPCODE
NORTHWEST HEALTHCARE CENTER	4GG1 PALL MALLROAD **BALTIMORE,MD21215**

(X4)1D PREFIX TAG	SUMMARY STATEMENT OFDEFICIENCIES (EACH DEFICIENCY' MUST BE PRECEDED BY FULL REGULATORY 0A LSC IDENTIFYING INFORMATION)	m PREFIX TAG	PROVIDER'S PIAN OF CORRECTION IEACH CCIRA£cnvE ACT10N SHOULD BE _,ERENCED T011<E APPROPRIATE DEFICIENCY)	cauunan DATE
F 761	Continued From page 12 shut The conlrolled substance drawer has a separate locked compartment that was still lacked but such drawers are lo be secured wllh two separale locks. The Administrator was lnlerw,wed on 6/24/19 and he said he understaad lhe findings. 2) Observation of lha medicaUon carts end treatment carts an 06/24/19 at 08:38 AM revealed lhe following: 1. Artificial lears had no dale loindicate when II was opened an Trealment Cart #1 on main hall. Artificial tears are eyedrops used to lubricate dry eyes and help malnlaln moisture an lhe outer surface of lhe eyes. 2. Timolol eye drops had no date to indicate when it was opened on Treatment Cart #1 on main hall. Tlmolol eye drops medlcaUon Is used lo treat high pressure inside lhe eye due to glaucoma. 3. Lanius insulin had no date ta indicate when It was opened on Treatment Cart #1 an main hall. Insulin is a hormone lhat works by lowering levels al glucose (sugar) In the blood. 4. Lalanoprost eye drops had no date lo Indicate when It was opened on Treatment Cart #1 an main hall.LalanDprost is used to treat high pressure inside lhe eye due toglaucoma. 5. Brea Ellipla had no date to indicate when It was opened an Treatment Cart #1 on main hall. Breo Ellipta is a prescripUon medicine used to treat chronic obstructive pulmonary disease (COPO) and aslhma in adults.	F761		1/30/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	IX1) PROVIDERISUPPUERICLIA IDENTIFICATION NUMBER:	CONSTRUCTION	k:11 DATE SURVEY CDMPLETED
	215346		C D6/26/2D19

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHWEST HEALTHCARE CENTER	4601PALL MALL **ROAD** **BALTIMORE, MD** 21215

(X4)1D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATIONJ	ID TAO	PROVIDER'S PINI 0f CORRECTION (EACH CORRECTIVE ACTION SHDUI.D BE CROSs-REA!RENCEDTDTHE APPROPRIATE DEFICIENCY)	11<51 COIA.E110N DATE
F 761	Continued From page 13 6. Genlamicin vial had no dale lo indicate when it was opened on Treatment Cart #2 on main hall. Gentamlcin injection is used to prevent or treat a wide variety of bacterial infecUons. 7. Prezista tablets had no date lo Indicate when it was opened on Treatment Cart #2 on main hall. Prezista is used 10 treat HIV. 8. Symbicort Inhaler had no date lo indicate when It was opened on Treatment Cart #2 on main hall. Symblcort is a medicine for the treatment of asthma and COPD. 9. Lithium boWe had no dale to indicate when it was opened on Treatment Cart #2 on main hall. Lithium isused lo treat the manic episodes of bipolar disorder (manic depression). Interview with the Director of Nursing on 06/24/19 08:38 AM confinned the facility staff faHed to ensure medications were thoroughly labeled with residents' name and dated indicating when they were opened.	F761		7/30/19
F 812 SS=D	Food Procuremenl,Slore/Prepare/Serve-Sanitary CFR(s): 483.60(i)(11(2) §483.60(i) Food safety requirements. The facmty must - §483.60(i)(1) • Procure food from sources approved or conSidered satisfactory by federal, stale or local authorities. (i) This may lndude food items obtained dlreclly from local producers, subject lo applicable Stale and local laws or regulations. (Ii) This provision does not prohlbil or prevent	F 81:		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XO PROVIDERISUPPUERICLIA IDENTIFICATION NUMBER:	l(f,UIRE CONSTRUCTION A ----:	JC3)DATE SURVEY COMPLETED
	215346	B WING	C 08/26/2019

NAME OF PROVIDER DR SUPPLIER	S1REET ADDRESS, CITY, STATE. ZIP CODE
NORTHWEST HEALTHCARE CENTER	4&01 PALL MALL ROAD **BALTIMORE, MD** 21215

IX4)1D PREFIX TAG	SU1,1MARV STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY' OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S Pl.AN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS,REFERENCEO10THE APPROPRIATE DEFICIENCY)	(I I S J ca'" -ETIIIN
F 812	Continued From page 14 facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (Iii) This provision does not preclude residents from consuming roods not procured by the facility. §483.60(11(2) • Store, prepare, distribute and serve food in accordance with professional standards for food service safely. This REQUIREMENT Is not met as evidenced by: Based on obse111auon of the facility's kitchen, ii was determined lhal food service employees failed to ensure that sanitary practices were followed, and equipment was maintained in order lo reduce the risk of foodbome illness. This deficient practice has the potential to affect all residents. The findings include: On 6/23119 at 8:26 AM, a tour oflha facility's kitchen was conducted and revealed the following: In the room being used 10 slore chemicals a cart containing uneaten, uncovered food was observed with drain flies circling around It. This room had plaslic trash, drink lids and food wrappers discarded on the ground. The drywall under the shelving which housed cleaning chemicals was absented In disrepair. At 8:32 AM the facility's refrigerators were inspected and revealed a dead fly on the bottom metal tray of lhe Victory freezer. The bottom of the True refrigerator was found to have ala,ge puddle of spilled milk. Inspection of the Traulsen refrigerator revealed unlabeled, undated	F 81:	**Correcri,·e action:** The refrigerator was cleaned and unlobeled and undated food ilems were removed. Chemical storage room was cleaned and the wall was repaired. Ceiling tile in dry storage room was fixed. Light bulb in fume hood was replaced and ice machine was cleaned. Identif>· others wllh potential to be affected: The dietary manager will audit the kitchen to ensure sanitary practices are being followed and audit the equipment to ensure Ibey are mainlained in order. Measures lo prevent reoccurrenee: -he Regional Dietary manager will reeducate he dietary staff on ensuring sanitary practices ore being followed and that equipment is naintained in order. Monitoring of corrective actions for rosldents affected rosldents: trhe Dietary Manager will perform a bi weekly audit x 2 and then monthly xl of the kitchen 10 nsure sanitary conditions and that lhe F'luipment is mainlained in order. Finding of the oudits will be brought to QAPI for review and **li:omment**	7/30/19

STATEMENT OF OEFICIENCIES AND PLANOF CORRECTION	(KI)PROVIDERISUPPLIER/CLIA IDENTIFICATION NUMBER:	CONSTRUCTION	113) DATE SURVEY CONPLETED
	215348	A---------; a wm-	C 08/28/2019

NAME OFPROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE. ZIP c;ooe
NORTHWEST HEALTHCARE CENTER	4&01PALL MALL ROAD BALTIMORE, MD 21215

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F812	Continued From page 15 conlalners of jelly, applesauce and sliced cheese. Al8:36 AM the kitchen Ice machine was observed with stains and spills on the outside cover and dark mold growth beginning to slick to lhe inside where ice Is produced. At 8:37 AM inspection of the dry goods storage room revealed a makeshift ceiling tile hanging down in disrepair. An 8:38 AM inspection of the facility's fume hood revealed a nonfunctioning light bulb on the left side of the hood. These findings were reviewed with the Administrator and Director of Nursing on 6126/2019 during lha eicit conference.	F 81,		'/30/19
F 923 SS=C	Venlilation CFR(s): 483.90(1)(2) §483.90(1X2) Have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two. This REQUIREMENT is not met as evidenced by: Based on surveyor observation, ft was determined that the facility failed to have adequate ventilation lo ensure **good** air cin:ulation. This was evident for both floors of the facility affecllng all residents, slaff and visitors. The findings Include: On 6123/2019 al 8:30 AM surveyors **entared and** began and initial tour of the facility. Immediately upon entering the building, a distinct smell of ammonia and feces was obseived by all	**F92:**	Corr.. tlve action: The vents in the downstairs bathroom adjacent 10 room 39 were repaired 10 facilitate adequate oir Dow. The vents on the unit were checked to ensure air Dow and good circulation. Identify others with potenllal to be affected: The Maintenance Director will complete an audit of the air vents to ensure adequate **ventilation to ensure good air circululion.**	

STATEMENT OF DEFICIENCIES AND PLAN CF CORRECTION	(XI) PROV1-.UPPLIER/CLIA IDENTIF&CATION NUMBER:	CONSTRUCTION	113) DATE SURVEY COMPLETED
	215348	A ... , B \\fINt:	C 08/28/2019

NAME OFPROVIDER OR SUPPLIER	STREET ADDRESS. CITY, STATE. ZIPC00E
NORTHWEST HEALTHCARE CENTER	4&01PALL MALL ROAD BALTIMORE, MD 21215

(X4)1D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EAOIDEFICIENCY MUST BE PRECEDED BY FULL REGUI.ATORY OR 1.SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	CIIIfil!TIIIN DATE
F923	ConUnued From **page 16** surveyors and was persistent lhroughout both flDOIS (Ground and 1st) of lhe facilily. Al8:46 AM the exhaust vents In two downstairs bathrooms adjacent to Room 39 were observed to have na detectable airflow. On 612512019 at 8:26 AM ii was noted that a clear smell of ammonia remained present on the top floor of the facllily in the main and resident hallways. The Administrator was made aware of these findings on 6/26/2019 during lhe exit conference.	F92,	Measures to prevenl reoccurrence: The Mainlenance direclor will be reeduca1ed by 1he Adminis1ra1or on ensuring <he facilil)' vents arc properly functioning. An audil tool has been **added** to Tels prevenlive maintenance system 10 idenliry air vents that may need to be repaired. Mnniloring orcorrective actions ror residents affected residents: The Maintenance Director will perform a for the nex13 months 10 ensure adequate ven1ilation lo ensure good air circulation. The findings of lhe audits will be presented at QAPI for1hc next 90 days for review and comment.	7/30/19

Office or Health Care Qualit

STATEMENT OFDEFICIENCIES ANDPLAN OF CORRECTION	(XI) PROVIDERISUPPLIERICLIA IDENTIFICATIOH NUMBER:	(X2) MULTIPI.E C0NSTRUCTION A. BUILDING:	[)13) DATE SURVEY COMPLETED
	215348	I• ·••-·-	C 06/2812019

NAME CF PROVIDER OR SUPPLIER	STREET ADDRESS. CITY. STATE, ZIP CODE
NOR1HWESTHEALTHCARECENTER	**4801 PALL** MALLROAD **BALTIMORE, MD** 21219

(X4)1D PREFIX TAG	SUMMARY STATEMENT OF OEFICIENCIES (EAOI DEFICIENCY MUST BE PRECEDED SY FULL REGULATORY OR LSC IDEN'nFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCEDTO THE APPROPRIATE DEFICIENCY)	(X5) COIRETE DA1E
S 004	Initial comments On June 23, 2019 through June 26, 2019, an annual Medicare/MedicaidRecertification Survey was conducted by the Office or Heallh Care Quality. The facility's licensed bed capacity Is 91 and the census was 86 at the time or the survey. Survey activities consisted or a review or medical records, Interviews with residents, famines, facility staff and the Ombudsman, as well as observations of residents and staff pracUces. Administrative repons and facifity policies and procedures were reviewed as well. An investigation or seven racillty reported Incidents: MD00125126, MD00125541, MD00131256, MD00133427, M000135093, MD00135226, MD00141529 and M000141262 was also conducted. The following deficiencies are a result or this survey: •	SOOD		7/30/19
S 51:	10.07.02.12 R Nsg Svcs: Charge Nurse Dally Rounds .12 Nursing SetVices. R. Charge Nurses' Dally Rounds. The charge nurse or nurses shall make dally rounds to an nursing units for which responsible, perfonning such funclions as: (1) Visiting each patient: (2)Reviewing cllnlcal records, medication orders, pallent care plans, and staff assignments: (3)To the degree possible, accompanying physicians when visiting patients.	S 512		

OHCQ
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Office of Heallh Care Qualit

STATEMENT OF DEFIQENCIES ANDPLAN OF CORRECTION	(lit)PROVIDERISUPl'I.IERICUA IDENTIFICATION NUMBER:	(X2)MULTIPLE CONS1RUCTION A.BUILDING:	X3)DATESURVEY COMPLETED
	215346		C 06/26/2019

NAME OFPROVIDER OR SUPPLIER	STREET ADDRESS, Cl]V, STATE. ZIPCODE
NORTHWEST HEALTHCARE **CENTER**	•&01PALL MALL ROAD BALTIMORE, MD 21215

(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 PIAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROS!i-REFERENCEO TO THE APPROPRIA'll! DEFICIENCY)	CXSJ COMP U!IE
S 51:	Continued Fram **page** 1 This Regulalian is nat met **as evidenced** by: Refer to CMS 2567 F697 and F761	S512	D)ease reference F 697 01ease reference F 761	7/30/19
S 931	10.07.02.15 C(1l(k) Phann Svea; Sched II drugs storage .15 Phannaceutical Services. C.Duties of Phannaceutical Services Commillee. Unless the Department decides that semiannual meetings are appropriate, the cammiltee shall meet al least quarterly to: (1) Establish policies and procedures which shaD Include, at least, statements which assure that: (k) Schedule II drugs shall be kept in separately tocked, securely fixed baxas or drawers In the storage area, under two locks. The tock an the door of a medication room shall be counted as one al the two lacks. This Regulation Isnot met as evidenced by: Reier lo CMS 2567, F761	S930	Please reference F 761	
S1247	10.07.02.26 R Physical Plant Req;Alr Conditioning .26 Physical Plant General Requirements. Unless otherwise Indicated, all general requirements apply to bath new construclian and existing factlities.	S1247		

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STATEMENT OF DEFICIENCIES ANDPLAN CF CCRRECTION	(XIIPROVdlER/SUPI'LIERICLIA IDENTIRCATION NUMBER:	(X2) MU1I 1PUi CONSTRUCTION A. BUILDING:	lC!I DATE SURVEY COMPI.EIED
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NAME OF PROVIDER OR SUPI'I.IER	5IREET ADDRESS. CITY, SfATE, ZIP CODE
NORTHWEST HEALTHCARE CENTER	4601PALL MALL **ROAD** BALTIMORE, MD 2121S

(X411D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC ID&NTIFYING INFORMAT«JN)	ID PREFIX TAG	PROIIIDER'S Pt.AN 0F CORAEC1ION (EACH CORRECTIVE ACTION SHOULD BE CROSIWIEFERENCED TO THE APPROPRIATE DEFICIENCY)	CO I F I. EIE
S1247	ConUnued From page 2 R.PJr Conditioning. PJI new faciliUes shall be equipped with a properly mainlained air conditioning system capable of malnlainlng 75' throughout the patients' section of thebuilding. The system shall be Incompliance with ASHRAE and NFPA Code and aD Slate and local codes. This Regulation is not met as evidenced by: Refer ID CMS 2567, F923	S1247	lease reference F 923	'/30/19
S1652	1D.07.02.34 B(1)Hskpgpestctrt, laundry;cleanliness .34 Housekeeping Senrices, Pest Control, and Laundry. **B.** Cleanliness and Maintenance. The following shall be observed: (1) The building and all Its parts and faciliUes shall be kepi In good repair, neal and attractive. The safety and comfort of the paUenls shall be the first consideration. Agency Note: Refer ID Regulation .26S of lhis chapter for window screening re lremenls. This Regulation Is not met as evidenced by: Refer to CMS 2567,	S1652		

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STATEMENT OF DEFICIENCIES AND PI.AN Of COUIECTIDN	ex,I PROVIDER/SUPPLIERICLIA IDENTIFICATION NUMBER:	(X2)MULTIPLE CONS1RUCTION A.DIIILD!NG·	lltl) DATE SURVEY COMPLETI!D
	215346		C 06/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE. ZIPCODE
NORTHWEST HEAL.TIICARE CENTER	C&DI PALL MALL ROAD BALTIMORE, MD 21215

(XA)ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FLJIL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OFCORRECTION (EACH CORRECTIVE Ac:noN SHOUI.O BE CROSS-REFERENCED T01HE APPROPRIATE DEFICIENCY)	COIR E TE
S165	Continued From page 3 F584	S1652	Please reference F 584	7/30/19
S5082	10.07.09.06 G Adm Conllacl;mad eligibility for MA .06 Admission Contract Required. G. An admission conllact used by a carllfiad Medicaid provider shall infonn the applicant, through a ronn established by the Department, that medical eligibility Is a requirement for Medical Assistance, and that Iha applicant should learn if the applicant meets the Medicaid eligibility requirement at the time or admission. This Regulation Is not met as evidenced by: Rerer to CMS 2567, F582	S5082	Please reference F 582	
S5091	10.07.09.0S C(3) Righi to dignified existence .0e Resident's Rights and Services. C. A re&ldent has the right to: (3) A dignified existence, selr-detennlnatlon, and communication with and access to indMduals and setvices ln&lde and outside Iha nursing racllity; This Regulation Is not met as evidenced by: Rerer to CMS 2567, F550	S5087	lease reference F *550*	

Office of Health Cara Qualit

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XII PROVIDER/SUPPUERICUA . IDENTIFICATION NUMBER:	CX2) MULTIPLE CONSTRUCTION A.BWLDING:	X31DATE SURVEY COM!'LE1ED
	215341		C 08/2812019

NAME OF PROVIDER OR SUPPUER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHWEST HEALTHCARE CENTER	U01 PALL MALL ROAD BALTIMORE, MD 21215

(X411D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY .. usr BE PRECEDED BY FULL REGULATORY DR LSC IDENTIfVING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLANOF CORRECTION (EACHCORRECTIVE ACTION SHOULD BE CROSS-REFERENCEDTOTHE APPROPRIATE DEFICIENCY)	(I<S) COMPLETE DATE
S600	Continued From page 4	S6000		7/30/19
S600	10.07.09.08 C (5) Right to freedom from abuse .08 Resident's Rights and Services. C. A resident has the right to: (5) Be free from: (a) Physical abuse; (bl Verbal abuse; (c) Sexual abuse; (d) Physical or chemical restraints Imposed for purposes of discipline or convenience; (e) Mental abuse; and (l) Involuntary seclusion; This Regulation Is not met as evidenced by: Refer lo CMS 2567, F600	56000	Please reference F 600	
56647	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. Al all times: (1) Food Is: (a) Not adulterated; and **(b)** Protected from contamination during slorage, preparaUon, display, service, and lransportation; (2) The intemal temperature of a food Is maintained according to the requirements or this	56647		

Office of Health Cara Qualit

STATEMENT DP DEPICIENCIES AND PIAN DF C0RR£CTIDN	(XI) PROVIDER/SUPPLIER/CUA IDENfIFICATIDN NUMBER:	pc!) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	21534&	A. **BUILDINr..:** - ------	C 08/26/2019

NAME *OF* PROVIDER DR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHWEST HEALTHCARE CENTER	4&01PALL MALL **ROAD** **BALTIMORE, MD** 21215

(X4)1D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH OEFICIENCY MUST BE PRECEDED BY FULL REGULATORY QR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PRD\IIDER'S PIAN DF CORRECTION IEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED**TO THE APPROPRIATE** DEFICIENCY)	lll 5 1
S6647	Continued Fram **page** 5 chapter to preclude the growth of pathogenic bacleria and Dlher mlcranrganlsms that could cause spoilage; (3) Except during necessary periods of preparation and seivlce, apotentially hazardous food Isrefrigerated or held hot as set forth in §8(7) of this regulation; This Regulation ls not met as evidenced by: Refer ID CMS 2567, F812	S6647	Please reference F 812	7/30/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215346	A. BUILDING _____ B. WING _____	R-C 07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHWEST HEALTHCARE CENTER	**4601 PALL MALL ROAD BALTIMORE, MD 21215**

(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 July 30, 2019 an off-site survey was conducted to review the facility's plan of correction for deficiencies that were cited during the survey ending June 26, 2019. Survey activities included the review of the facility's plan of correction and credible evidence. Effective July 30, 2019, the facility was determined to be in compliance with the requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities.	{F 000}		

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.

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
	215346	A. BUILDING: _____ B. WING _____	R 07/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHWEST HEALTHCARE CENTER	**4601 PALL MALL ROAD BALTIMORE, MD 21215**

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215346	A. BUILDING _____ B. WING _____	07/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHWEST HEALTHCARE CENTER	**4601 PALL MALL ROAD BALTIMORE, MD 21215**

(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
E 000	Initial Comments A COVID-19 Focused Emergency Preparedness Survey was conducted by the Office of Health Care Quality as part of the Focused Infection Control Survey at this facility on 7/30/2020 and 7/31/2020. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6).	E 000		

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	215346	A. BUILDING _____ B. WING _____	07/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHWEST HEALTHCARE CENTER	**4601 PALL MALL ROAD BALTIMORE, MD 21215**

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F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was conducted at this facility on 7/30/20 and 7/31/20, by the Office of Health Care Quality. Surveyors conducted onsite survey activities on 7/30/20. The licensed bed capacity for this facility is 91, the resident census at the start of the survey was 88, and there were 5 residents included in the sample. Survey activities consisted of a review of medical records, facility documentation, interviews with residents, staff, family members, and observations of resident and staff practices. Administrative reports and facility policies and procedures were also reviewed. The facility was found to be in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. COVID-19 (Coronavirus Disease 2019), is a disease caused by the coronavirus SARS-CoV-2. COVID-19 spreads from person to person, mainly through respiratory droplets produced when an infected person coughs or sneezes.	F 000		

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Office of Health Care Quality

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHWEST HEALTHCARE CENTER	4601 PALL MALL ROAD BALTIMORE, MD 21215

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	215346	A. BUILDING _____ B. WING _____	R-C 09/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHWEST HEALTHCARE CENTER	**4601 PALL MALL ROAD BALTIMORE, MD 21215**

(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 September 9, 2019 an off-site survey was conducted to review the facility's plan of correction for deficiencies that were cited during the survey ending August 1, 2019. Survey activities included the review of the facility's plan of correction and credible evidence. Effective September 9, 2019, the facility was determined to be in compliance with the requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities.	{F 000}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHWEST HEALTHCARE CENTER	4601 PALL MALL ROAD BALTIMORE, MD 21215

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	215346	A. BUILDING _____ B. WING _____	R-C 09/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHWEST HEALTHCARE CENTER	**4601 PALL MALL ROAD BALTIMORE, MD 21215**

(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 September 24th, 2019 a revisit survey was conducted by the Office of Health Care Quality at this facility to determine compliance with the plan of correction submitted for deficiencies cited during an complaint survey conducted on July 3rd, 9th, 10th, 11th, 12th and 15th, 2019. Survey activities included the review of the medical records of 3 residents, observations of resident care and staff practices, and interviews. The facility's licensed bed capacity is 91 and the census was 80 at the time of the revisit. There were no deficiencies as a result of the revisit.	{F 000}		

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

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Office of Health Care Quality

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	215346	A. BUILDING: _____ B. WING _____	R-C 09/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHWEST HEALTHCARE CENTER	4601 PALL MALL ROAD BALTIMORE, MD 21215

(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
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..Maryland
DEPARTMENT OF HEALTH
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5/8/2020

Timothy Johnson
Northwest Healthcare Center
460 I Pall Mall Road
Baltimore, MD 21215

RE: NOTICE OF CURRENT DEFICIENCIES, IMPOSITION OF A DAILY CIVIL MONEY PENALTY UNDER STATE REGULATIONS

Dear Timothy Johnson,

On May 8, 2020, an administrative review was conducted by the Office of Health Care Quality to determine if your facility was in compliance with State requirements for nursing homes. This administrative review found that your facility was not in substantial compliance with Maryland regulations found at COMAR 10.07.02, as described in the attached state form.

I. PLAN OF CORRECTION (PoC)

A Plan of Correction ("PoC") for the deficiencies must be submitted within 10 days after the facility receives its State form. Failure to submit an acceptable PoC within the above time frames may result in the imposition of an additional 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;
- What corrective action will be taken;
- What measures will be put into place 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; and
- Specific date when the corrective action will be completed.

II. IMMEDIATE IMPOSITION OF A CIVIL MONEY PENALTY UNDER CODE OF MARYLAND REGULATIONS

Under Maryland Health General Article Sections 19-359 and 19-1401 et. seq., and COMAR 10.07.02.70 through .74, the Maryland Department of Health has the authority to impose a civil money penalty (CMP) based upon the existence of a deficiency or deficiencies at a comprehensive care facility.

Based upon the deficiencies cited at your facility, I hereby impose a total Civil Money Penalty (CMP) of $250, calculated based upon the one day of violation cited. The deficiencies upon which the CMP is based are enclosed with this letter on the State Form. Specifically, the facility failed to submit daily reporting information through the Chesapeake Regional Information System for our Patients (CRISP) health information exchange system as required by COMAR I 0.07.02.09L and Governor and Health Secretary orders and directives, during a decl,m:cl Stllte emergency and healthcare pandemic.

In determining whether to impose a CMP, the Department took into consideration the following factors:

1. The number, nature, and seriousness of the deficiencies;
2. The extent to which the deficiency or deficiencies are part of an ongoing pattern during the preceding 24 months;
3. The degree of risk to the health, life, or safety of the residents of the nursing facility caused by the deficiency or deficiencies;
4. The efforts made by, and the ability of, the nursing facility to correct the deficiency or deficiencies;
5. A nursing facility's prior history of compliance in general and specifically with reference to the cited deficiencies; and
6. Such other factors as justice may require.

The Department also considered current federal guidelines for civil money penalties and whether the amount of the proposed civil money penalty will jeopardize the financial ability of the nursing facility to continue operating as a nursing facility;

III. OPPORTUNITY FOR A HEARING TO CONTEST THE IMPOSITION OF A CIVIL MONEY PENALTY

The facility may request a hearing on the decision to impose a CMP. Any hearing will be held in accordance with State Government Article, Title 10, Subtitle 2, Annotated Code of Maryland, and COMAR 28.02.01 and 10.01.03. Any request for a hearing must be submitted in writing to Paul Ballard, Office of the Attorney General, 300 West Preston Street, Suite 302,

Baltimore, Maryland 21201, no later than 30 days after receipt of this notice. The request shall include a copy of this letter. If the informal dispute resolution process referenced elsewhere in this letter does not result in settlement of this matter, this matter will be referred to the Office of Administrative Hearings to hold a hearing and issue a proposed decision within 10 working days of the hearing. The aggrieved person may file exceptions as provided in COMAR 10.01.03.35. A final decision by the Secretary shall be issued in accordance with COMAR 10.01.03.35. If you do not request a hearing within 30 days after the receipt of this notice, the imposition of the CMP will become final at that time.

Per COMAR 10.07.02.74(A), the CMP payment is due 15 calendar days after the time period for requesting a hearing has expired and a request for a hearing was not received; or 15 calendar days after receipt of a written request from the facility to waive its right to a hearing and reduce the amount of the CMP by 40 percent, provided the written request is received by the Department within 30 calendar days of the Department's order imposing the civil money penalty. If you wish to reduce the amount of the CMP by 40 percent, please make your check payable to the Maryland Department of Health and submit it to the attention of David Cherry, Deputy Director ofT.one Tf:1m r.<1re, Office of Health Care Quality, 7120 Samuel Morse Drive, Second Floor, Columbia, Maryland 21046.

Pursuant to COMAR 10.07.02.73B, if the facility files a timely request for a hearing, the nursing facility shall deposit the amount of the CMP in an interest-bearing escrow account. The nursing facility shall bear any costs associated with establishing the escrow account, and the account shall be titled in the name of the nursing facility and the Maryland Department of Health as joint owners.

When the Secretary issues the final decision of the Department, the funds in the escrow account, plus accrued interest if applicable, shall be distributed in accordance with COMAR 10.07.02.73C.

IV. INFORMAL DISPUTE RESOLUTION

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an oppotiunity, 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 David Cherry, Deputy Director of Long Term Care, Office of Health Care Quality, 7120 Samuel Morse Drive, Second Floor, Columbia, Maryland 21046, by fax at 410-402-8234, or by email to david.chen-v@maryland.gov

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.

If you have any questions concerning the instructions contained in this letter, please contact Patti Melodini, Health Facilities Survey Coordinator at (410) 402-8244.

Sincerely yours,

1/nr#

Patricia Tomsko Nay, M.D.
Executive Director
Office of Health Care Quality

Enclosures: State Fann

cc: Paul Ballard
Stevanne Ellis
Ronda Washington
Cuunly Ht:allh Offict:r
File II

Office of Health Care Quall

STATEMENT OF DEFICIENCIES AND PIAN OF CORRECTION	(X1) PROVIDERISUPPLIER/CLIA IDENTIFICATIONMJMSER	(X2) MULTIPLE CONSTRUCTION	(X3} DATE SURVEY COMPLETED
	215346	A BUILDING: _____ B.WING _____	C 05/0812020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY. STATE. ZIP CODE
NORTHWEST HEALTHCARE CENTER	4601 PALL MALL ROAD BALTIMORE, MD 21215

(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-REf'ERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COIA.ETE DATE
S 000	Initial Comments	SOOO		

On May 8, 2020, an administrative review was conducted by the Office of Health Care Quality to investigate complaint MD00154067. The facility is licensed for 91 beds. Survey activities consisted of a review the Chesapeake Regional Information System for Our Patients (CRISP) daily report.

The administrative review identified non•compliance with Stale requirements lhal were reviewed in relationship to complaint MD00154067.

S 160 10.07.02.09 L Administration and Resident Care — S 160

.09 Administration and Resident Care.

L. Availability of Information. The administrator shall make available to *the* Secretary such information as may be requested to insure that the facility is meeting the requirements of these and other applicable regulations.

This Regulation is not met as evidenced by:
Based on review of required reporting data, the facility failed to submit daily reporting information through the Chesapeake Regional Information System for our Patients (CRISP) health information exchange system as required by Governor and Health Secretary order during a declared State emergency and healthcare pandemic. This deficient practice occurred May 8, 2020.

The findings include:

On March 5, 2020 the Governor of Maryland issued a Declaration of State of Emergency and

is Plan of Correction, Is being prepared and xecuted and not as an admission of the alleged eficiency cited. The response is to adhere to [regulation set forth in COMAR Regulations .07.02.

e healthcare Center does not admit or deny e allegations listed as a statement of :deficiencies.

1. lhe center reported the daily report to CRISP on 5-8-20. The ED contacted the CRISP representative on Monday 5-11-20 to follow up in alleged deficient practice. Per CRISP representative there was no way to validate the submission or delivery as there was no receipt generated.

2. The center since CRISP make adjustments now provides credible evidence with sending receiving emails daily upon report submission. The center will maintain validation responses. The center will conduct audits to ensure compliance of State mandates.

3. The Regional Director of Operations in-serviced the administrator regarding daily reporting to CRISP in accordance to the State Order.

4. The administrator or designee *with* report the findings of CRISP related to COVIG-19 reporting monthly to the OAPI Committee for 3 months or until the State Executive branch of Maryland terminates the Order- State of Emergency.

-22-20

OHCQ
LABORATOAYDIRECTOR OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Dir — (X6) DATE: 6-1-20

Office of Health Care Qualitv

STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION	(Xt) PROVIO!!R/SUPPUERICLIA IDENTIFICATIONNUMBER	(X2) MULTIPLE CONSTRUCTION	(XI) DATE SURVEY COMPLEIcO
	215346	A BUILDING: _____ B.WING _____	C 05/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET AODReSS, CITY, STATE. ZIP CODE
NORTHWEST HEALTHCARE CENTER	**4601 PALL MALL ROAD** BALTIMORE, MD 21215

(X4)1D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	10 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROss-REFERENCED TO THE **APPROPRIATE** DEFICIENCY)	{X5; COLA.Era DATE
S 160	Continued From page 1	**S 160**		

Existence of Catastrophic Health Emergency - COVID-19.

On April 29. 2020 the Governor of Maryland issued an Executive Order stating "The Secretary Is hereby ordered to issue directives under this Order requiring each Nursing Home to: ...vi. Regularly report to CRISP and the applicable local health department such information as the Secretary deems necessary to monitor the spread of the COVID-19 in and around Nursing Homes."

On April 29, 2020, the Secretary of Maryland Department of Health (MOH) issued a Directive and Order Regarding Nursing Home Matters. This order superseded the Directives and Orders Regarding Nursing Home Matters, dated April 24th, April 9th, and April 5th. The order included the following instructions:

1

•e. Facility Reporting to Health Department:
In addition to all current reporting requirementsto stale and local health departments, all facilities shall report the following infonnation to the Chesapeake Regional Information System for Our Patients (CRISP). On a dally basis, each facility report should include at least thefollowing:
I. The census of occupied beds;
II. Number of residents with positive COVID-19 test results;
111. Number of residents with suspected COVID-19:
IV. Number of residents with negative COVID-19 test results;
V. Number of deaths, by COVID-19 status;
VI. Number of staff with positive COVID-19test results;
VII. Number of residents with severe respiratory infection or COVID-19 resulting in hospitalization;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215346	A. BUILDING. ___ _ _ _ B. WING _____	C 05/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHWEST HEALTHCARE CENTER	4601 PALL MALL ROAD BALTIMORE, MD 21215

(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)	DATE
S 160	Continued From page 2 VIII. Number of staff with severe respiratory infection or COVID-19 resulting in hospitalization; IX. Number of residents or staff with new-onset respiratory symptoms that occur within 72 hours of another resident or staff developing respiratory symptoms; and X. Any other information required." Review of reports submitted to CRISP revealed that on May 8, 2020 the facility failed to submit the required daily reporting as required under the Governor and Secretary Order and you have been determined to not be in compliance with the requirements of COMAR 10.07.02.09(L).	S 160		

..Maryland
DEPARTMENT OF HEALTH
Lar T Hogan, Goul'rnor · BOJ,d K Rutherford, Lt. Goi:crnor · Robat R.. N"e11lf, Sccrct11T)'

5/7/2020

Timothy Johnson
Northwest Healthcare Center
460 l Pall Mal I Road
Baltimore, MD 21215

RE: NOTICE OF CURRENT DEFICIENCIES,
IMPOSITION OF A DAILY CIVIL MONEY
PENALTY UNDER STATE REGULATIONS

Dear Timothy Johnson,

On May 7, 2020, an administrative review was conducted by the Office of Health Care Quality to determine if your facility was in compliance with State requirements for nursing homes. This administrative review found that your facility was not in substantial compliance with Maryland regulations found at COMAR 10.07.02, as described in the attached state form.

I. PLAN OF CORRECTION (PoC)

A Plan of Correction ("PoC") for the deficiencies must be submitted within IO days after the facility receives its State form. Failure to submit an acceptable PoC within the above time frames may result in the imposition of an additional 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;
- What corrective action will be taken;
- What measures will be put into place 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; and
- Specific date when the corrective action will be completed.

II. IMMEDIATE IMPOSITION OF A CIVIL MONEY PENALTY UNDER CODE OF MARYLAND REGULATIONS

Under Maryland Health General Article Sections 19-359 and 19-1401 et. seq., and COMAR 10.07.02.70 through .74, the Maryland Department of Health has the authority to impose a civil money penalty (CMP) based upon the existence of a deficiency or deficiencies at a comprehensive care facility.

Based upon the deficiencies cited at your facility, I hereby impose a total Civil Money Penalty (CMP) of $250, calculated based upon the one day of violation cited. The deficiencies upon which the CMP is based are enclosed with this letter on the State Form. Specifically, the facility failed to submit daily reporting information through the Chesapeake Regional lnfo1mation System for our Patients (CRISP) health information exchange system as required by COMAR I 0.07.02.09L and Governor and Health Secretary orders and directives, during a declared State emergency and healthcare pandemic.

In determining whether to impose a CMP, the Department took into consideration the following factors:

I. The number, nature, and seriousness of the deficiencies;
2. The extent to which the deficiency or deficiencies are part of an ongoing pattern during the preceding 24 months;
3. The degree of risk to the health, life, or safety of the residents of the nursing facility caused by the deficiency or deficiencies;
4. The efforts made by, and the ability of, the nursing facility to correct the deficiency or deficiencies;
5. A nursing facility's prior history of compliance in general and specifically with reference to the cited deficiencies; and
6. Such other factors as justice may require.

The Department also considered current federal guidelines for civil money penalties and whether the amount of the proposed civil money penalty will jeopardize the financial ability of the nursing facility to continue operating as a nursing facility;

III. OPPORTUNITY FOR A HEARING TO CONTEST THE IMPOSITION OF A CIVIL MONEY PENALTY

The facility may request a hearing on the decision to impose a CMP. Any hearing will be held in accordance with State Government Article, Title I 0, Subtitle 2, Annotated Code of Maryland, and COMAR 28.02.0I and I0.01.03. Any request for a hearing must be submitted in writing to Paul Ballard, Office of the Attorney General, 300 West Preston Street, Suite 302,

Baltimore, Maryland 21201, no later than 30 days after receipt of this notice. The request shall include a copy of this letter. If the informal dispute resolution process referenced elsewhere in this letter does not result in settlement of this matter, this matter will be referred to the Office of Administrative Hearings to hold a hearing and issue a proposed decision within 10 working days of the hearing. The aggrieved person may file exceptions as provided in COMAR 10.01.03.35. A final decision by the Secretary shall be issued in accordance with COMAR 10.01.03.35. If you do not request a hearing within 30 days after the receipt of this notice, the imposition of the CMP will become final at that time.

Per COMAR 10.07.02.74(A), the CMP payment is due 15 calendar days after the time period for requesting a hearing has expired and a request for a hearing was not received; or 15 calendar days after receipt of a written request from the facility to waive its right to a hearing and reduce the amount of the CMP by 40 percent, provided the written request is received by the Department within 30 calendar days of the Department's order imposing the civil money penalty. If you wish to reduce the amount of the CMP by 40 percent, please make your check payable to the Maryland Department of Health and submit it to the attention of David Cherry, Deputy Director of Long Term Care, Office of Health Care Quality, 7120 Samuel Morse Drive, Second Floor, Columbia, Maryland 21046.

Pursuant to COMAR 10.07.02.73B, if the facility files a timely request for a hearing, the nursing facility shall deposit the amount of the CMP in an interest-bearing escrow account. The nursing facility shall bear any costs associated with establishing the escrow account, and the account shall be titled in the name of the nursing facility and the Maryland Department of Health as joint owners.

When the Secretary issues the final decision of the Department, the funds in the escrow account, plus accrued interest if applicable, shall be distributed in accordance with COMAR 10.07.02.73C.

IV. INFORMAL DISPUTE RESOLUTION

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an oppo11unity, 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 David Cherry, Deputy Director of Long Term Care, Office of Health Care Quality, 7120 Samuel Morse Drive, Second Floor, Columbia, Maryland 21046, by fax at 410-402-8234, or by email to david.chcrry(rornarylancl.go

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.

If you have any questions concerning the instructions contained in this letter, please contact Patti Melodini, Health Facilities Survey Coordinator at (410) 402-8277.

Sincerely yours,

Patricia Tomsko Nay, M.D.
Executive Director
Office of Health Care Quality

Enclosures: State Form

cc: Paul Ballard
Stevanne Ellis
Ronda Washington
County Health Officer
File II

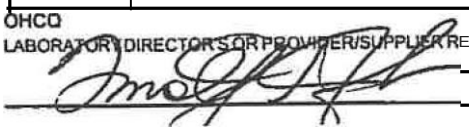
Office of Health Care Qualitv

STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIDER/SUPPUER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X31 DATE SURVEY COMPLETED
	215346	A BUILDING:_____ B. WING _____	C 05(07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS.CITY, STATE.ZIPCODE
NORTHWEST HEALTHCARE CENTER	4601 PALL MALL ROAD BALTIMORE, MD 21215

(X4)ID / PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IOENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) C0tA'LETE DATE
S 000	Initial Comments On May 7, 2020, an administrative review was conducted by the Office of Health Care Quality to investigate complaint MD00154067. The facility is licensed for 91 beds. Survey activities consisted of a review the Chesapeake Regional Information System for our Patients (CRISP) daily report. The administrative review identified Non-compliance with State requirements that were reviewed in relationship to complaint MD00154067.	S000	This Plan of Correction, is being prepared and executed and not as an admission of the alleged deficiency cited. The response is to adhere to e regulation set forth in COMAR Regulations 0.07.02. [he healthcare Center does not admit or deny e allegations listed as a statement of deficiencies.	
S 16[	10.07.02.09 l Administration and Resident Care .09 Administration and Resident Care. L. Availability of Information. The administrator shall make available to the Secretary such Information as may be requested to insure that the facility is meeting the requirements of these and other applicable regulations. This Regulation Is not met as evidenced by: Based on review of required reporting data, the facllity failed to submit dally reporting information through the Chesapeake Regional Information System for our Patients (CRISP) health information exchange system as required by Governor and Health Secretary order during a declared State emergency and healthcare pandemic. This deficient practice occurred May 8, **2020.** The findings include: On March 5, 2020 the Governor of Maryland issued a Declaration of State of Emergency and	S 160	1. The center reported the dally report to CRISP on 5-7-20. The ED contacted the CRISP representative on Monday 5-11-20 to follow up in alleged deficient practice. Per CRISP representative there was no way to validate the submission or delivery as there was no receipt generated. Since 5-13-20 there Is now a generated receipt after daily submission to CRISP. 2. The ED and/ or designee will report to CRISP daily as well as CRISP making adjustments that now provides credible evidence receiving emails daily upon report submission. The center will maintain validation responses. The center will conduct audits to ensure compliance of State mandates. 3. The Regional Director of Operations in-serviced the administrator regarding daily reporting to CRISP in accordance to the State Order. 4. The administrator or designee will report the findings of CRISP related to COVIG-19 reporting monthly to the OAPI Committee for 3 months or until the State Executive branch of Maryland terminates the Order- State of Emergency.	-22-20

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



Executive Dir

6-1-20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	()(3) DATE SURVEY COMPLETED
	215346	A. BUILDING: _____ BWING _____	C 05/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHWEST HEALTHCARE CENTER	4601 PALL MALL ROAD BALTIMORE, MD 21215

(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 160	Continued From page 1 Existence of Catastrophic Health Emergency - COVID-19. On April 29, 2020 the Governor of Maryland issued an Executive Order stating "The Secretary is hereby ordered to issue directives under this Order requiring each Nursing Home to: ...vi. Regularly report to CRISP and the applicable local health department such information as the Secretary deems necessary to monitor the spread of the COVID-19 in and around Nursing Homes." On April 29, 2020, the Secretary of Maryland Department of Health (MOH) issued a Directive and Order Regarding Nursing Home Matters. This order superseded the Directives and Orders Regarding Nursing Home Matters, dated April 24th, April 9th, and April 5th. The order included the following instructions: "B. Facility Reporting to Health Department: In addition to all current reporting requirements to state and local health departments, all facilities shall report the following information to the Chesapeake Regional Information System for Our Patients (CRISP). On a daily basis, each facility report should include at least the following: I. The census of occupied beds; II. Number of residents with positive COVID-19 test results; III. Number of residents with suspected COVID-19; IV. Number of residents with negative COVID-19 test results; V. Number of deaths, by COVID-19 status; VI. Number of staff with positive COVID-19 test results; VII. Number of residents with severe respiratory infection or COVID-19 resulting in hospitalization;	S 160		

Office of Health *Care* Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(XJ) DATE SURVEY COMPLETED
	215346	A. BUILDING: _____ B. WING _____	C 05/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CI1Y, STATE, ZIP CODE
NORTHWEST HEALTHCARE CENTER	**4601 PALL MALL ROAD BALTIMORE, MD 21215**

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S 160	Continued From page 2 VIII. Number of staff with severe respiratory infection or COVID-19 resulting in hospitalization; IX. Number of residents or staff with new-onset respiratory symptoms that occur within 72 hours of another resident or staff developing respiratory symptoms; and X. Any other information required." Review of reports submitted to CRISP revealed that on May 7, 2020 the facility failed to submit the required daily reporting as required under the Governor and Secretary Order and you have been determined to not be in compliance with the requirements of **COMAR** 10.07.02.09(L).	S 160		

Northwest Nursing and Rehabilitation Center
4601 Pall Mall Road
Baltimore, Maryland 21215

Provider# 215346

August 21, 2019

Ms. Laura Norman
Health Facilities Survey Coordinator
Office of Health Care Quality
7120 Samuel Morse Drive, Second Floor
Columbia, Maryland 21046-3422

Dear Ms. Norman;

Please accept the signed CMS form 2567 as the Revision to Statement of Deficiencies for May 24, 2019 Survey as requested.

Sincerely yours,

Michael E. Moranz, M.P.H, LNHA
Administrator

MARYLAND
Department of Health

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

June 14, 2019

Meir Preis, Administrator
Northwest Healthcare Center
4601 Pall Mall Road
Baltimore, MD 21215

PROVIDER# 215346
RE: NOTICE OF IMMEDIATE ,JEOPARDY, SUBSTANDARD QUALITY OF CARE, AND POSSIBLE IMPOSITION OF OTHER REMEDIES

Dear Mr. Preis:

On May 17, 2019 and May 20 - 24, 2019, a complaint health survey was conducted at your facility by the Office of Health Care Quality to determine if your facility was in compliance with Federal patticipation 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 form CMS 2567, this survey found that your facility was not in substantial compliance with participation requirements. In fact, conditions at your facility posed immediate jeopardy to the health and safety of residents. The deficiency that forms the basis for the finding of immediate jeopardy is attached. Removal of the condition(s) that posed immediate jeopardy was confirmed by the survey team on May 24, 2019.

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

The facility's noncompliance with the following regulations constitutes immediate jeopardy to the health and safety of residents:

F 689, 483.25 Quality of Care

I. .RECOMi\1ENDED 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 8, 2019. Informal dispute resolution for the cited deficiencies will not delay the imposition of the enforcement actions recommended on July 8, 2019. A change in the seriousness of the noncompliance on July 8, 2019 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 identifying non-compliance, (i.e., August 24, 2019) the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions. (§§488.41?(a))

We are also recommending to the CMS Regional Office and/or the State Medicaid Agency that your provider agreement be terminated on November 24, 2019 if substantial compliance is not achieved by that time.

II. AUTOMATIC CONSEQUEN : AS A RES JLT OF PROVIDING SUBSTANDARD QUA ITY OF CARE

Your facility's noncompliance with the following:

42 CFR 483.2S(d) constitutes substandard quality of care as defined at §488.301, Sections I819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) of the Code of Federal Regulations. As a result of providing substandard quality of care, surveyors conducted an extended, or partial extended, survey at your facility. The Federal regulations at 42 CFR §483.151 (b)(2)(iii), 42 CFR §483.151 (b)(3)(i), (ii) and (iii), and 42 CFR §483.151 (e) require that any nursing facility that has been subject to an extended or partial extended survey, a denial of payments for new admissions or a Civil Money Penalty of not less than $5,000.00, must have the approval for their nurse aide training and competency evaluation program (NATCEP) withdrawn for a period of two years. Therefore your facility is prohibited from operating a nurse aide training program for two years from the last day of the survey. See §483.151.

You have the right to appeal to CMS the loss of your nurse aide training program as a result of a finding of Substandard Quality of Care (SQC); however, your nurse aide training program must cease to operate pending an appeal.

If you disagree with this action imposed on yom facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 CFR §498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DABE-File) at hll '>.://dab. 'Jil ·.hhs., Jv n la(r than ixl 60 du· aft r r c iving this letter. A copy of the hearing request shall be submitted to:

Chief Counsel
Office of the General Counsel
801 Market Street
Suite 9700
Philadelphia, PA 19107

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide

an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building - Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree, 42 CFR §498.40(b)(1). It should also specify the basis for contending that the findings and conclusions are incorrect, 42 CFR §498.40(6)(2). You may be represented by counsel at a hearing, at your own expense.

Should we take action to terminate your participation in the Medicare program, we will advise you of your appeal rights as a result of that action. Please note that those appeal rights arc separate and distinct from the appeal rights cited above.

You will be notified separately by the Maryland Medicaid State Agency regarding their application of the remedies in this letter.

In addition, Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care as well as the State board responsible for licensing the facility's administrator be notified of the substandard quality of care. In order for us to satisfy these notification requirements, and in accordance with §488.325(g), you are required to provide the following information to this agency within 10 working days of your receipt of this letter (sec the attached form to be used to provide this information). Residents affected include: Resident #3. Please refer to the previously provided Roster/Sample Matrix for resident names.

III. PLAN OF CORRECTION (PoC)

Based on the findings of this survey, an opportunity to correct the identified deficiencies will not be afforded prior to our recommendation of the imposition of remedies by the CMS and the State Medicaid agency. 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 additional remedies.

Your PoC must contain the following;

What conective 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; and;

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.

Date by which 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 resident names in documents since the documents are released to the public.

IV. INFORMAL DISPUTE RESOLUTION

In accordance with '488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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 the deficiency(ies), (or why you are disputing the scope and severity assessments of deficiencies which have been found to constitute SQC or immediate jeopardy) to Margie Heald, Deputy Director, Office of Health Care Quality, 7120 Samuel Morse Drive, Columbia, MD 21046-3422, phone 410-402-8201, fax 410-402-8234. This request must be sent within 10 days of receipt of this letter. Inforn1al dispute resolution for the cited deficiencies will not delay the imposition 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 and credible evidence of compliance for these deficiencies within lO 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.

In the event a revisit reveals that conections have not been achieved, a mandated staffing pattern may be imposed in accordance with COMAR J0.07.02.070(3) to assist you in the delivery of an adequate level of resident care.

If you have any questions concerning the instrnctions contained in this letter, please contact Laura Norman, survey coordinator at (410) 402-8003.

Sincerely,

Patricia Tomsko Nay, M.D.
Executive Director
Office of Health Care Quality

Enclosures: CMS 2567
State Form
Attending Physicians' Form

cc: Claire Pierson, Esq.
Jane Sacco
Ginger Levesque, CMS RO
Ruby Potter
Ronda Washington
Stevanne Ellis
MFCU
File II

STATEMENT OF DEFICIENCIES AND PLAN OF CORRt:;C'[ION	(X1) PROVIDER/SUPPLIER/CUA ID[NTIFIC/\TIOt, NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X31DATE SURVEY COMPI CTITJ
	215346	A. BUii.DiNG _____ B.'MNG _____	C 05/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, z1r GODE
NORTHWEST HEALTHCARE CENTER	4601 PALL MALL ROAD BALTIMORE, MD 21215

(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 On May 17, 2019 and May 20, 2019 through May **24,** 2019 an investigation was conducted at this facility by the Office of Health Care Quality of ten complaints MD00138360, MD00137373, MD00136317, MDD0135427, MD00130833, MD00129628, MD00128885, MD00128397, MD00127531, and MD00127364. The census was 89 and the licensed bed capacity is 91. Survey activities consisted of a review of residents' medical records, observation, interview of the facility staff and residents and a review of administrative records_ The survey identified non-compliance with Federal and State requirements that were reviewed in relationship to complaints: MD00137373, MOOD127531, MD00128885, MD00136317, MD00128885 and MD00130833_ On May 22, 2019 at 2:26 PM, an immediate jeopardy was called by the Office of Health Care Quality related to a multi-system failure resulting in repeated violations of the smoking policy by Resident #3, thereby jeopardizing the health and safety of current and future residents. The facility submitted an initial plan of action to the surveyor and the Office of Health Care Quality for review at 5:08 PM. This initial plan was not accepted_ Revised plans were submitted at 8:33 PM and 8:55 PM which were not accepted. The facility submitted a revised plan of action at 9:48 PM that was reviewed by the survey team and the Office of Health Care Quality. The plan was accepted but the immediate jeopardy was not removed until 5/24/19 at 4:15 PM.	F 000		

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Any deficiency·,:/alement bndfng with an 11st1:1t<sk (1denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide!l,Jffrcle11t protecti patients_ (See instructions.) Except for nursing homes, the findings stated above are disciosable 90 days following the date of survey whether or not a plan al 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 facilit/. If deficiencies are ciled, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PI.AN Of CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENI IFICATION NUMBFH:	()(2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLEIf.D
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 000	Continued From page 1 SEE F689 The extended survey was completed on May 23, 2019 and May 24, 2019.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s) 483.21(b)(1) §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 §483.10(c)(2) and §483.10(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 (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. **(8i** The ft,5ident's prenmmce and poteni:iai for	F 656		

STATEMENT OF DEFICIENCIES fll D PL/;N Or COR1<r:c·IION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. 8Ul;_[@G _____ 8W-ING _____	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 656	Continued From page 2 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 medical record review and staff inleNiew it was determined the facility staff failed to develop and implement individualized care plans for its residents to address smoking safety, based on a comprehensive assessment of the residents' needs. This was true for 6 out of the 26 residents (Resident #7, # 10, #14, #15, and #16, #17) reviewed from the smoking list during this complaint suNey. The findings inclL1de: 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. Smoking Aprons- Aprons for Smokers are intended for individuals who smoke and require a protective cover to shield against hot ashes and dropped cigarettes. 1) Medical record review on 5/23/19 revealed Resident #7 was identified as a current smoker. Review of the Smoking Assessment dated **5/23/ g IC\iea!ed th€i • l\Jent** vv'o **atsse-ss -d- c:1s** an "independent smoker", despite having the	F 656	. urrccth"c nrtion: l he care plans forres1dcn1 IJ7, 10,l/1.,\,J>l5, l6 ha\'c been updated lo rcncct 1hc residents +,111ok1ng salety based off the co111prehi.':n5i\'e e,1dc.111·s needs. Resident *fl* 17 not mdicated on the resident roster so unable to corrcs:l. 1[1dcutif)Milers wilb polc11lin! lo he affoctcd: l lit.: Director or nursing will complel" nn uutl1t 1r current rcs.idcnls to cn urc the residents cnre •lans arc accurately n:Oecting the residents mok.mg s,ifcty b:iscd off or the comprc.hcnsh *c* sidcnts needs l:\1c.i 11rcs **to** prc\'clll rcuccun-cncc: 'I he regional d1rcc1or of clinical operation will p·eecJucu\ the dm:clor of mIrsIng , licensed bturse i; and the socml worker lo ensure the moking asse,;sment is completed accurately nd that !he residents eurc plans ore accurately cflecting the residents smoking safely based ff of the comprehensive resident's needs. fonitoring of corrective ;tctions for residents affected residents: The director of nursing will perform a audit wi,;ckly x4 and then monthly for two months ol 10\\' admi sions, readmits and residents with la change in condition who smoke to ensure tlmt the residents care plnns .ire ilccurntely **tre-fh.rdin i.ht: rC,,id-i:rHS ;iinu-kiJlg- uft:lybascci** p[f of tbe resident's needs. The findings of 1he	7/8/19 ?

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NORTHWEST HEALTHCARE CENTER	,\601 PALL MALL ROAD BALTIMORE, MD 21215

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F 656	Continued From page 3 need for a smoking apron. The assessment did not indicate if the resident was able to dispose of cigarettes appropriately. The form noted that selecting the independent designation indicated the resident did not require supervision or other accommodations to maintain safety during smoking. The care plan, with an initiation date of 10/6/17 contained a goal that the resident would smoke safely with supervision as evidenced by no injuries such as burns to herself/himself or to his/her clothing. It was unclear from the assessment if the resident was an independent smoker or required supervision. 2) Medical record review on 5/23/19 revealed Resident #10 was identified as a current smoker. Review of the Smoking Assessment dated 5/20/19 revealed the resident was assessed as an "independent smoker", had an unspecified dexterity problem and was unable to dispose of cigarettes appropriately. A Smoking Assessment dated 5/22/19 indicated the resident needed supervision with smoking, did not have a dexterity problem and was able to dispose of cigarettes appropriately. The care plan, with an initiation date of 5/21/19, noted the resident was assessed as an independent smoker and was not based on a comprehensive assessment as evidenced by the inconsistencies in the assessments dated 5/20/19 and 5/22/19. 3) Medical record review on 5/23/19 revealed was identified as a current smoker.	F 656	udi1s will be prc5ented at QAPI for the 11ext 0 days for review and comment.	

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F 656	Continued From page 4 Review of a Smoking Assessment dated 5/22/19 revealed Resident#14 required a smoking apron and supervision when smoking to maintain safety. Further review of the medical record on 5/23/19 revealed the facility staff failed to develop a care plan that addressed smoking. 4) Medical record review on 5/24/19 revealed Resident #15 was a long-term care resident identified as a current smoker. Review of the Smoking Assessment dated 5/23/19 revealed the resident was assessed as an "independent smoker." The care plan, with an initiation date of 5/23/19, noted the resident was at risk for potential burns related to smoking. The plan contained an intervention to observe the resident's hands during the weekly skin check to ensure there were no burns. The assessment of the resident as an independent smoker was inconsistent with someone who was at risk for burns while smoking. The risk for burns would indicate a need for supervision. 5) Medical record review on 5/23/19 revealed Resident #16 was a long-term care resident identified as a current smoker. Review of the Smoking Assessment dated 5/23/19 revealed the resident was assessed as an "independent smoker." The care plan, with an initiation date of 5/22/19, noted the resident was at risk for potential burns related to smoking and required supervision at all smoke breaks. The ;:ric1n wntain8U an fttililrvnf-o11tv oUs rv - ihc resident's hands during the weekly skin check to	F 656		

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F 656	Continued From page 5 ensure there were no burns. The assessment of the resident as an independent smoker was inconsistent with someone who was at risk for burns while smoking. The risk for burns would indicate a need for supervision, 6) Medical record review on 5/23/19 revealed Resident #17 was a long-term care resident identified as a current smoker. The medical record contained a care plan that addressed a behavior probl.em related to Alzheimer's as evidenced by forgetfulness, repetitive questioning, and confusion. Review of the Smoking Assessment dated 5/23/19 revealed the resident was assessed as an "independent smoker." The care plan, with an initiation date of 3/11/19, noted the resident was an "independent smoker" but was supervised during all smoke breaks. The Smoking Assessment tool has an area designated for assessing the resident's safety and needs for adaptive equipment. If the resident is deemed an independent smoker that is an indication that the resident does not require adaptive equipment sucl1 as an apron or a cigarette holder or supervision. A Resident Smoking Policy with a review date of 4/1/16 noted the assessment, observation and designation of independent or supervised smoker will be made by the treatment team for each resident who requests to smoke in the facility. It w__ pntprl. ,,iirinn th_ s1 uNAV th t n1ir-=-c::: rnmnl.atc the assessments independently.	F 656		

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F 656	Continued From page 6 The inconsistencies between the assessments and the care plans regarding the residents ' safety needs were discussed with the Director of Nursing and Administrator on 5/23/19 at 4:21 PM. The Director of Nursing failed to acknowledge and correct the inconsistencies until the Regional Director of Clinical Services intervened and clarified the assessment process.	F 656		
F 657 SS=D	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- (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 **Wvlfip. rr.:::. •.:::.** iAlid :-.uolt.:.riv Mv:c:w-;	F 657		

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F 657	Continued From page 7 assessments. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview it was determined the facility staff failed **to** revise care plans that addressed: **1)** the individualized treatment needs of a resident (Resident #3) with a history of smoking utilizing a multidisciplinary approach; and 2) the refusal of care for a functionally, cognitively and sensory impaired resident (Resident #8). This was evident for 2 of 3 residents reviewed for care plan revisions during this complaint survey. The findings include: A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess and evaluate the effectiveness of the resident's care. 1) Medical record review on 5/17/19 revealed Resident #3 was admitted to the facility in —for skilled nursing services. A Smoking Assessment completed on 2/8/19 revealed the resident was determined to be an "independent smoker with supervision." The form noted that selecting the independent designation indicated the resident did not require supervision or other accommodations to maintain safety during smoking. A Behavior Note dated 2/9/19 at 1O:18 PM reported that at approximately 9:50 PM the resident had a visitor, after which the writer smelled the strong odor of Marijuana smoke r-:;.ornir,,g fro fJ1.e r -si.den_t's r0qm Th-e. ;id n,t' door was locked on the inside and after several	F 657	**\..:orrcctive action:** Residcnl #3 no longer resides nl lhe racility. rt'he Resident *t/8* comprehensive 1ssessmem was reviewed and the interdisciplinary teflm developed care plan CJ rcllccl the residents cog.nilive, personal 1ygiche, urinary inccmlinencc ::incl visual are plans to meet residenl needs.. Identify others **with** potential to \Jc llffcctcd: l) The director of nursing will complete ai iaudit ol"the smoking care plans of the iresidenls who smoke to ensure their care jPlans reflecl their needs. i) The director of nursing will complele an i:.iuclit of residents who have a behavior of iresisting care to ensure their cognitive, jPersonal hygiene, urim1ry incontinence nnd visual care plan are reviewed and 1pc\J ed.!!), rcllei;Uh .r. i ent neerl.,;. ,lc;7trcs t;pm•c l rco -.;rrc cc; l')The regional director of clinical opcrntions will reeducate the nursing supervisors nnd the llllliily assurnncc nurse will reeducate the censed nursing staff lo ensure that the cnrc l;ms for residents who smoke met their needs)TIie Quality assurance nursi: will reeducate ie interdisciplinary team on to ensure the cognitive, personal hygiene, urinary ,incontinence and vi5ual care plans accurately reOec1 the resident needs.	7/8/19

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F 657	Continued From page 8 knocks on the door from security and other staff the resident unlocked the door to reveal even more pungent smell of Marijuana smoke coming from the room. The medical record contained a document entitled Guidelines for Resident Behavior that was signed by the resident on 2/11/19. The document contained information regarding rules relative to smoking, drug and alcohol use, and possession of weapons in the facility. It was noted that non-compliance with the rules could result in the initiation of a behavioral management plan, referral to local law enforcement or discharge from the facility. A care plan with initiation dates of 2/13/19 and 4/24/19 addressed the resident's desire to smoke and noted the resident was assessed as an "independent smoker." Interventions included monitoring the resident's safety during smoking and complete a smoking assessment, quarterly, annually and with a change in condition. A Behavior Note dated 2/17/19 reported the resident had visitors today in her/his room. The writer noted a towel was placed at the inside the bottom of the door and the room smelled of marijuana. A Social Services note dated 3/4/19 reported the resident was re-educated on the facility Smoking Policy and the Guidelines for Resident Behavior thats/he signed on 2/11/19. The resident was informed that any continued non-compliance **of** the Smoking Policy could possibly lead to an involuntary discharge notice being given. !) **G re -*Pl.* ncte 9-:;ted 3/4/1'9 *3t.* 4:5-e PM** reported the resident was noted to be smoking	F 657	**lon.itoring of corrective actions for rt!sitlcnts affected residents:** !)Director of nursing will complete a audil l'eekly x4 und then monthly for 1wo months or 01cw odmissiuns, readmissions and n:sidcnls with a clrnngc in condi1ion who smoke and rcr.idents who viofote the smoke policy to ·nsure their care plans are nccuralcly rcilcctinJ! U1eir needs. J) The Director of nursing will perfom1 n monthly audit for three munths no less thnn 120% of residents who have a behavior o[resi tini; care I cnsu_re cog_nitive, personal hygiene and unnnry mcantmencc mid visual arc plans .ire nccuraiely reflecling their needs The findings of the uudits will be presented at QAPJ for the next 90 days for review nnd ommen1.	

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F 657	Continued From page 9	F 657		

marijuana in the shower room on 3/3/19, was educated about the smoking policy and was asked to turn over any lighter, cigarettes, or marijuana s/he may still have in his/her possession. It was noted that the resident denied smoking and having possession of a lighter, cigarettes, or marijuana. A Nurse's Note dated 3/11/19 at 11:23 PM reported the resident was in the shower room smoking. The resident was educated on the danger of smoking inside the facility.

A Behavioral Health Services note dated 3/13/19 noted the resident was evaluated for continued use of marijuana at the facility. The Behavior Management Plan, noted by the Nurse Practitioner, was that staff would provide structured socialization, structured activities of daily living (AOL) care, and staff were to approach the resident respectfully and be clear about upcoming nursing care.

A Skilled Documentation note dated 4/4/19 at 2:23 PM reported the resident had a visitor with whom s/he went outside in the courtyard and smoked Marijuana_ It was noted that the resident was re-educated on the risks of her/his behavior but denied using/smoking marijuana.

The medical record contained care plans, with initiation dates of 4/24/19 that addressed a behavior problem related to smoking marijuana and cigarettes in the facility and/or allowing guests to smoke in her/his room, a history of marijuana abuse/substance abuse and soliciting staff for money to purchase marijuana. Interventions included but were not limited to ssis!_i g t'1e r'",_sJdent to develop mQ!"e appropriate ways of coping, encourage the

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F 657	Continued From page 10	F 657		

resident to express his/her feelings appropriately, discuss behaviors, explain why behaviors are inappropriate, intervene as necessary to protect the rights and safety of others, and obtain a psychiatric consult as needed. Specific interventions to maintain the resident's safety including adjusting the level of supervision was not addressed.

A Smoking Assessment dated 5/21/19 indicated the resident was an "independent smoker requiring supervision." The resident's care plan directed staff to reassess the resident with a change in condition. The resident had multiple episodes of smoking in non-designated areas before slhe was reassessed.

A Behavior Note dated 5/5119 at 11:32 PM reported the resident was smoking in her/his room and was educated on the risks of smoking in bed. A Behavior Note dated 5/7/19 at 10:54 PM noted the resident was smoking Marijuana along with another resident in her/his room.

A Nurses Note dated 5/14/19 at 11:35 PM reported the Resident was in another resident's room and staff smelled cigarette smoke coming from the room. A Behavior Note dated 5118/19 at 11:30 PM reported the resident was noted to be smoking in her/his room during rounds at the beginning of the shift. The writer reported the resident started spraying air freshener, but the room was still filled with cigarette smoke ands/he was re-educated on the risk of smoking in the room.

During an interview with the surveyor on 5/17/19 at 3:45 PM th!?- [lirec.tor of Nu.r-sing 'Ale>s .2s!.<..ed what actions wer t k n regarding

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F 657	Continued From page 11 11011-compliance with the smoking policy. The DON stated the Social Worker would talk to the resident about non-compliance and issue a 30-day notice if the problem persists. In interview with the surveyor on 5/21/19 at 12:35 PM the Social Services Director stated s/he has been meeting with the resident's caseworker to discuss the behaviors. The Social Services Director stated s/he has a behavior contract with the resident and has reviewed that with the resident several times. The Social Worker was referencing the Guideline for Resident Behavior. During an interview with the Administrator on 5122/19 at 11:15 AM the surveyor asked about the process for implementing a behavior management plan as outlined in the Guidelines for Resident Behavior and s/he stated the facility reached out to the resident's caseworker to ascertain what services or resources were available to the resident that could be utilized while tt1e resident was in the facility. During this interview the surveyor discussed concerns that a behavior management plan had not been developed and the resident's care plan was not updated to include measures to maintain the resident's safety. The facility's smoking policy states residents will be assessed on admission, readmission, quarterly, with significant change or upon violation of the safe smoking policies. Review of the medical records failed to reveal the reassessments were completed as indicated with adjustments to the resident's care plan based on his/Iler response to tile interventions identified in tho ,...rP. nl n	F657		

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F 657	Continued From page 12 2) Medical record review on 5/21/19, revealed Resident #8 was a long-term care resident admitted to the facility with diagnoses that included but were not limited to Schizophrenia, Bipolar Disorder, Glaucoma, and Contractures of both hands. Contractures are the chronic loss of joint motion due to structural changes in non-bony tissue. It the joints, muscles, ligaments, and tendons are not exercised they will contract or stiffen. (medlineplus.gov) Surveyor review of complaint #MD00136317 revealed a concern that Resident #8 was not being bathed/ showered routinely. The medical record contained a care plan initiated on 12/15/17 that addressed the resident's refusal of care including showers and changing his/her clothes. The goal was for the resident not to have behavioral episodes daily, by the review date of 6122119. Interventions included; 1) explain procedures to the resident before starting; 2) discuss the resident's behavior and explain why the behavior may be inappropriate; 3) monitor behavior episodes and attempt to determine the underlying cause; 4) document behavior and potential causes; and 5) educate the resident on the risks and benefits of refusing care. A care plan initiated on 3/29/18 addressed the resident's impaired cognitive function and impaired thought processes and decision making related to Schizophrenia and Bipolar Disorder. Review of the annual Minimum Data Set (MOS) assessment dated 12/22/1B revealed the facility staff entered a Brief Interview tor Mental Status (BIMS) score of 14 out of 15 in Section C Cqanitive Patterns, Staff no!P.rl in thA m1.<1rtArlv Mo's ;s s ;,f dat d 2/19/1g th t the.r 'iderit	F 657		

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F 657	Continued From page 13	F 657		

was unable to complete the interview and review of subsequent quarterly assessments dated 3/6/19 and 4/1/19 revealed the resident's mental status was not assessed but it was noted that there were no acute changes in the resident's mental status.

The Minimum Data Set (MDS) is a comprehensive assessment of the resident completed by the facility staff. The MDS is a multi-disciplinarian tool that allows many facets of the resident's care [cognition, behavior, mobility, activities of daily living, accidents, activities, weight, pain and medications to name a few] to be addressed. The MOS assessment is part of a broader RAI (Resident Assessment Instrument) process. The RAI process ties the assessment and care plan to the delivery of care lo meet the needs of the resident.

Brief Interview for Mental Status (BIMS) is an assessment that assists staff in determining a resident's cognitive status. A score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment.

Review of the MOS assessment dated 4/1/19 revealed facility staff coded the resident in Section G Functional Status GO110 Activities of Daily Living G- Toileting as a 0/0 (independent), J-Personal Hygiene as a 1/2 (required supervision of 1 staff) and in GO12O Bathing as a 4/2 (totally dependent on the assistance of 1 staff). Facility staff coded the resident in section HO3OO Urinary Continence and section HO4OO Bowel Continence as a O (always continent).

Review of the Nursing Assistants' task

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F 657	Continued From page 14	F 657		

documentation for Personal Hygiene for the period April 21, 2019 through May 20, 2019 revealed the resident was coded as independent except on 4/24/19 and 5/13/19.

During an interview with the surveyor on 5/17/2019 at 2:05 p.m. Staff #1 stated the resident was not aggressive, just non-compliant. S/he further stated the resident does not want to bath or change his/her clothes or take medications but there isn't much staff can do about it.

On May 17, 2019 at 3:20 PM Surveyor #1 and #2 observed Resident #8 on the ground floor of the facility, sitting in a wheelchair, near the activities room. The resident was wearing black sweat pants and a long-sleeved gray shirt which had stains on them and a very strong odor of urine was noted coming from the resident. On May 22, 2019 at 1:45 PM the resident was observed by Surveyors #1 and #2 wearing black sweat pants and gray shirt that were soiled and a very strong odor of urine was noted. During an interview with Surveyor #2 on this date the resident stated that s/he does not want help from staff for bathing and eating, s/he tells staff to get a wash cloth and soap and s/he will take care of it. The resident was asked about visual limitations and told the surveyor s/he could see shapes and colors.

During an observation of the resident on 5121/19 at 2:05 PM the surveyor noted the resident was sitting in a wheelchair wearing sweat pants that were soiled. There was a very strong odor of urine present.

[illegible] interview with S[illegible] on May 22, 2019 at 3:10 PM, GNA#1 stated the

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F 657	Continued From page 15 resident does not want assistance with bathing, getting dressed, or feeding/eating and that s/he consistently refuses all care. GNA#1 also stated the resident will not allow the staff to go into his/her closet retrieve soiled clothing and will pile the dirty clothes on the floor of the closet. Surveyor #2 asked the GNA if slhe believed the resident is bathing, changing into clean clothes, toileting himself/herself and performing oral care. GNA #1 agreed that slhe does not believe the resident is completing the AOL's. ADLs (Activities of Daily Living) refer to daily self-care activities such as bathing, grooming and dressing. During an interview with Surveyor #1 on 5/24/2019 at 10:35 AM the resident was asked if slhe toilets himself/herself and the resident replied "yes". The resident was sitting in a wheelchair at this time wearing black sweat pants and gray long-sleeved shirt, both stained and the strong odor of urine was present. The resident was asked ifs/he could see the images on the television and s/he replied, "not really" and stated s/he just listens to the TV. Medical record review failed to reveal the facility utilized an interdisciplinary approach to develop a care plan based on a comprehensive assessment of the resident's needs and included the resident's cognitive, functional and visual impairments. The findings were discussed with the Administrator and Director of Nursing during the exit conference on 5124/19 at approximately 4:30 **PM.** Refer to F684	F 657		

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F 684 SS=D	Continued From page 16 Quality of Care CFR(s): 483.25	F 684 F 684		

§ 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 and review of other pertinent documentation, observation and staff interview, it was determined the facility staff failed to provide treatment and care in accordance with professional standards of practice and a comprehensive person-centered care plan as evidenced by the failure to: 1) ensure a physician's order for weekly skin assessments for Resident #8 was carried out; 2) identify and develop a plan of treatment to address significant weight loss for Resident# 11; and 3) complete a thorough admission assessment of Resident #6's wounds, and follow through with a physician's order for foot care in a timely manner. This was evident for 3 of 4 residents reviewed for quality of care during this complaint survey.

The findings include:

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

\leasures to prevent reuccurrencc:

I/\) The Quality us urnnce nurse will eed11ct1te licensed mirsi:.4, Ml)S coorl.linalor lnd social worke on cnsur'lnl,I lhc per::ona\ i)•gicne and bathing i:are µ\mis n:fl.:ct the :lcknt m:e<ls. In llddition lhc Quality a5sumncc nurse will reeducate the nurses aides n documenting and reporting residcnl5 who eli.Jse care.

B) The Quality nsst1ra11cc nurse will n.:educat [he liccn cd nursing on the i1npDrlance of c(1n1plctiny weekly skin agscssnu:nts .is per hy 11:inn orders.

) Tht: Quality ;is,urancc 1111rsc will rccducatc 1hc diclkian and licenst:<l nursing on t:nsuring lmt residents with si1,1nilicanl weight loss are Jcmifil:d mid a plan Dftrealme111 is dC\eloped. n ucldition c<lucalion will be prO\1dc<l on the (n ilitic5 weight chance policy.

0) The Quality assurance nurse will reeducate r,liC licensed nursim! staff on cnsurinu the 1dmission ..-iss..:ssmen1s cvah1ation reflect the es1de111• wounds. In nddilion cducn1io11 will e providc<l on ensuring physicinn order, for oot care are completed per order.

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F 684	Continued From page 17 1) The facility failed to implenient a plan lo ensure Resident #8 had routine skln assessments to prevent the development of skin injuries. Medical record review on 5/2i/19 revealed a care plan initiated on 1/19/18 that addressed the potential for impaired **skin** integrity related to decreased mobility and noted the resident had a boil on his/her back. It was also noted that the resident had a wound to the left foot, 2nd toe. Interventions included but were not limited to identification and elimination of potential causative factors and keep the resident's skin clean and dry. A Care Plan **Note** ct·ated 5/20/19 reported the resident has a behavior **of** refusing wound dressings to left 2nd toe and refusing to lake a shower when offered. It was noted that the Resident was educated on the risks and benefits of refusing wound dressings and showers such as infection and other complications. The physician and resident's responsible party were made aware. The plan was to continue to monitor. The medical record contained *an* order tor weekly skin checks *on* Tuesday, 11-7 shift. Review of the Treatment Administration Record for May 2019 revealed It was not signed off 5r7/19 or 5/14/19 as having been done and there **were** no progress notes to indicate why the assessments were not done. Lymphedema is a condition in which the lymphatic system does not properly *remove* excess fluid from the body, which results in acc11,nulale9 fl_L1_ict in a part of the br0y l:"!.!.Ch 2s? leg or an arm. At times this excess fluid is	F 684	Monitoring of corrective actions for residents nffoctcd residents: I A) D1ree1ur of nursing will complclc an nt1dil w.:ekly x four and !lien monthly audit for the nex1 t\1'0 months of no l<:ss than ::!0"-u or n:sitknt who h.i,•c li::e11identified by tlteir comprehensive a sessmei11 nf 11 defi·ieniJy of per onnl hygiene and balhing 10 ca:urc 1he1r person centered care phm is reflective of 1hcir l'ft!(:JtT:..;; In addition the unit managers will perform an Judi! daily x 5 days for 4 weeks than monlhly x2 of point click care clinicul ulens for residents wilh consistent refusals to ensure l.:art: plan ndjustments are being mode to meet the resident"s needs. In addition during neighborhood rounds IDT will perfom1 an audit ofno less thnn 20% of residents with consislcnt refusals of care lo validate that their c.irc plans ;ire being followed. B)The nursing\lpervisers will perform _nn dl1weekly x four and then monthly m1d11rur c r\cxt Lwo rnon1hs of no le:s 111111125% of sidcn\s \\ith o weekly skin a. scssmcnt order o ensure the phy$ici1rns order Is being ollowcd. *1)* The Director of nursing will pcrforn1 u twdit weekly .x four und then monthly for 1hc m:.xl 1wo months to ensure residents will a wcighl los hn,·e *a* trrmtmcnt pion i111plcme111ed. 3) The Nun;ing supervisor. will complete 11 nudit weekly x four nnd then monthly uudi1 for the ne. I 1wo months or new admissions ta rnsme ndmission :1i;sesi.ments of wounds wen: ::omplcted 1horoughly. In uddi!ion Lill monthly udil x three will be co111ple1cd of resillen1s with wot111tli:10 cn 1rrc llmt orders for root cnr<!=	

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F 684	Continued From page 18 referred to as edema. This condition tends to cause the person's weight to go up and down. 2) A review of Resident #11's medical record on 5/22/19 at 4:10 PM, revealed and History and Physical signed by the attending physician dated 313/19 that documented the resident was admitted on - and was being treated for chrqti1c lyinphedema in the legs. Review of the active care plan documented a focus of "Chronic Venous Insufficiency (the blood is not being transported back to the heart in a sufficient manner) r/t Lymphedema with an intervention to monitor and document excessive edema (swelling) for the resident." Further review of the record revealed a Weight and Vitals Summary from 2/27/19 through 5/7/19 that documented the resident's weights as followed: 2/27/19: 154 lbs. (pounds), 3/13/19: 150 lbs. 3/27/19: 136 lbs. with a re-weight on 3/28/19: 136 lbs. 4/18/19: 135 lbs. 5/7/19: 133.6 lbs. A concLirrenl review or the resident's active care plan documented a Focus, for "unexpected weight loss" with an intervention to "monitor and evaluate any wel'ghl loss and detem1ine percentage lost and follow facility protocol for weight loss." An intel'view with LPN Staff #1 on 5/22/19 at 5:20 PM revealed staff did not document a measurement of Resident# 11's leg swelling by giving the level of pitting edema or providing a measurement of the legs to gauge improvement ne/she wasn't sure if the right leg was that he/she wasn't sure if the right leg was	F684	lhc llnmng 01 me audits will be pre. cnlcd a\ :)API for the next 90 days for review and :ommcnl.	

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F 684	Continued From page 19	F 684		

swollen at admission. Staff #1 reported that the resident could not have lost 10% of his/her weight due to the improving edema in the legs.

An interview with the Director of Nursing (DON) on 5/22/19 at 5:25 PM, revealed that when a resident has a significant weight loss that he/she expected staff to follow the "Resident Weight" facility policy. The DON also stated that he/she was aware of the condition of the resident upon admission but was unable to state if Resident #11's leg swelling was significant enough that its reduction could cause a 10% weight loss.

Review of the "Resident Weight" policy revealed that when a weight loss is suspected the resident is re-weighed within 24 hours; if the weight loss was validated by a nurse; the Interdisciplinary Team, the resident's attending physician and family would be notified. In addition, the resident's weight loss would be addressed weekly during the facility's clinical meetings.

However, further review of medical records at the time of weight loss failed to find documentation to support that any of the facility's weight protocols were followed for the resident. A review of the Registered Dietitian's notes failed to show that s/he was aware of the initial 4-pound weight loss after admission or that the resident's physician was notified of any of the resident's weight losses. A review of a physician visit noted dated 3/27/19 failed to mention that the resident had weight loss during that time. In addition, during the 5/22/19 at 5:25 PM interview with the DON, s/he failed to acknowledge that the resident's weight loss was addressed at their weekly clinical mcc ti ng. Th h -mi:i-t r:=a t"lr an - fiO l 'tle o made aware of surveyor's concerns on 5/22/19 at

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F 684	Continued From page 20 9:00 PM. 3) A review of Resident #6's medical record was conducted on 5/22/19 at 9:45 AM. Review of an 513/19 admission assessment note written by Licensed Practical Nurse (LPN) Staff #3 revealed thal the resident had wounds located in the chest, front right hip, back of rigl1t hand from pressL1re, front of left thigh vascular, and sacrum from pressure. However, review of the Treatment Administration Records (TAR) dated 5/2118 - 7/31/18, documented several additional areas will, wounds; a blister of unknown location, left buttocks, left forearm surgical incision, lert knee, left lower extremity, right buttocks, right knee, and right lower extremity that-were not found In the admission records. An interview with the Direetor of Nursing (DON) on 5/22/19 at 4:15 PM, revealed s/he was not sure that the resident had lower extremities, and therefore was unaware of the condition of the wounds on the lower extremities. Review of a 6/7/19 consultation note written by the wound physician *(Staff* #50) indicated a recommendation for Resident fl.6 lo be seen by a podiatrist. Fur[her review revealed a physician order dated 6/7/18 for the resident lo be seen by a podiatrist On 6/12/19 the order was discontinued and re-entered and staled the appointment was for 6/28118 at 10:15 AM. However, further review found nn document.itlon of the outcome of lhls consultation had occurred. During a follow-up interview with the DON on 5/22/19 at 4:15 PM s/he revealed thats/he was *ri..Dt_a are* that lQe r1:1 irl"nt s r.e "mme.Ad-e.d ta see a podiatrist. However, s/he would provide the	F 684		

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F 684	Continued From page 21 missing consult notes from the 6/28/19 visit However, on 5/24/18 a review of the notes submitted to the state survey agency did not include podiatry visit. The Nursing Home Administrator and DON were made aware of the findings on 5/22/19 at 9:30 PM.	F 684		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d}(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview It was determined the facility failed lo: 1) provlde ongoing supervision to Resident #3 who was known to l1ave smoked marijuana and cigarettes in his/her room and had an episode of suspected drug overdose requiring the administration or Narcan; arid 2) Investigate these lnc[denls to prevent future occurrences. This was evident for 1 of 3 residents reviewed for safety/supervision during this complaint survey. The facility's failure to provide adequate supervision for Resident#3 and promptly investigate the repeated Incidents of Illicit drug use, smoking Violations and develop a definitive plan for safety and prevention of harm for current r.	F 689	**C r ccli\'c action:** Rcsidcnl t/3 no longer resides at Ilic focility. Identify others with polcntial to bl! affcctctl: Resident in the facility who smoke have been eeducatcd on the fncililies smoke policy, the fron1 desk staff asks resident visitors or e·idculs returning on LOA if they huvc any making items for the residents and if1hey do they must be immediately turned over the };laff. Rcsidem who .ire alen have been given and resident familie5 hn\'e been mailed u lcllt:r i1,1Corn1i11£ them of the focili1ics smoke policy. f'11e residents who smoke hove hod their rooms .carched to ensure no smoking paraphcnmlia is in the resident rooms.	7/8/19

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F 689	Continued From page 22	F 689		

to resident health and safety. Therefore, an immediate jeopardy situation was identified on May 22, 2019 at 2:26 PM. The facility submitted an acceptable plan of action at 9:48 PM on May 22, 2019 that was reviewed and accepted by the survey team and the Office of Health Care Quality. The immediate jeopardy was removed on May 24, 2019 at 4:15 PM while the surveyor was on-site. After removal of the immediate jeopardy, the deficient practice remained for potential for more than minimal harm and at a scope and severity of D.

The findings include:

A Resident Smoking Policy with a review date of 411/16 noted smoking hours are posted by the facility and smoking materials are secured in a locked area when not in use by the resident.

Medical record review on 5/17/19 revealed Resident #3 was admitted to the facility in [redacted] for [redacted] skilled nursing services with diagnoses that included but were not limited to fracture of the foot, Bipolar Disorder and a history of Marijuana use.

A Smoking Assessment completed on 2/8/19 revealed the resident was determined to be an "independent smoker with supervision". The form noted that selecting the independent designation indicated the resident did not require supervision or other accommodations to maintain safety during smoking. The designation of an independent smoker that requires supervision is inconsistent with the facility's policy.

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reported that at approximately 9:50 PM the

Measures to prevent rcuccurrcncc:
The regional dircc1or Or clinical operations wil I cduca11: the director Or nursing, the 1ad111111is1ra1or and the nursing supervisors of nsuring investigMions arc initiated timclr and intcrvenLion put in place when an incident of a .:sidcut smoking or presumed illicit substance ·1husc in the focility is identified.

fh_quality as urance nmse will re_ed'.1cnt,e the 1u11 on reporting any mc1den1s or 1nlrnc11011s tu the director of nursing, the administrator I iind the nursing supervisors.

\Jonitoring of corrective m:lions for -cslclcnts nffcctcd residents:
lfhc administer will perfonn a audit weekly x four and then monthly audit for the next two 1months to ensure incidents of residents \5mokmg in the _facility or presumed illicit J:<;ubsi:rncc abuse to ensure lhe incident in investigated pro1erly and interventions to P.re e ·ed '-t: -i' c' s1Iftcifiiiht'lcl:-..... .. ."
TiicadriiinisTraior will comple<e an audit t1•eekly x 4 and then monthly x2 of the csioent moke break to ensure residents who !lqui c aprons have the aprons on and that the ;;mokmg Items are locked up ofter the smoke

h rqurk. [Th e findings o[the audiL<; will be a< QAPI fo, the""" 90 da,,.

STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTIOf/	(X1) PROVIDER/SUPPLIER/CUA IOEN"IIFICATION NUMEJER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, :JTATE, ZIP CODE
NORTHWEST HEALTHCARE CENrER	4601 PALL MALL ROAD BALTIMORE, MD 21215

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F 689	Continued From page 23 resident had a visitor, after which the writer smelled the strong odor of Marijuana smoke coming from the resident's room. The resident's door was locked on the inside and after several knocks on the door from security and other staff the resident unlocked the door to reveal even more pungent smell of Marijuana smoke coming from the room. The medical record contained a document entitled Guidelines for Resident Behavior that was signed by the resident on 2/11/19. The document contained information regarding rules relative to smoking, drug and alcohol use, and possession of weapons in the facility. It was noted that non-compliance with the rules could result in the initiation of a behavioral management plan, referral to local law enforcement or discharge from the facility. A care plan with initiation dates of 2/13/19 and 4/24/19 addressed the resident's desire to smoke and that the resident was assessed as an independent smoker. Interventions included monitoring the resident's safety during smoking and to complete a smoking assessmen quarterly, annually and with a change in condition. A care plan is a guide that addresses the unique needs of each resident 11 is used to plan, assess and evaluate (he effectiveness of the resident's care. A Behavior Note dated 2/17/19 reported the resident had visitors that day in her/his room. The writer, licensed practical nurse (LPN #1), noted a towel was placed at the bottom of the door, inside 'ijuana. It was noted that the building manage marijuana. It was noted that the building manager	F 689		

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NORTHWEST HEALTHCARE CENTER	4601 PALL MALL ROAD BALTIMORE, MD 21215

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F 689	Continued From page 24	F 689		

and security were notified to witness the smell in the room. The writer documented that s/he would continue to monitor throughout shift for any other changes in behavior. There was no evidence of an investigation regarding how the resident obtained the smoking materials or if staff were able to determine if the smoking materials were brought in by visitors.

A Care Plan note dated 3/4/19 at 4:58 PM reported the resident was noted to be smoking marijuana in the shower room on 3/3/19, was educated about the smoking policy and was asked to turn over any lighter, cigarettes, or marijuana s/he may have still had in her/his possession. It was noted that the resident denied smoking and having possession of a lighter, cigarettes, or marijuana.

A Social Services note dated 3/4/19 reported the resident was re-educated on the facility Smoking Policy and the Guidelines for Resident Behavior thats/he signed on 2/11/19. The resident was informed that any continued non-compliance of the Smoking Policy could possibly lead to an involuntary discharge notice being given.

A Nurses Note dated 3/11/19 at 11:23 PM reported the resident was in the shower room smoking. The resident denied smoking when asked by the nurse. The resident was educated on the danger of smoking inside the facility.

A Behavioral Health Services note dated 3/13/19 noted the resident was evaluated for continued use of marijuana at the facility. It was noted the resident denied use of marijuana even though staff noted the smell of marijuana coming from the resident's room on multiple occasions. The

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHWEST HEALTHCARE CENTER	4601 PALL MALL ROAD BALTIMORE, MD 21216

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F 689	Continued From page 25	F 689		

Behavior Management Plan, noted by tile Nurse PraclitJoner, was that staff would provide structured socialization, structured activities of daily living (AD) care, and staff were to approach the resfdent respectfully and be clear about upcoming nursing care. This plan was compared to a plan for Resident #2 and found to be identical, therefore not individualized for Resident #3. Activilles of Daily Living, ADLs refer to daily self-care actMlies such .is bathing, grooming, eating and dressing.

A Behavior Note dated 3/26/19 at 10:44 PM reported the resident was demanding staff to take her/17im outside to smoke at 1O:15 PM. S/he was educated and redirected on the time schedule for smoking, but stated s/he did not care because s/he needed to smoke to cairn her/his nerves. The resident was reportedly yelling/screaming, cursing at statf and broke the hand rail close to the nurses' station. The resident threatened to wake all the patients up on every noor and smoke in lier/his room and burn the bLJilding down. The Supervisor was made aware.

A Skilled Documentation note dated 4/4/19 at 2:23 **PM** reported the resident had a visitor with whom s/he went outside in the courtyard and smoked Marijuana. It was noted that the resident was re-educated on the risks of her/his behavior but denied using/smoking marijuana.

A physician's note dated 4/9/19 noted that per reports from nursing staff lhe resident had been meeting people onllne, bringing them into the facility and was caught smokfng weed given to her/him by these individuals.

On 4/10/19 the psychiatric Nurse Practitioner

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRFSS. CITY, STATE, ZIP CODE
NORTHWEST HEALTHCARE CENTER	4601 PALL MALL ROAD **BALTIMORE, MD 21215**

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F 689	Continued From page 26 documented that the resident was encouraged to avoid using marijuana at the facility. The medical record contained care plans, with initialion dates of 4/24/19 that addressed a behavior problem related lo smoking marijuana and cigarettes in the facility and/or allowing guests to smoke in her/his room, a history of marijuana abuse/substance abuse and soliciting staff for money to purchase marijuana. Interventions included but were not limited to assisting the resident to develop more appropriate ways of coping, encourage tt,e resident to express his/lier feelings appropr ately, d1scuss behaviors, explain why behaviors are inappropriate, intervene as necessary lo protect the rigt,ls and safety of others, and obtain a psychiatric consult as needed. Specific interventions to maintain the resident's safety including adiusling the level of supervision was not addressed. A Smoking Assessment dated 5/21/19 indicated the resident was an "independent smoker requiring supervision". The resident's care plan directed staff to reassess the resident with a change in condition. The resident had multiple episodes of smoldng in non-designated areas before s/11e was reassessed. A Behavior Note dated 5/5/19 at 11:32 PM reported the resident was smoking in her/his room and was educated on the risks *of* smoking in bed. A Behavior Note dated 5/7/19 at 10:54 PM noted the resident was smoking Marijuana along with another resident in her/his room, The resident told staff to go away when they knocked tC' fl_J r **th r q,e!1t'S** fQ.Q"n. **!t "'Z!&.go** o._N **thgt .the** resident was educated on the risks/danger of	F 689		

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NORTHWEST HEALTHCARE CENTER	4601 PALL MALL ROAD BALTIMORE, MD 21215

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F 689	Continued From page 27 smoking in her/his room. A Behavioral Health services note dated 5/9/19 reported the resident's visiting privileges were taken away due to smoking in her/his room. The facility issued a notice to the resident, dated 5/9/19 that her/his visiting privileges were suspended for 1 week. A Care Plan note dated 5/10/19 at 12:23 PM reported that on 5/9/19, the resident was noted to be drowsy, incoherent and could hardly open her/his eyes and could not propel herself/himself in the wheelchair. The physician was notified and ordered the resident to be given Narcan which was administered. It was noted that the Narcan was effective. A Nurses Note dated 5/14/19 at 11:35 PM reported the Resident was in another resident's room and staff smelled cigarette smoke coming from the mom. A Behavior Note dated 5/18/19 at 11:30 PM reported the resident was noted to be smoking in her/his room during rounds at the beginning of the shift. The writer reported the resident started spraying air freshener, but the room was still filled with cigarette smoke and s/he was re-educated on the risk of smoking in the room. During an interview with the surveyor on 5/17/19 at 3:45 PM the Director of Nursing (DON) was asked what actions were taken regarding Resident #3's repeated non-compliance with the smoking policy. The DON stated the Social Worker would usually talk to the resident about non-compliance and issue a 30- day notice if the problem persists. A Snr-i t C:: r\1}r0 - ri.:-t .dated "'i111 a {n• r'i': th0 survey) at 6:09 PM noted the Social Worker met	F 689		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATF, 7IP GOOF.
NORTHWEST HEALTHCARE CENTER	4601 PALL MALL ROAD **BALTIMORE, MD 21215**

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F 689	Continued From page 28 with the resident lo discuss and re- educate him/her on the Guidelines for Resident Behavior- contract that was signed upon admission. The discussion was to re-educate on the facilities smoking policy. This writer did inform the resident of the no tolerance for smoking in the facility or having cigarettes and lighting material in possession or stored in resident rooms. This writer did discuss visitor guidelines including visitors' obligation to forward smoking material to the supervisor or front desk to be given to Activities staff for locked storage. The resident was told ifs/he was found in violation of the smoking policy s/he would be given a 30-day discharge notice for continued violation of the facility's smoking policy and the Guidelines of Resident Behavior contract. In inteNiew with the surveyor on 5/21/19 at 12:35 PM the Social Services Director stated s/he had been meeting with the resident's caseworker to discuss the behaviors. The Social SeNices Director stated s/he has a behavior contract with the resident and has reviewed that with the resident several times. The Social Worker was referencing the Guideline for Resident Behavior. During an interview with the surveyor on 5/21/19 at 3:45 PM the Administrator stated s/he did not issue a 30-day notice for continued violation of the smoking policy because slhe thought Resident #3's discharge was imminent and because the facility had not identified a safe discharge destination. During an interview with the surveyor on 5/21/19 at 4:05 **PM** the attending physician stated she fr:lV n .qrrf.:ar ..:='.....h..a c:M ..... tha l::-Oe:-ion+1z history. The physician reported she did not see	689		

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NORTHWEST HEALTHCARE CENTER	4601 PALL MALL ROAD BALTIMORE, MD 2121S

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F 689	Continued From page 29 the resident on 5/9/19 but was told by staff that the resident was unresponsive. A Drug screen done on 5/9/19 was negative for opioids or other Illicit drugs. The surveyor asked if staff knew how the resident may have obtained illicit substances and she replied that she did not know but there's a lot of trading going on out back (referring to the courtyard). The physician stated she was aware of the resident's marijuana use. Stated she did not discontinue the resident's oxycodone because the resident does not ask for it and would like to keep the order in case the resident experienced severe pain. The physician further stated she believed the resident was competent and was not interested in addressing substance use. During an interview with the Administrator on 5/22119 at 11:15 AM the surveyor asked about the process for implementing a behavior management plan as outlined in the Guidelines for Resident Behavior and s/he stated the facility reached out to the resident's caseworker to ascertain what services or resources were available to the resident that could be utilized while the resident was In the facility. During this interview the surveyor discussed concerns that a behavior management plan had not been developed for the resident. The facility's failure to contact law enforcement regarding the presence of illicit s.ubstances in the facility, as oulljned in the behavior contract. Impose further visiting restrictions, and conduct investigations to ascertain how the resident was getting smoking materials and illicit substances was also discussed. As a result of these findings, an immediate] " rdv sit e.tjp " ?,.$!rl ntifie C-.'1 M?..Y:22, 201@ at 2:26 PM. The facility submitted an initial plan of	F 689		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHWEST HEALTHCARE CENTER	4601 PALL MALL ROAD BALTIMORE, MD 21215

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F 689	Continued From page 30	F 689		

action to the surveyor and the Office of Health Care Quality for review at 5:08 PM. This initial plan was not accepted. Revised plans were submitted at 8:33 PM and 8:55 PM. PM which were not accepted. The facility submitted a revised plan of action at 9:48 PM that was reviewed by the survey team and the Office of Health Care Quality. The plan was accepted but the immediate jeopardy was not removed until 5/24/19 at4:15 PM.

The plan included:
• Police were notified regarding resident's visitor bringing in drug paraphernalia on 5/22/19
• The Resident was placed on a 1:1 monitoring on 5/21/19;
• The Resident's visitations will be supervised only, beginning 5121/19;
* The Resident was reassessed for smoking safety on 5/21/19;
• The Resident's room was searched for smoking materials on 5/21/19;
* The Resident was re-educated on the smoking policy on 5/21/19;
* The Resident's room was checked for illicit drugs and smoking materials on 5/21/19;
• The resident is to engage in smoking activities only under supervision. 5/21/19;
• The resident's care plan was updated to reflect new interventions on 5121/19 & 5/22/19;
• An Ad Hoc QAPI meeting conducted to review updated Smoking Policy on 5/21/19;
* Residents who smoke were re-educated that all smoking paraphernalia will be secured and locked up by staff. 5/21/19;
• Smoking assessments were completed on residents at risk for smoking. 5/21/19 & 5/22/19;
* .Niirs.tqg _t ff w.iltrea &. .rgzf.de:'1t. Grnc -g assessments. 5/22/19;

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F 689	Continued From page 31 •Smoking area was assessed for all safety equipment including ashtrays, aprons, fire extinguishers, etc. 5/21/19; and •care plans updated to reflect most current assessment. 5/22/19. Education: • All residents who smoke were reeducated on the facilities smoking policy and process 5/21/19; • Staff education was provided to the staff to go over the smoking policy and process Started 5/21/19; • Front desk staff are being reeducated to ask all visitors and residents returning on LOA if they have any smoke paraphernalia. If they do, they need to get the items and give them to the nurse to secure; * The nurse will be reeducated on properly completing a smoking assessment and the nurse managers and social worker on updating the care plan; • Supervisors will be reeducated to conduct thorough investigations for residents smoking in the facility or in possession of illicit substances; Systems Change: * If a resident and or visitor is caught smoking in their room and or using illicit substances the supervisor, Executive Director (ED), Director of Nursing (DON) and Medical Director (MD) and law enforcement must be notified and a thorough investigation will be completed ED and or DON; * Social services will educate all new residents on the smoke policy; • Nursing supervisors will be educated to observe for smoking in the facility when they are completing rounds; [illegible] and of responsible parties will sent a letter informing [illegible] be sent a letter informing them not to bring	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORREC rJON	()(1) PROVIDER/SUPPLIER/CUA IDC:NTIFICATION NUMBrn:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689	Continued From page 32 residents any smoking paraphernalia rather bring it to the facility staff; and * The Behavior contract is being reviewed. Monitoring: • Nursing supervisor and or Social worker will audit daily X 5 d, then weekly for 3 weeks and then monthly X 3 will search residents who are smokers for having smoking paraphernalia in their rooms or on their possession. Audits will be reviewed at QAPI. Once it has been determined that enhanced system interventions and monitoring have been made, the frequency of the auditing process will be determined. • Audits will be completed of investigations of residents smoking in their room or using illicit substances weekly for intervention, care plan and investigation purposes for the next 4 weeks and then monthly x 3. * Audits will be completed of smoking assessments for new admissions to ensure accuracy of the smoking accuracy and care planned for the next 4 weeks and then monthly x 3 • Education will be completed by the end of the day 5/23/2019. • Staff will be educated prior the onset of the shift. The surveyor conducted an extended survey on May 23, 2019 and May 24, 2019 that included a review of other residents that were identified as smokers to determine if assessments and care planning regarding safety needs were appropriate. The surveyor also reviewed in-service training, policies and procedures related to smoking and conducted additional staff interviews to determine their knowledge of the [illegible] and care planning for residents who smoke and the policies related to	F 689		

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NORTHWEST HEALTHCARE CENTER	4601 PALL MALL ROAD BALTIMORE, MD 21215

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F 689	Continued From page 33 smoking.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(9)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastroslomy tubes, both percutaneous endoscopic gaslrostomy 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 tes!denl's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(9)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(9)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on medical record review it was determined the facility staff failed to establish and maintain a system for ensuring accuracy In weight measurements for a nutritionally compromised resident (Resident #8). This was evident 1 of 3 residents reviewed for possible weight loss durtng this complaint survey. The findings include:	F 692	Corrective action: fhysicinn wn no1ificd 1hn1an accu.rnle wcigb1 vnsn'l vcrilicd *for* the rc. idci11s weight 1.i c11 ,12119/18. A11 nc,;umtc wciylu 1111$ been ob1ained for rc iclcnt #8, The C,irc plan wns updn1cd bosed on the weight C\'.1lun1ion	7/8/19

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NA!AE OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHWEST HEALTHCARE CENTER	4601 PALL MALL ROAD BALTIMORE, MD 21215

(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 692	Continued From page 34 measures for ensuring accuracy of weight measurements for Resident #8 who was at risk for weight loss. Medical record review on 5/21/19, revealed Resident #8 was a long-tenn care resident admitted to the facility with diagnoses that included but were not limited to Glaucoma, Contractures of both hands Schizophrenia and Bipolar Disorder. Contractures are the chronic loss of joint motion due to structural changes in non-bony tissue. If the joints, muscles, ligaments, and tendons are not exercised they will contract or stiffen. (rnedlineplus.gov) Review of complaint MD00127531 revealed a concern that the facility was not entering accurate weights in the electronic medical record system. Further review of the medical record revealed the following weight measurements in pounds; 5/7119: 138 lbs. method not specified 4/10/19: 134.6 lbs. standing 3/7/19: 129.4 lbs. wheelchair 12119/18: 112 lbs wheelchair 3/6/2018: 136.0 lbs. wheelchair scale 2/L1/201A· 1:.R.n lh<:; method not specified	F 692	**Jclcntify others with potential to be affected:** The Dietitian will perform an llllldi1 of rcsidcnt;; weighed this month lo ensure llrnt any residents vho li.id a significant weight loss were re-lwcighcd to validate .iccuracy. 111 addition an audit by the dietitian will be completed lo 1Cr1surc the consistent method or obtaining a veight is being dorie, I\lcasurcs lo prcycnt rcoccurrcncc: The Quality assurnnce nurse will reeducate the licensed nurses and the dietician to ensure csiclcnl with a signil1cant weight loss is eweighed 1o verify accuracy and thnt a onsistcnt method of obtaining a weight is done.. i\loniluriu or corrective 11ctions for residents affected **residents:** !The director of nursing will complete a audit vcckly :c four and then monthly audit for the next two months of resident, with a potential ignil'icant weight loss were re-weighed to i\'Dlidatc accuracy und that consistent method.or ,b,,.inin" aweight was. The findings of the f11be presented .it QAPI for the next review and comment.	

STATEMENT OF DEFICIENCIES AND PU\i OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFIC/TION NUi,1B[R:	(XZ) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPU•:TCD
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS. CITY, STATE, ZIP COD[
NORTHWEST HEALTHCARE CENTER	4601 PALL MALL ROAD BALTIMORE, MD 21215

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F 692	Continued From page 35 1/5/2018: 137.0 lbs. method not specified The Dietitian noted in a Weight Change Note dated 3/18/19 at 8:43 AM thats/he was unsure if the December 2018 weight was accurate due to the resident's very thin appearance and occasional poor intake related to paranoia. The facility's policy for residents' weights with an effective and review date of 5/19/16 instructed staff to re-weigh the resident if a variance of 5 pounds or more is noted. Medical record review failed to reveal evidence that the resident was re-weighed to verify the accuracy of the weighl obtained on 12/19/18. The weight was crossed out dming the survey and the Director of Nursing indicated it was incorrect, however there was no documentation at the time the measurement was taken to verify the accuracy or inaccuracy. The findings were discussed with the Administrator and Director of Nursing during the exit conference on 5/24/19 al approximately 4:30 PM.	F 692		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(1)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release Information that ls resident-identifiable to the public. (in The facllity may release Information that is resident-Identifiable to an agent only in accordance with a contract under which the agent a.grees not to use or disclose Lhe Information except to the extent the facility Itself is permitted to du so.	F 842		

STATEMENT OF DEFICIENCIES /\ND PLAN OF COHREC. I ION	(X1) PROVIDER/SUPPLIER/CUA IDHDIFICATION NUM8Ef<:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY CO).'!r'I FTUI
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F 842	Continued From page 36 §483.?0(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 §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	F 842		

STATEMENT OF DEFICIENCIES ANll PLAN OF CORI ECTIOt,	(X1) PROVIDERISUPPLIER/CLIA IDf'NTIFIClTION NUMBER;	(X2) MULTIPLE CONSTRUCT/ON	(X3) DATE SURVEY COMf'LETED
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F 842	Continued From page 37 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)(S) The medical record must contain- (i) Sufficient infonnalion to identify the resident; (ii) A record of the resident's assessments; (iil) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluallons and determinations conducted by lhe State; (v) Physician's, nurse's, and o\her licensed professional's progress notes; and (vi) Laboratory, radiolo.gy and other diagnostic services reports as required under §483.50. This REQUIREMENT Is hOI met as evidenced by: Based on medical record review and staff interview it was determined that the facility staff failed to have a resident's medical record eomplate, accurate. and in chronological order. This was evioent for 1 of 16 residents (Resident #6) reviewed l'or complaint investigations during the survey. The findings include: A medical record review for Resident #6 on 5/22/19 at 9:45 AM, revealed progress notes, physician's orders, and consultation notes were not in chronological order in the chart. In addition, records dated for 2018 and 2019 were mixed together wl1ich made it difficult to determine the tlmeline of care and treatments. Further review revealed that the medical record the prosthetic physician were not on the medical	F 842	**Corrective nction:** The medical record for resident #6 is complele :md in chronological order. Resident hnd no 1cga!lvc outcomes. dcntiry others with potcnti,11 to hr affrctcd: Thu Regional Electric Menllh nur,e will perform nn audit of Medical records charts for csidcnts ll"ho discharged in 11tc lnsl 30 days to ·nsurc tbc record iR complett:, accurJte and in order. ;\lcasun•s to prcn-nt rcoccurrcncc: The Regional Electric Health nurse will reeduc:He the electric heu1th records nurse on lie intportanl.]e of maintaining di5chargcd csidcnl records accurately and in -hronologicaJ order.	7/8/19

STATEMENT OF DEFICIENCIES /NL1 Pl.AN OF CCJRHEC·1 ION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICAI ION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLEf[L)
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE. ZIP CODE
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F 842	Continued From page 38 record and had to be obtained at the time of the survey. During an interview with the Director of Nursing on 5/22/19 at 4:15 PM, he/she was made aware of and acknowledged the above findings.	F 842	Monitoriui; of corrccti\'l! nctions for ·csidc.nts nffcclcLI residents: The electric he.a.1th nurnc will pcrfonn a 10n1h!y a11di1 for the ne:<1 three mo111hs·of klischarged re idcnts 10 en ure their rnedkul irecords urc a1:curQlc, cumph:tc and in Jchrono!ogicnt order. The fincling!-of the aud1ls \l**i**l**t** be prescmed ut QAPI far the nex1 90 clny · eview and comrnenl.	
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview with facility staff, it was determined the facility failed to maintain an environment that was safe, sanitary, comfortable and functional for the residents, staff and visitors. This deficient practice had the potential to affect all residents. The findings include: Surveyor tour of the facility on 5/17119 at 3:00 PM revealed the following concerns: Room 39- The wall outside of the door was spackled but not painted. The door had numerous chips and scraps that could possibly lead to a resident sustaining a skin tear. There was a hole in the tile near the door. The blinds had broken and bent slats. Room 38- The privacy curtain had holes in it. The handrail outside of the room was not firmly attached to the wall	F 921	Corrective nction: I) Room 39-wall outside room has been painted, the door is being replaced and the !blinds have been replaced)Room 38-the privacy curtains have been replaced and the handrail has been firmly secured lo the wail) Room 36- the wall scrapes were cpaircd r-1) Room 49-Powcr cord has been replaced! 15) Room 24-The TV cable has been secured 6) Room SO- the molding near the handrai lj 1as been fixed. 7) Therapy room-the wall has been fixed outside of the therapy room 8)Shower room #2 has been cleaned and inspected for fruit flies	1/B/ 7 19

STATEMENT OF DEFICIENCIES N'1D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICAI ION tsUMBrn:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPI.E-TED
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F 921	Continued From page 39 Room 36- There were numerous scrapes on the walls. Room 49- The power surge cord attached to the air conditioner was pulled taut. Room 24- The TV cable was not secured. Room 50- The molding near the handrail was falling off. Therapy Room- There were holes in the wall near the floor molding, outside of the therapy room. **A** facility tour on 5/21/19 at 11:36 **AM** revealed the following: Shower Room #2- There was a very strong odor of urine. Pants and a gown were on the floor and flies were noted in the shower. The concerns were discussed with the Maintenance Director on 5/22/19 at 10:38 AM. The Maintenance stated s/he and other department heads conduct environmental rounds weekly.	F 921	**Identify others with potential to be affected:** **The** maintenance director will complete a oom to room audit to identify and correct[he items and areas noted above. , Mcasur<'s to prcrcnt r<'occurnncc: rrhe quality assurance nurse will reeducate 1hc maintenance director and housekeeping upervisor on ensuring thm the 5afe and comfortable cnvironmenl 1 he Administrator will educate the IDT on \ ·omplcting biweekly rounds of residents rooms! o nsure the rooms are m order and nr.: n omfonnblc environment lbr the residents. lonitoring of c:orreclivc nctions for residents affected residents: T_he 11111inten<111cc director will perform a htwcckly audit x2 nnd then monthly for 1he 1c:<1t\Vo months of the resident room. to ensure th!! nbovc 111en1ioncd items ore no1 le111ilied. The findings of the uuclilli will qe re en1ed nt QAJ>J for tho next 90 dnys review nd comment.
F 925 SS=D	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation and review of complaints it was determined that the facility failed to maintain an effective pest control program as evidenced by	F 925		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECI ION	(Xf) PROVIDER/SUPPLIER/CUA !DEN rhC/ITICJN NUMBER:	(X2) MUI.TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPL[H:D
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F 925	Continued From page 40 the potential to impact all residents. The findings include: Surveyor review of complaint MD00136317 revealed a concern that the facility was infested with fruit flies. Surveyor tour of the facility on 5/17/19 at 3:00 PM revealed the following concerns: 1) In room 39 flies were noted in and around a fruit cup and in the shower next to the room. 2) Flies were noted flying around the New Wing nurses' station. 3} Flies were noted in Shower Room #2 on 5/21/19 at 11:36AM. On 5/22/19 at 10:38 AM the surveyor discussed the presence of the flies with the Maintenance Director. S/he stated that each unit has a pest control log and staff are to enter information in the log when pests are noted. The Exterminator checks the logbooks and treats the facility accordingly. The surveyor discussed the findings with the Administrator 5/22/19 at 11:1O AM ands/he stated the exterminator comes every other week.	F 925	Corr ctivc action: The identified area were inspected and <rea!cd necessary by 1he exlerminotor. Identify others with potential to be arrcctcd: f11t: Housekeeping supervisor will complete an udit of lhe resident rooms, shower rooms and nursing stations to check for fruil flies. h•nsur{'S to prevent rcoccurnncc: The regional direclor of environmentlll services will reeducate the housekeeping staff 10 ensure the nursing lations and shower room nnd re. idcnl rooms arc free of fruil !lies. fhc Quality assurance nurse will reeducillc the j1u,sings1aff10 ensure nuri;ing slations and hower room and resident rooms are free of rruit Oies. In addition education will be provided lo the on entering pest issues into the pc.qt control logs. Monitoring of corrective actions for csidcn ts nffected residents: The_ housekeeping supervisor wi11 perform an rndn weekly x4 and then a monthly audit for _hœ. _1 lwo months 10 ensure !he nursing lii.ions, sl_im :er rooms and rcs1dcnt rooms arc t:c of fru11 01es. The find mg. of the nudits ..-1I be presented al QAPI for 1he next 90 days enew and comment.	17/8/19

Office of Health Care Quallty

STATEMENT OF DEFICIENCIES /\ND PI\N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IfIFNTIFICATION NIJM8ER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPI.[fffl
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S 000	Initial comments On May 17, 2019 and May 20, 2019 t11rough May 24, 2019 an investigation was .conducted at this facility by the Office of Health Care Quality of ten complaints MD0D138360, MD00137373, MD00136317, MD00135427, MD00130833, MD00129628, MD00128885, MD00128397, MD00127531, and MD00127364. The census was 89 and the licensed bed capacity is 91. Survey activities consisted of a review of residents' medical records, observation, interview of the facility *staff* and residents and a review of administrative records. The survey identified non-compliance with Federal and State requirements that were reviewed in relationship to complaints: MD00137373, MDD0127531, MD00128885, MD00136317, MD00128885 and MD00130833. On May 22, 2019 at 2:26 PM, an immediate jeopardy was called by the Office of Health Care Quality related to a multi-system failure resulting in repeated violations of Ille smoking policy by Resident #3, thereby jeopardizing the health and safety of current and future residents. The facility submitted an initial plan of action to the suNeyor and lhe Office of Health Care Quality for review at 5.08 PM. This initial plan was not accepted. Revised plans were .submitted at 8·:33 PM and 8:55 PM which were not accepted. The facility submitted a revised plan of action at 9:48 PM that was reviewed by the survey team and the Office of Health Care Quality. The plan was accepted butthe immed[ate jeopardy was not removed until 5/24/19 at4:15 PM. SEE F689	S 000		

ORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (XS) DATE

Executive Director — 5-21-2019

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Office of Health Care Qualilv

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA ID:=NTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLFTFO
	215346	A. BUILDING: _____ __ B. WING _____	C 05/24/2019

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S 000	Continued From page 1 The extended survey was completed on May 23, 2019 and May 24, 2019.	S 000	lfhis plan of correclion is being prepared an-d .executed is being prepared and executed because it is required by 1hc provisions of the lnte and federal law, on not because Northwest Hcollhcarc Center admits or denies the validity oflhc allegations or citations listed Ion 1l1c pa es of the slrilcmcm of dcficicndci;. Northwest. Heolthcare Ccmcr mainta.ins that 1he itlleged deficiencies do notjeopurdize the health and safety of the residents, nor are they Orsuch c\rnrnctcr as lo limit our capacity lo render adequate cri re.	7/8/19
S 230	10.07.02.07 A Administration 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 F 689 F 921 F 925	S 230		
S 480	10.07.02.12 G Nsg Svcs;Responsibilities DoN .12 Nursing Services. G. Responsibilities of the Director of Nursing. The responsibilities of the director of nursing shall include: (1) Assisting in the development and updating of statements of riursing philosophy and objectlve·s, defining the type of nursing care the facility shall	S 480	! ee F tag 689 ee F tag 921 ee F tag 925	7/8/19

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STATEMENT OF DEFICIENCIES /ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION /I UUIUJII,G: B. WING	(X3) DATE SURVEY COMPI ETEO
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s 480	Continued From page 2 provide; (2) Preparation of written job descriptions for nursing personnel; (3) Planning for the total nursing needs of patients to be met and recommending the assignment of a sufficient number of supervisory and supportive personnel for each tour of duty; (4) Development and maintenance of nursing service policies and procedures to implement the program of care; (5) Participation in the coordination of patient services through appropriate staff committee meetings (pharmacy, infection control, patient care policies, and utilization review) and departmental meetings; (6) Cooperation with administration in planning the orientation program and the staff development program to upgrade the competency of the personnel; (7) Ensurance that the philosophy and objectives are understood and practiced by nursing personnel; (8) Participation in planning and budgeting for nursing services; (9) Establishment of a procedure to ensure that nursing personnel, including private duty nurses, have valid and current Maryland licenses; (10) Execution of patient care policies (unless delegated to principal physician, medical director); (11) Participation in the selection of prospective admissions to ensure that facility's staff is capable of meeting the needs of all patients admitted; (12) Coordination of the interdisciplinary patient care management efforts; (13) Supervision of medicine aides to ensure that t er. ft".i? i': " r m f olimit - ':'n :o"'. restrictions placed upon them.	S 480		

Off'ice of Health Care Quallty

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMAER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 480	Continued From page 3 This Regulation is not met as evidenced by: Refer to CMS 2567 F 689 F 684	S 480	| ee Flag 689 !See F lag 684	f7/B/ 9
S 512	10.07.02.12 R Nsg Svcs; Charge Nurse Daily Rounds .12 Nursing Services. R. Charge Nurses' Daily Rounds. The charge nurse or nurses shall make daily rounds to all nursing units for which responsible, performing such functions as: (1) Visiting each patient; (2) Reviewing clinical records, medication orders, patient care plans, and staff assignments; (3) To the degree possible. accompanying physicians when visiting patients. This Regulation is not met as evidenced by: Refer to **CMS** 2567 F 689 F684 F 692	S 512	Isee F ta9 689| See F l;:ig 684 See F lag 692 i	17/8/19
S1652	10.07.02.34 B (1) Hskpg pest ctrl, laundry;cleanliness .34 Housekeeping Services, Pest Control, and Laundry. B. Cleanliness and Maintenance. The following	S1652		

Office of Heall!. Care Qualily

STATEMENT OF DEFICIENCIES ANO PIAN 01' CORRECTION	(X1) PROVIDER/SUPPLIER/CUA \DENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY CDl,1PLFTED
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S1652	Continued From page 4 shall be observed: (1) The building and all its parts and facilities shall be kept in good repair, neat and attractive. The safety and comfort of the patients shall be the first consideration. Agency Note: Refer to Regulation .26S of this chapter for window screening requirements. This Regulation is not met as evidenced by: Refer to CMS 2567 F 921 F 925	S1652	pee F tag 921 !See F tag 925 I	7/8/19
S1G60	10.07.02.34 B (5) Hskpg; pest control pgm .34 Housekeeping Services, Pest Control, and Laundry. B. Cleanliness and Maintenance. The following shall be observed: (5) The facility shall be maintained free of insects and rodents by operation of an active pest-control program, either by use of maintenance personnel or by contract with pest-control company. Care shall be exercised in the usage and storage of toxic and flammable insecticides and rodenticides. Usage shall conform to the U.S. Environmental Protection Administration and Mai yiand Departrnent of Agrrculture requirements.	S1660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBFR:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215346	A. BUILDING: _____ B. WING _____	C 05/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHWEST HEALTHCARE CENTER	**4601 PALL MALL ROAD BALTIMORE, MD 21215**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETE DATE
S1660	Continued From page 5 Agency Note: Refer to Regulation .26S of this chapter for window .screening requirements. This Regulation is not met as evidenced by: Refer to CMS 2567 F 925	S1660	See F tag 925	7/8/19
S1670	10.07.02.35 Resident Care Management System .35 Resident Care Management System. A Each comprehensive care facility and extended care facility shall establish and maintain a resident care management system. B. The resident care management system shall be comprised of three interrelated components: (1) Resident status assessment and data gathering; (2) Care planning; and (3) Actions in response to care plan approaches. This Regulation is not met as evidenced by: Refer to CMS 2567 F684	S1670	See F tag 684	7/8/19
S1730	10.07.02.37 E Care Planning; Organization of plan .37 Care Planning, E. Organization of Care Plan.	S1730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORrJECTION	(XI) PROVIDER/SUPPLIER/CUA IDENTlclCATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLET[cD
	215346	A B!JILDING: _____ ___ B WING _____	C 05/2412019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHWEST HEALTHCARE CENTER	4601 PALL MALL ROAD BALTIMORE, MD 21215

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S1730	Continued From page 6 (1) Problems and needs shall be identified, based upon the interdisciplinary assessment. The care plan shall address all of the resident's special care requirements necessary to improve or maintain the resident's status. The interdisciplinary team shall incorporate resident input into the care plan. (2) The team shall establish goals for each problem or need identified. The goal shall be realistic, practical, and tailored to the resident's needs. Goal outcome shall be measurable in time or degree, or both. (3) Approaches to accomplishing each goal shall be established. Approaches shall communicate the work to be done, by whom it is to be done, and how frequently it is to be performed. This Regulation is not met as evidenced by: Refer to CMS 2567 F656 F657	S1730	! !See F tag 656 :See F tag 657 !	7/8/19
S1850	10.07.02.46 C QA Plan; Ongoing Monitoring .46 Quality Assurance Plan. C. Ongoing Monitoring. The quality assurance plan shall include: (1) A description of the measurable criteria for ongoing monitoring of all aspects of resident care including: (a) Medication administration; (b) Prevention of decubitus ulcers, dehydration, and malnutrition; (c) Nutritional status and weight loss or weight gair1; (d) Accidents and injuries;	S1850		

STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION	()(1) PROVIDER/SUPPLIER/CUA IOENTIFICATIOI NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3} DATE SURVEY CDMPI.UED
	215346	A IJUILDING: _____ __ B. IMNG _____	C 05/24/2019

NAME OF PROVIDER OR SUPPLIER	GTI1CCT ADDRC3S, CITY, STAT£. ZIP CODE
NORTHWEST HEALTHCARE CENTER	4601 PALL MALL ROAD BALTIMORE, MD 21215

(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
S1850	Continued From page 7 (e) Unexpected death; and (f) Changes in physical or mental status; (2) The methodology for collection of data; (3) The methodology for evaluation and analysis of data to determine trends and patterns; (4) A description of the thresholds and performance parameters that represent acceptable care for the measured criteria; (5) Time frames for referral to the quality assurance committee; (6) A description of the plan for follow-up to determine effectiveness of the recommendations: and (7) A description of how the quality assurance activities will be documented. This Regulation is not met as evidenced by: Refer to CMS 2567 F692	S1850	See F tag 692	7/8/19
S1860	10.07.02.46 E QA Plan;Accidents and Injuries .46 Quality Assurance Plan. E. Accidents and Injuries. The quality assurance plan shall include: (1) A definition of accident and injury that is appropriate to the type of resident served by the nursing home; (2) A description of the process for reporting accidents and injuries including: (a) Who shall report incidents; (b) The time frame for reporting incidents; and (c) The procedure for reporting incidents; (3) A poiicy :;i:aiemehtihat inciudes a provision that reporting incidents can be done without fear	S1860		

STATEMENT OF DEFICIENCIES /IND PL/IN OF GORRI:CTION	()(1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	()(2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPI f·;T[D
	215346	I\, BUILDING: _____ ___ B. WING _____	C 05/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHWEST HEALTHCARE CENTER	4601 PALL MALL ROAD BALTIMORE, MD 21215

(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)	(X5J COMPLETE DATE
s1860	Continued From page 8 of reprisal; (4) A description of how internal investigations of accidents and injuries will be handled including: (a) Assessment of any injury; (b) Interview of the resident, staff, and witness; (c) Review of any relevant records including the resident's medical records, discharge summary, hospital records, etc.; and (d) Time frames for conductihg the investigation; (5) A description of the process for notifying family or guardian about the incident; (6) A description of a process for the ongoing evaluatioh of accidents and injuries to determine patterns and trends; and (7) A description of how relevant information will be referred to the quality assurance committee. This Regulation is not met as evidenced by: Refer to CMS 2567 F689	S1860	See Flag 689	7/8/19
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: (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	S5095	SeeF tag 684 Sile ray ii2i	I 7/8/19

Otnce o Health Care Qual tv

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPI ETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHWEST HEALTHCARE CENTER	4601 PALL MALL ROAD BALTIMORE, MD 21215

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Northwest
HEALTHCARE CENTER
Serving with Pride.

Provider# 215346

August 10. 2019

Ms. Laura Norman
State of Maryland
Office of Health Care Quality
7120 Samuel Morse Drive
Columbia, Maryland 21046-3422

Dear Ms. Norman;

Please accept the signed CMS form 2567 POC for the Complaint Survey which was conducted on July 15, 2019, as our allegation of compliance.

Regards,

Michael E. Moranz, M.P.H, LNHA
Administrator

MARYLAND
Department of Health

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

August 1, 2019

Mr. Michael Moranz, Administrator
Northwest Healthcare Center
4601 Pall Mall Road
Baltimore, MD 21215

PROVIDER# 215346
RE: NOTICE OF IMMEDIATE JEOPARDY, SUBSTANDARD QUALITY OF CARE, AND POSSIBLE IMPOSITION OF OTHER REMEDIES

Dear Mr. Moranz:

On July 15, 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. The survey was also conducted for the purposes of State licensure. As documented in the attached form CMS 2567, this survey found that your facility was not in substantial compliance with participation requirements. In fact, conditions at your facility posed immediate jeopardy to the health and safety of residents. The deficiency that forms the basis for the finding of immediate jeopardy is attached. Removal of the condition(s) that posed immediate jeopardy was confirmed by the survey team on July 15, 2019.

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

The facility[1]s noncompliance with the following regulations constitutes immediate jeopardy to the health and safety of residents:

F600, 483.12 Freedom from Abuse, Neglect and Exploitation

Based on the complaint survey which was conducted at your facility on May 24, 2019, the facility was initiated on an enforcement track. Based on the enclosed findings of July 15, 2019 complaint survey, the enforcement track continues, with remedy imposition dates based on the survey that initiated the enforcement track on May 24, 2019.

I. IlVlP , lTfON Of REMEI l -;

As a result of our finding that your facility is not in substantial compliance, the following remedy (ies) will be imposed:

hnposition of denial of payment for new admissions, effective August 24, 2019.

If substantial compliance is not achieved by November 24, 2019, the CMS Regional Office and/or the State Medicaid Agency may terminate your provider agreement that date.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should CMS determine that termination or any other remedy is warranted, CMS will provide you with a separate formal notification of that determination.

IL A(ITOMATIC CONSEQUENCES AS A RESULT *OF* PROVIDIN r SUBSTANDARD QU/\LITY OF CARE

Your facility's noncompliance with the following:

42 CFR 483.12

constitutes substandard quality of care as defined at §488.301, Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) of the Code of Federal Regulations. As a result of providing substandard quality of care, surveyors conducted an extended, or partial extended, survey at your facility. The Federal regulations at 42 CFR §483.151 (b)(2)(iii), 42 CFR §483.151 (b)(3)(i), (ii) and (iii), and 42 CFR §483.151 (e) require that any nursing facility that has been subject to an extended or partial extended survey, a denial of payments for new admissions or a Civil Money Penalty of not less than $5,000.00, must have the approval for their nurse aide training and competency evaluation program (NATCEP) withdrawn for a period of two years. Therefore your facility is prohibited from operating a nurse aide training program for two years from the last day of the survey. See §483.151.

You have the right to appeal to CMS the loss of your nurse aide training program as a result of a finding of Substandard Quality of Care (SQC); however, your nurse aide training program must cease to operate pending an appeal.

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 CFR §498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DABE-File) at https://d 1b.cfile.bJ1s.go no lat.r th.in sixty (0) days aft r rccejving thiR leUer. A copy of the hearing request shall be submitted to:

Chief Counsel
Office of the General Counsel
801 Market Street
Suite 9700
Philadelphia, PA 19107

Requests for a hearing submitted by U.S. mail or commercial caiTier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, **S.W.**
Cohen Building - Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree, 42 CFR §498.40(b)(l). It should also specify the basis for contending that the findings and conclusions are incorrect, 42 CFR §498.40(b)(2). You may be represented by counsel at a hearing, at your own expense.

Should we take action to terminate your participation in the Medicare program, we will advise you of your appeal rights as a result of that action. Please note that those appeal rights are separate and distinct from the appeal rights cited above.

You will be notified separately by the Maryland Medicaid State Agency regarding their application of the remedies in this letter.

In addition, Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care as well as the State board responsible for licensing the facility's administrator be notified of the substandard quality of care. In order for us to satisfy these notification requirements, and in accordance with §488.325(g), you are required to provide the following information to this agency within 10 working days of your receipt of this letter (see the attached form to be used to provide this information). Residents affected include: Resident(s) #1. Please refer to the previously provided Roster/Sample Matrix for resident names.

III PLAN OF CORRECTION (PoC)

Based on the findings of this survey, an opportunity to correct the identified deficiencies will not be afforded prior to our recommendation of the imposition ofremedies by the CMS and the State Medicaid agency. A PoC for the deficiencies must be submitted within IO days after the facility receives its Form CMS 2567. Failure to submit an acceptable PoC within the above time frames may result in the imposition of additional 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; and;

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.

Date by which 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 resident names in documents since the documents are released to the public.

IV. JNFORMAL DISPUTE RESOLUTION

In accordance with '488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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 the deficiency(ies), (or why you are disputing the scope and severity assessments of deficiencies which have been found to constitute SQC or immediate jeopardy) to Margie Heald, Deputy Director, Office of Health Care Quality, 7120 Samuel Morse Drive, Columbia, MD 21046-3422, phone 410-402-8201, fax 410-402-8234. This request must be sent within 10 days of receipt of this letter. Informal dispute resolution for the cited deficiencies will not delay the imposition 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 and credible evidence of compliance for these deficiencies within 10 days ofreceipt 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.

In the event a revisit reveals that corrections have not been achieved, a mandated staffing pattern may be imposed in accordance with COMAR 10.07.02.070(3) to assist you in the delivery of an adequate level of resident care.

If you have any questions concerning the instructions contained in this letter, please contact Laura Norman at (410) 402-8003 or by fax at (410) 402-8234.

Sincerely,

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Patri·ia·r msko Na . M.D.
Executive Director
Office of Health Care Quality

Enclosures: CMS 2567
State Form
Attending Physicians' Form

cc: Paul Ballard, Esq.
Jane Sacco
Ginger Levesque, CMS RO
Ruby Potter
Ronda Washington
Stevanne Ellis
MFCU
File II

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

J=ORM APPROVED
0MB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	{X1) PROVIDER/SUPPUERiCLIA IDENTIFICATION NUMBER:	{X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215346	A. BUILDING _____ B. WING	07/15/2019

NAME OF PROVIDER OR SUPP.LIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHWEST HEALTHCARE CENTER	4601 PALL MALL ROAD J3ALTIMORE, MD 2.1215

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F 000	INITIAL COMMENTS	F ODO		

On July 3rd, July 9th, July 1oth, July 11th, July 12th and July 1.5th, 2019, a complaint investigation survey was conducted at this facility by the Office of Health Care Quality. The facility's licensed bed capacity is 1 and the census was 32. Two int?kes were investigated: Complaint MDD0142217 and Facility Reported Incident MDD0142621. Investigative activities included a tour of the facility, interviews with facility staff; review of the medical records, facllity investigation, and observations of residents and staff practices.

This survey identified noncompliance with Federal and State requirements with that were reviewed in relationship to: Complaint MD00142217 and Facility Reported Incident MD00142621.

Based on the findings, on Thursday 7/11/19, at 3:35 PM an Immediate Jeopardy was called related to the neglect of Resident #1. The facility submitted an Initial plan of action to the surveyors and the Office of Health Care Quality for review at 8:15 PM on 7/11/19. This lnltlal plan was not accepted and a revised plan was at submitted at 8:32 PM on 7/11/19, which was also not accepted. The facility sub.mltted another revised plan of action at 9:35 PM on 7/11/19, that was reviewed. by the surveyors and the Office of Health Care Quality. The plan was accepted but the lmmedi.ate Jeopardy was not removed until _Monday 7/15/19 at 3:13 PM, after the plan of correction was implemented. After removal of the Immediate Jeopardy, the deficient practice

than niinimal harm and a cope and severity of a

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(Xll) DATE
		7-10-19

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.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHWEST HEALTHCARE CENTER	46D1 PALL MALL ROAD BALTIMORE, rv_'ID 21215

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F 000	Continued Frcim page 1 D. The extended suiveywas completed on 7/15/19. The following deficiencies are a result of thls survey.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv}(15) §483.10(g)(14) Notification of Changes. (I) A facllity must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there ls- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (8) A significant change in the resident's physlcal, mental, or psychosocial status (that Is, a deterioration In health, mental, or psychosocial status In either life-threatening conditions or clinical complications}; (C) A need to alter treatment significantly (that Is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D} A decision to transfer or discharge the resident from the facility as specified in §483.15(c}(1)(ii). (ii) When making notification under paragraph {g) (14){i) of this. section, the facility must ensure that all pertinent information specified i.n §403.15(c){2) is available and provided upon request to the physician. (iii) Jhe facility mu_st also promptly notify the resident and the resident representative, if any,	F 580	**Corrective action for those residents affected:** Resident #1 no longer resides at the facility. **Identification others with potential to be affected:** The Director of nursing will audit c ent residents with a change in condition via the 24 hour report summary to ensure the residents physician was notified. **Measures put into place to prevent reoccurrence:** The staffing educator will educate the licensed nurses on the process for notification of a residents physician whenever a	9/9/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDEJit'SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PijOVIOER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZJP CODE
NORTHWEST HEALTHCARE CENTER	4601 PALL MALL ROAD BALTIMORE, MD 212.15

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F 580	Contlnued From page 2 as specified in §483.10(e}(6); or {B) A change in resident rights under Federal or State law or regulations as specified In paragraph {e}(10) of this section. (iv) The facility must record and periodically update the address (majllng and email) and phone number cif the resident representative(s). §483.1O(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined In §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on a review of the facility investigation, medical records, interviews with facllity staff and other pertinent documentation It was determined that the facility falled to notify the physlclan of the worsening condition of Resident#1's wound after maggots were discovered on 6/13/19. This was true for 1 or 4 residents (Residents #1) reviewed as part of the complaint survey that ended 7/15/19. The findings include: During an investigation of complaint #MD00142217, an Interview was conducted on Tuesd y 7/9/19 at 6 pm, with the Terrace Charge Nurse (Staff#17) s/he stated that sometime in the beginning/middle or end of June), "I went to clean [Resident#1's] wound with Dakin's Solution	FSBO	**Monitoring to prevent reoccurrence:** The Director of nursing will complete a audit weekly **x 4** weeks and then monthly X2 of current residents with change in condition to ensure that if a change or worsening of condition occurred that the residents Physician was notified. The results of the audit will be recorded at the monthly QAPI meeting for three consecutive months and then quarterly or as directed by the QAPI committee to achieve substantial compliance.	

STATEMENT OF DEFI01EN·C1ES AND PLAN OF CORRECTION	(X1) PROV1ciER1SUPPLIER1cLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X:3) DATE SURVEY COMPLETED
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NORTHWEST HEALTHCARE CENTER	46D1 PALL MALL ROAD BALTIMORE, IVID 21215

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F 580	Continued From page 3 as orde'red by the physician on the left side of his/her face. During the treatment, I noticed maggots coming from the wound on his/her face. I took the resident into the bathroom and removed the maggots using a suture removal kil I then reported the incident to the 3-11 supervisor (Staff #10). When asked by the surveyor, If the physjclan was ever notified of the maggots in June 2019, Staff #17 replied no. During an interview on Wednesday 7/10/19 at 1 om, with the Regional Director of Operations (Staff #14), Regional Director (Staff #15), and the Director of Clinical Seivice_s (S ff# 16), the findings were verified. Staff #14 stated, that according to the facility Investigation the maggots were first noted on 6/13/19 during 3-11 pm shift. On Thursday 7/11/19 at 1:45 PM, resident#1's primary physician (Staff #22) was Interviewed S/he stated, "the first time I was notified about this resident having maggots was by the Director of Nurses on 7/1/19."	F 580		
F 600 SS:::J	Free from Abuse and Neglect CFR{s): 4B3.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-	F600		

DEPA TMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

t-'HIN I ED: 08/02/2019
FORM APPROVED
0MB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORftECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE_CONSTRUCTION	()(3) DATE SURVEY COMPLETED
	215346	A. BUILDING _____ B.WING _____	C 07/15/2019

NAME QF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHWEST HEALTHCARE CENTER	4601 PALL MALL ROAD ALTJMORE, MD 21215

(X4) !0 PREFIX TAG	SU MMAIlY STATEMEtffOF DEFICIENCIES (EACH DEFICIENCY UST 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 DEFICIENt;YJ	(XS) COMPLETIOI'I DATE
F 600	Continued From page 4 §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seqlusion; This REQUIREMENT is not met as evidenced by: Based on review of the facility Investigation, medical records, interviews with facllity staff and other pertinent documentation it was determined that the facility failed to: 1) notify the physician of the worsening condition of Resident #1's wound after maggots were discovered on 6/13/19, resulting In the resident being transferred to the hospital for further evaluation, 2} to document such worsening condition accurately and timely In the medical record, and 3) provide and implement a revised plan of care to meet the resident needs. This was true for 1 of 4 residents (Residents #1) reviewed as part of the complaint survey that ended 7/15/19. Based on the findings, on July 11th, 2019 at 3:35 PM an Immediate Jeopardy was called related to the neglect of Resident (#1). After removal of the immediate jeopardy, the deficient practice remained for 3 days with the potential for more than mlnlmal harm and a scope and severity of a D. The findings Include: of history, Resident#1 was hospitalized in -at [county name} and transferred to [hospital name} after belng found on the driveway with ants and maggots on his/her face. Resident #1 was admitted to the nursing facility in [redacted], with a diagnosis that included Malignant Melanoma of the skin, Dementia without behavioral disturbance, cachexia, and	F600	**Corrective action for those residents affected:** Resident #1 no longer resides at the facility **Identification others with potential to be affected:** **1)** The Director of nursing will complete an audit of current residents with a change in condition to ensure that if a change or worsening of condition occurred that the residents Physician was notified. 2) The Director of nursing will complete an audit of current residents with a change in condition to ensure that if a change or worsening of condition occurred that the nurse appropriately and timely documented the change in the resident's medical record. 3) The Director of nursing	9/9/19

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

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FORM APPROVED
0MB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215346	A. BUILDING _____ 8W, I N G _____	C 07/15/2019

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NORTHWEST HEALTHCARE CENTER	4601 PALL MALL ROAD BALTIMORE, MD 21215

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F 600	Continued From page 5 Anemia. According to the hospital discharge summary dated the resident was transferred to the facility for managerr(ent of his/her Malignant Melanoma and rehabllitation services due to resident's inability to care for his/herself in the community. Review of Reslident#1's medical record on 7/3/19 at 11:30 AM, revealed the that on- Sodium Hypochlorite Solution was ordered to be applied to his/her body topically two times a day for melanoma skin rash; 7-3 PM and 3-11 PM shift until 1/4/19. A nursing note dated 9/29/18 at 6:42 AM documented: resident has melanomas all over the body, refused to receive treatment. Some bleeding occasionally. Review of Resident **#1's** treatment administration record for October 2018 revealed all treatments signed off 7-3 PM and 3-11 PM shift as being administered for the entire month. Resident #1's November 2018 record revealed the order for Sodium Hypochlorite Solution applied to the body topically two times a day for melanoma skin rash. For 11/15/1B (3-11 PM shift) and 11/16/18 (3-11 PM shift) staff documented "5" (treatment held). Review of the medical record on 7/11/19 at 8:10 AM revealed a nursing note dated 11/15/18 at 1_8:51 (6:51 PM) and 11/16/18 at22:09 (10:09 PM), which revealed the Sodium Hypachlorite Solution was not available from the pharmacy. Review of Resident #1's medical record revealed Hypochlorite Solution-apply to body topically two times a day for melanoma skin rash 7-3 PM and	F600	will complete an audit of current residents with a change in condition to ensure that if a change or worsening of condition occurred that the residents care plan was revised and updated to meet the resident's needs. **Measures put into place to prevent reoccurrence:** l)The staffing educator will educate the licensed nurses onnotifying the resident's physician when there is a change or worsening of condition is identified. 2) The staffing educator will educate the licensed nurses on appropriately and timely documenting in the residents medical record when there is a change or worsening of condition.	

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NORTHWEST HEALTHCARE CENTER	4601 PAL MALL ROAD BALI"IMORE, MD 21215

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F 600	Continued Froni page 6 3-11 PM shift. All treatriil:Int were signed off on 7-3 PM and 3-11 PM shift as being administer d for the entire month of December: In addition, a nursing note d_ated 12/16/18 at 10:40 PM documented: facial Myeloma on left cheek appears larger than u_sual. A care plan note dated 1/2/2019 at 11:18 AM revealed the following: "Resident #1 ls resistive to care. Refusing to seek medical attention/intervention for the melanoma growing but the side of his/her face. The resident declined the oncologist to remove the growth on his/her face. Refused several attempts to send hlm/her to the emergency room for treatment of the melanoma on his/her face. The Unit Manager and the Director of Nursing spoke with the resident about the melanoma growing bigger and the need to seek medical attention/intervention. The resident stated that It does not hurts/he is just fine and s/he has been picking pieces of it slowly but surely; resident RP made aware." January 2019 physician orders revealed the Sodium Hypochlorite Solution applied to body topically two times a day for melanoma skin rash 7-3 PM and 3-11 PM shift order was continued. According to the medical record, the treatment was administered on 1/1/19, 1/2/19, 1/3/19, and 1/4/2019 on 7-3 PM shift and 111/19, 1/2/19, 1/3/19 on 3-11 PM shift. On 1/4/19 the Sodium Hypochlorite Solution wa discontinued. On 1/10/19 a new physician order was obtained for 0.125% Dakin's Solution - apply of the medical record on 7/11/f9 failed to reveal why treatment Was discontinued.	FBOO	3) The staffing educator will educate the licensed nurses on updating and revising a residents care plan to meet a residents needs whenever a resident has a change or worsening of condition. **Monitoring to prevent reoccurrence:** **1)** The Director of nursing will complete an audit weekly x 4 weeks and then monthly X2 of current residents with a change in condition to ensure that if a change or worsening of condition occurred that the residents Physician was notified. 2) The Director of nursing will complete an audit weeklyx 4 weeks and then monthly X2 of current residents witha change in condition to ensure that if a change or worsening of change was appropnately	

FORM CMS•2567(02-99} Previous Versions Obsolete Event 1D:5L6J11 Facility ID: 30033 If continuation sheet Page 7 of 23

STATEMENT OF DEFICI_ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER;	(X2) MU LTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NORTHWEST HEALT!1CARE CENTER	**4601 PALL MALL ROAD BALTIMOR,I:, MD 21215**

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Further medical record review revealed that nursing staff continued to document concerning the resident's melanoma. The following documentation was noted the resident's record:

-1/16/19 at 05:22 AM Nursing note - Reslident scheduled for oncology appointment on 1/28/19. Resident denies pain. Melanomas growing rapidly;
-1/28/19 at 2:37 PM Nursing note - resident was seen by oncology doctor. The resident refused treatment for cancer. The resident was educated and aware of the circumstances. The recommendation is for palliative care. Responsible Party (RP) and physician aware;
-1/28/19 at 10:51 PM Nursing note- Follow-up treatment for melanoma declined. MD (medical doctor) and RP aware. The resident received the treatments from 1/11/19 thru 1/31/19 with no refusals documented.

Review of a 2/28/19 at 6:48 PM wound care nursing note revealed wound care visited Resident #1 to assess the resident's left arm wound, however, the resident refused and requested the visit be rescheduled.
Treatment records showed that Resident #1 refused the treatment with Dakin's Solution to the face bid (two times a day} for melanoma on 2/20/19 at 8 AM and on 2/4/19 at4 PM, however, there were no progress notes related to refusal.
Askin/wound nursing note dated 3/1/19 at 7:17 PM stated, "Resident has a history of facial melanoma: sites ... Treated with Dakin's Solution refusing surgical interventions ..."
No refu als were documented on the Treatment and timely documented in the resident's medical record.

3) The Director of nursing will complete an audit weekly x 4 weeksand then monthly X2 of current residents with a change in condition to ensure that if a change or worsening of condition occurred that the residents care plan was updated and revised to meet the resident's needs.

The results of the audits will be recorded at the monthly QAPI meeting for three consecutive months and then quarterly or as directed by the QAPI committee to achieve substantial compliance.

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Administration Reco'rd (TAR) for March 2019, for the resident's facial Dakin's solution.

On 216/19, a new order was placed for wound treatment to Resident #1 's left forearm with the instrucUons: "Dakin's Solution to left forearm every day. Pat dry and apply secondary Oil Emulsion dressing, place dry dressing, wrap with Kling." Review of the resident's .TAR for March 2019, revealed that Code '9' was entered on 3/20/19 and 3/23/19. No progress notes could be found addressing either date.

On 7/11/19@8:36 AM-Interview with Staff#10 revealed that code "9" indicates there should be a nursing note to explain why the medication was not given. No refusals were documented on the TAR for April 2019, for the resident's facial Dakin's Solution. The wound treatment ordered to the resident's forearm was administered on 4/1/19 and 4/2/19 and then was discontinued. A new order was begun on 4/3/19 with instructions: "Dakln's solution to left arm, apply Flagyl, crushed to wound bed, apply secondary Oil Emulsion dressing, place dry dressing, wrap with Kling." It was documented as administered for the remainder of the month except for 4/3/19 when a code "9" was entered. No related progress notes could be found to explain the code "9" on 4/3/19.

Resident #1's medical record review indicated that from 5/1/19 - 6/30/19, Resident #1 was still ordered the Oakin's solution to left am,, apply Flagyl, crushed to wound bed, apply secondary Oll Emulsion dressing, place dry dressing, wrap with Kling, and Dakin's Solution to the face bid

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refusals documented for these treatments during this time period.

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Continued review of Resident#1's medical record revealed a nursing note Written by the Director of Nurses {DON), dated -at 16:29 (4:29 PM): "Resident's tumor on the left side of the face was assessed today. Area boggy and appeared Infected ...The resident's physician was notified, and the resident was sent to the hospital."

Review of complaint MDD0142217 on
ii d esday 7/3/19 at 6:30 AM, revealed that on a Police Officer responded to an Emergency Medical Services call at this facility. Upon arrival, the Officer was advised by the medic that Resident #1 had a severe wound on the left side of his/her face and the wound was filled with "full-grown" maggots. The officer reported that the maggots were crawling around on the resident's face.

Review of 911's (EMS)se ecy Medical Services summary on t 7:00 AM, revealed the following: On a call was received from [Northwest Nursing] Facility for a reported hemorrhage/laceration of a vulnerable adult At 16:04 (4:04 PM) upon EMS arrival, Resident #1 Wal. in his/her room, sel?ted upright In bed with dried blood st.alned on his/her pajama top, neck and bilateral hands. The resident had what appeared to be bruising on the face and darkened areas underne th his/her eyes. The Resident had head wound/mass to the left side of his/her face wlth indentations and exposed tissue. The resident appeared to have sluggish, active bleeding from the mass on the left side of his/her head; resident appeared to be alert and oriented as!a'i5ie\'fb 1'etay-s6rn,e-perunent"lll1□ rnnauon hls/her name and birth date to EMS. Upon EMS asking the resfdent what happened regarding

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NORTHWEST HEALTHCARE CENTER	4601 PALL MALL ROAD BALTIMORE, MD 21215

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his/her head, the resident touched the wcii.md and stated t at s/he "had It for months, It's always been there." During EMS further assessment to the resident head/face wound, small movements were noted within the wound. Upon further inspection, the resfdent had a maggot Infestation that appeared to be em edded deep into the wound. The resident denied any pain or symptoms pertaining to his/her head/face. The resident has also had a bandage on the left forearm. The resident stated," the staff changes it sometimes." A supervisor was requested. The Director of Nursing, as well as a supervisor, entered the room, asking "what the issue is?" And when questioned about the resident's wound and maggot infestation, all the staff reported that they did not know of the problem nor how the maggots got into the wound. The resident's head wound was wrapped with gauze and cling while still In the facility by EMS. EMS contacted the [city name] Police Department to report possible abuse/neglect of a vulnerable adult. A Police Officer responded. The police escorted EMS to the hospital.

Review of Resident #1's hospital medical record from lhospltai name] on 7/3/19 at 8 *NI'.,* revealed a nursing noted dated -"Resident #1 presented to the Emergency Department (ED) from the nursing home via EMS with bleeding from the facial wound. Past medical history lncl1Jded m lanorna, dementra. The resident had a large lesion on left facial area, nose and left lower arm frorri skin cancer. The facial lesion was bleeding ;:ind Infected with maggots. EMS reported the nursing home staff did not know fil go1flg WiU1"'1ne resrcient:-Wri'lftrasi<e"ff for a supervisor s/he was reportedly abrupt wlth EMS and stated the reslden t does not allow staff

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NORTHWEST HEALTHCARE CENTER	46D1 PALL MALL ROAD BALTIMORE, MD 21 15

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F 600	Continued From page 11	f 600		

to change his/her dressing. According to the ED documentation, the resident was cooperative and pleasantly confused In the ED and allowed staff ta a place dressing on lesions. The reslident was admitted with a fever of 38.5 (101.3}."

During an interview with the Hospital 4th floor Unit Manager on 7/3/19 at 9 AM, s/he stated that Reside'tit #1, had allowed the hospital nursing staff to cleanse and dress his/her left facial area and left lower arm without refusal.

During an interview with the hospital case manager on 7/3/19 at 9:15 AM, s/he stated that due to neglect issues the reslident would not be returning to the previous nursing home.

During an interview with Resident #1 on - at 9:30 AM at the hospital, when questioned about the wounds on his/her left side of the face and the left arm, the resident stated, "I had lt for months, it started to bleed so they sent me here." S/he stated that the wound on his/her left arm resulted from his/her fall on the driveway a year ago. The resident was observed by this surveyor, with a dressing to the left side of the face and arm during the interview.

During an Interview with the DON on 7/3/19 at 1 PM, the DON stated that Resident #1 was transferred to the hospital on-after maggots were found, in the wound on the left side of Resident #1's facet During the Interview, the DON admitted to seeing the maggots. When asked why he did not document them, he stated, "the nurse should have documented the incident."

stated, "this is the first time, I heard of [the

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F 600	Continued From page 12 maggots]."	F600		

During an lnteNiew with the surveyor on 7/3/19 at 1:15 PM the Administrator, "the resident was sent to the hospital on-after the nurse saw maggots coming from the resident_face." When asked had this occurred before, the administrator replied no.

An Interview with the surveyor on 7/9/19 at 3:30 PM revealed the wound nurse (Staff #20) revealed the Resident #1 was seen by the wound care team every three weeks for a left-arm lesion. The wound nurse stated, "I knew nothing about the [maggots] until 7/2/19 when I returned from vacation."

In anInterview with the surveyor on Tuesday 7/9/19 at 3:40 pm, the Wound Care Doctor (Staff #21), stated, sfhe was not notified of maggots being found on Resident #1's face.

During an interview with the 3-11 nursing supervisor (Staff #10) on 7/9/19 at 4 PM, s/he stated that Resident #1 was an the lower level and s/he had not seen the resident Staff #10 reported the first-time s/he heard of the maggot Incident was when the police came to the facility on-in the evening.

During an interview with the surveyor on 7/9/19 at 6 pm, the Terrace Charge Nurse (Staff #17) stated ::mmetime in June (was not able to remember whether it was the beginnlngfmiddle or end of June), [11] I went to clean Resident#1's wound with Dakin's Solution as ordered by the physician and when I removed the dressing during the treatment, I noticed maggots coming from the wound on his/her face. I took the resident into the

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F 600	Continued From page 13 batliitiom and refmovea the·matigt;>ts T1silil:f a suture removal kit. I then reported the Incident to the 3-11 PM supervisor (Staff #10)." When asked why Reslident#1's medical record failed to reveal any documentation that the resident was noted with maggots prior to - Staff #17 replied, "the 3-11 PM supervisqr (Staff #10) told me not to document the incident." When asked by the surveyor, if the physlcian was notified, Staff#17 replied no. Staff #17 stated that s/he did contact the Unit Manager (Staff #29) and made him/her aware of the incident. On 7/9/19 at 6:30 PM during a second Interview with Staff #10, s/he amended his/her previous statement to Include s/he was made aware of the maggots on 6/13/19 around 11 PM by Staff #17. S/he (Staff #10) stated, "I told the nurse (Staff #17) to clean the area up. I als_o notified the wound nurse the next day." When asked by the surveyor if s/he documented this in the resident record or notified the physician, s/he replied no. This surveyor asked ifs/he saw Resident #1's face that night after being Informed of the maggot's and Staff#10 replled, "yes, I saw the maggots." During an inteiview with the surveyor on 7/10/19 at 11:30 AM, the New Wing/Terrace Level Unit Manager (Staff #29) stated, tha,t on 6/14/19, "I was informed by the nurse (Staff#17) about maggots being on Resident #1's face. I then texted my DON about it. He called me and told me to go to the unit and see for myself if there were maggots on Resident #1's face. There weren't any maggots present at the time. I asked D- •--_ ta, f#'l'Jf,'81tff tmomt n'e-s6peMsar1wlieff' - ;;- .'.... [s/he] saw them, [s/he] stated the supervisor told me not to document anything. I called the wound	F600		

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F 600	Continued From page 14 nurse to inform [him/her] of th_e maggots. [S/he} stated, [s/he) would contact the Wound Doctqr. Meanwhile, all you can do is clean it with Dakin's Solution. I had informed my Administrator about the maggots, and he asked if the DON was made aware. I told him 'yes'; I was told by the DON." On 7/10/19 at 12 noon by phone, Reslden t#1's primary physician (Staff #22) was interviewed. S/he stated, "the first tinie I was notified about lii!dent having maggots was by the DON on On Wednesday 7/10/19 at 1 PM, the Regional Director of Operations (Staff #14), Regional Director (Staff #15), and the Director of Clinical Services (Staff #16) asked to meet with this surveyor. It was revealed at that time the facility had started an investigation after intervlewlng Staff {#17 and #29} on 7/9/19. Staff#14 stated the DON and the Admln.istrator had prior knowle t Resident #1 had facial maggots prior to -and there was no documentation and/or physician notification done. Staff #16 stated the bON and the Administrator were placed on suspension for neglect of Resident #1, pending the outcome of the Investigation. A review of the DON and Administrator personal file on 7/10/19 at 1:30 pm, verified the suspensions. During an interview with Nurse#30 on 7/11/19 at 8:00 AM, s/he stated code 5 means the treatment was on hold and there should be a nursing note for that date and time. On 7/11/19 at 8:36 AM, during interview with Staff #1O, she revealed code "9" indicated there should	F600		

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	215346	A BUILDING _____ B.WING	C 07/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CO E
NORTHWEST HEALTHCARE CENTER	4601 PALL MALL ROA□ BALTIMORE, MD 21215

(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 600	Continued From page 15 be a nursing·note to-explain why the medication was not given. On 7/11/19 at 9:28 AM, Residen\ #1's primary care physician was Interviewed, s/he stated, the resident is seen *by* the Nurse Practitioner and s/he cor:ne to the facility on Tuesdays but does iiot see all his/her residents. When asked about the lapse In treatment from 1/4/19 -1/10/19, s/he stated the resident was refusing the treatments. On Thursday 7/11/19 at 1:45 PM, Resident #1's primary physician (Staff#22) was Interviewed for the second time in the facility. S/he stated, "the first time I was notified about this resident having maggots was by the DON o-n It is not unusual for this to happen, due to the resident's refusal of treatments. The area was decaying, but no one ever notified me of Resident #1 having maggots to face area, prior to-'' When asked by the surveyor if s/he would have changed the plan of care for Resident #1. The physician replied, "yes ...the situation would have been considered crltlcal then. I would have sent him/her out to the hospital." Review of Resident #1 TAR (Treatment Administration Record) on 7/11/19 at 2 PM, revealed that from 9/2018 thru 7/1/2019, Resident #1 was documented as refusing treatment to the left facial Malignant Melanoma wound his/her wound approximately 5 times. Review of the facility pest control log on 7/11/19 at 2:30 PM, revealed Resident #1's room was treated for flies on 6/14/19, 6/24/19 and 7/3/19. On 7/11/19 The factlity submitted an initial plan of	F 600		

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

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FORM APPROVED
0MB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION.	(X1) PROVIDER/SUPPLIEfVCLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(Xa} DATE SURVEY COMPLETED
	215346	A. BUILDING _____ B.WING	C 07/15/201°9

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CDDE
NORTHWEST HEALTHCARE CENTER	4601 PALL MALL ROAD BALTIMORE, MD 21215

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F 600	Continued Fram page 16 action to the surveyors and the Office of H alth Care Quality for review at 8:15 PM. This inilial plan was not accepted and a revised plan was submitted at 8:32 PM on 7/11/19 which was not accepted. The facility submitted a another revised plan of action at 9:35 PM on 7/11/19 that was reviewed by the surveyors and the Office of Health Care Quality. The plan was accepted on, 7/11/19 but the Immediate Jeopardy was not removed untll 7/15/19 at 3:13 PM, after the plan of correction was implemented. The Immediate Jeopardy Abatement Plan included: The resident was transferred to the hospital and admitted for wound evaluation and treatment on The Director of Nursing and Nursing Home administrator were suspended pending investigation of neglect due to delay In reporting a change in condition initially Identified 6/13/19 to the physician and due to the omission of documentation in the medical record. State reportable event was completed on 7/10/19. Upon further Investigation, the decision was made to terminate the Director of Nursing due to gross misconduct and neglect. A report was made to the Maryland Board of Nursing on 07/11/19. The facility was notified on July 10, 2019, by the hospital Social Worker, that the resident will not be returning to this facllity. Identification of others:	F600		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF OEFICIENCiES ANO PLAN OF CORRECTION	(X1) PRO DEFUSUPPLIER/CUA IDENTIFICATION NUMBER:	{X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COII/IPLETEO
	215346	A. BUILDING _____ B. WING _____	C 07/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHWEST HEALTHCARE CENTER	4601 PALL !','ALL ROAD BALTIMORE, MD 21215

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F 600	Continued From page 17	F600		

Current residents will have a skin check completed, d9cumented on a Shower Sheet !3Udit and new orders/treatments as appropriate with Care plan updates. Completed 7/11/19.

Current residents have the potential to be affected by neglect. The current residents deemed Interview able are Interviewed related to the pcisslbllity of abuseineglect on 7/11/19 using the Resident interview and Observation tool (CMS-20050}. In addition, non-interview able residents will be observed using the Centers for Medicare and Medicaid services Family Interview and Observation tool (Form CMS-20049). Identified issues will be immediately Investigated and reported as necessary.

Clinical meeting Interdisciplinary Team will review progress notes for the last 2 weeks for Identifying a change in conditions, wound complications and notification of the MD for change In conditions, in accordance with regulation. They wlll also be monitoring for instances of potential abuse. Completion date 7/11/19.

Education:

Staff development coordinator will provide education to current staff on the definitions of abuse/neglect, investigation, and prevention of abuse/neglect Those not able to be reached will be sent notice that they must compiete the education related to abuse/neglect prior to the start of their next shift. New Hires will have their background checked for potential previous abuse complaints. Annually and upon hire, the staff is

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investigation and monitoring systems. The Staff will have a competency test completion to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPUER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215346	A. BUILDING _____ B.WING	C 07/15/2019

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NORTHWEST HEALTHCARE CENTER	4601 PALL MALL RO AD BALTIMORE, MD 21215

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F 600	Continued From page 1B document understanding of training material. Full time and Part-time staff will have abuse/neglect education completed by July 12, 2019. Nurses will be provided education by the Staff Development Nurse on the proper comprehensive documentation of skin areas requiring treatment and updating Care plan, Treatments as ordered. MD notification and the completion of the Concurrent Review will also be included in the education as to reporting Change in Condition of residents and completed by July 12,2019 Department Heads were trained by Regional Leadership on neglect, integrity and the requirement for proper reporting of neglect. This was reviewed during the Ad Hoc QAPI meeting on 7/10/19. System Change: Weekly Wound rounds completed by the Interim DON/Unit Managers (UM) wlll validate the presence of wounds identified. The documentation of the wounds will be completed on the Weekly Wound Log as well as validation of Care plan and Treatment Interventions. Monthly during leadership rounds, three interview able re.sidents per week will be interviewed for potential abuse and neglect. Additionally, 5 non-interview able residents per week will have completed the Centers for Med.icare and Medicaid servic s·Reslident Interview and Observation tool (Form CMS-20050). The 24-hour report will be reviewed by the Interim 001\J/UM daily for changes In condition, proper	F600		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHWEST HEALTHCARE CENTER	4601 PAU MALL ROAD BA\,.TIMOR!i=, MD 21215

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F 600	Continued From page 19 notification of the MD,-RP, and documentation in the medical n:icord, The Quality of Care log will be utilized to review for additional auditing by the R ional Director of Clinical Operations weekly x 4weeks. Monitoring: An audit by the Registered Nurse (RN) Unit Managers weekly of 3 Residents with wounds to ensure assessments are timely and completed with new conditions, admissions or change In condition and include proper order for treatment and care planning of interventions. This audit will be completed 3x weekly then monthly x 3 by the RN Unit Managers. Weekdays the Social Service Director will review grievance log for potential allegations of abuse/neglect that may need Investigation and follow up. This will be completed weekly x 3 then Monthly x2. The Quality of Care log will be utilized to review for additional auditing by the Regional Director of Clinical Operations weekly x 4 weeks. Result of all audit trends will be reviewed through QAPI meeting monthly X 2 for trend and change in plan needed by the Administrator/Regional Director of Clinical Operations.	F 600		
F 842 SS=D	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 /.'fesiclentficl ntffiao1 "fo.t e,./'puollc = =- J;;;;;;.'.\';i,•• •=--• {il) The facility may release information that is	F B42		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER	STREET ADD ESS, CITY, STATE, ZIP CODE
NORTHWE T HEALTHCARE CENTER	4601 PALL MALL ROAD BALTIMORE, MD 21216

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F 842	Contim.iec(From page 20 iesidentwidentifiable to an agent only in accord mce with a contract under which the agent agrees not to use or disclose the Information except to the extent the facility Itself ls permitted to do so. §483.70(1) Medical records. §4B3.70{i){1) In acqordance with accepted professional standards and practices, the facllity must maintain medical records on each resident that are-- (1) Complete; (ii) Accurately documented; (iii)Readily accessible; and (iv) Systematically organized §483.70(1)(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 directc;irs, and to avert a serious threat to health or safety as pennitted by and iri compliance with 45 CFR 164.512. §483.70(1)(3) The facility must safeguard medical 'f6"0'6Ycrlfnfcirrnmton aga1n's Pioss aesfrucifon, of unauthorized use.	F842		

DEPARTMENT OF HEALTH ANO HUMAN SERVIGES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	()(3) DATE SURVEY COMPLETED
	2153 46	A. BUILDING _____ B. WING _____	C 07/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY. STATE. ZIP CODE
NORTHWE T HEALTHCARE CENTER	46D1 PALL MALL ROAD BALTIMOR , MD 21215

{X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICiENCY MUST BE PRECEDED BY FULL REGULATORY ORISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PRDVIDER•s PLAN OF CORRECTION (EACH CORRECTIV ACTION SHOULD BE CROSS.REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION OATE
F 842	Continued From page 21 §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 preadmisslon screening 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 review of the facility investigation, medical records, interviews with facility staff and other pertinent documentation it was determined that the facility failed to document the worsening condition of Resident#1's wound after maggots were discovered on 6/13/19. This was true for 1 of 4 residents (Residents #1) reviewed as part of the complaint survey that ended 7/15/19. The findings include: During an investigation of complaint #MD00142217, an interview was conduoted on '"ffl'f'n\lJal'ofiif\';.o::Witn'tl'l !Sfe •e ffai'g'e<rrfaYse (Staff #17) s/he stated that sometime In June {was not able to remember whether it was the	F842	**Corrective action for those residents affected:** Resident #1 no longer resides at the facility **Identification others with potential to be:** The Director of nursing will complete an audit of current residents with achange in condition to ensure that if a change or worsening of condition occurred that the nurse appropriately documented the change in the resident's medical record. **Measures put into place to prevent reoccurrence:** The staffing educator will educate the licensed nurses on appropriately documenting in the residents medical record when there is a change or worsening of condition	9/9/19

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

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	215346	A. BUILDING _____ __ B. WING__-'----------	C 07/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDREI;IS, CITY, STATE, ZIP CODE
NORTHWEST HEALTHCARE CENTER	4601 PALL.MALL ROAD BALTIMOijE, **MD 21215**

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F 842	Continued From page 22 beginning/middle or end of·June), "I went to clean resldent#1's wound with Dakin's Solution as ordered by the physician on the left side of [his/her] face. While during the treatment, I noticed maggots coming from the wound on [his/her] face. I took the resident into the bathroom and removed the maggots using a suture removal kll I then reported the incident ta the 3-11 supervisor (Staff #10)." When asked why Resident #1's medical record failed to reveal any documentation that the resident was noted with maggots In June 2019, Staff #17 replied, "the supervisor told me not to document the incident." During an interview on 7/10/19 at 1 pm, with the Regional Director of Operations (Staff #14), Regional Director (Staff #15), and The Director of Clinical Seivlces (Staff# 16), verified the findings. Staff#14 stated, that according to the facllity investigation the maggots were first noted on 6/13/19 during 3-11 pm shift.	F 842	**Monitoring to prevent reoccurrence:** The Director of nursing will complete a weekly audit x 4 weeks and then monthly X2 of current residents with change in condition to ensure that if a change or worsening of condition occurred that the change was appropriately documented in the residents medical record. The results of the audit will be recorded at the monthly QAPI meeting for three consecutive months and then quarterly or as directed by the QAPI committee to achieve substantial compliance.	

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Office of Health Care Qualt

STATEMENT oFDEFICIENCiES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHWEST HEALTHCARE CENTER	4601 PALL MALL ROAD BALTIMORE, MD 21215

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S 000	Initial Comments On July 3rd, July 9th, July 10th, July 11th, July 12th and July 15th, 2019, a complaint investlgalion survey was conducted at this facllity by the Office of Health Care Quality. The facility's licensed bed capacity Is 91 and the_ census was 82. Two intakes were Investigated: Complaint MD00142217 and Facility Reported Incident MD00142621. Investigative activitles included a tour of the facility, in'terviews with facility staff; review of the medical records, facility nvesUgation, and observations of residents and staff practices.· This survey Identified noncompliance with Federal and State requirements with that were reviewed in relationship to: Complaint MD00142217 and Facility Reported Incident MD00142621. Based on the findings, on Thursday7/11/19, at 3:35 PM an Immediate Jeopardy was called related to the neglect of Resident #1. The facllity submitted an Initial plan of action to the surveyors and the Office of Health Care Quality for review at 8:15 PM on 7/11/19. This initial plan was not accepted and a revised plan was at submitted at 8:32 PM on 7/11/19, which was also not accepted. The facility submitted another revised plan of action at 9:35 PM on 7/11/19, that was reviewed by the surveyors and the Office of Health Care Quality. The plal') was accepted but the Immediate Jeopardy was not removed until Monday 7/15/19 at 3:13 PM, after the plan of correction was implemented. After removal of the Immediate Jeopardy, the deficient practice mi .a-'ial.'t5&1.1uh1tb tes sbf .!!• ... than minimal harm and a scope and severity of a D.	SOOD		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REP. RESENTATIVE'S SIGNATURE TITLE (X6) DATE
Executive Director 5-16-19
STATE FORM 6899 5L6J11 If conUnuaUon heel 1 of 9

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Office of Health Care Quam.

STATEMENTOF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(XS) DAT_E SURVEY COMPLETED
	215346	A. BUILDING: _____ B. WING _____	C 07/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHWEST HEALTHCARE CENTER	4601 PALL MALL ROAD BALTIMORE, D 21215

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S OOO	Continued From page 1 The extended survey was completed on 7/15/19. The following deficiencies are a result of this survey.	sood		
S 100	10.07.02.09 A-8 Administration and Resident Care .09 Administration and Resident Care. A. Responslbllity. {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 regulation . (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. B. Delegation to Administrator: (1) The llcensee, if not acting as an administrator, shall appoint as administrator a responsible person who is: (a) Qualified by training and experience; and (b) Licensed by the Board of Examiners of Nursing Home Administrators for the State. (2) The administrator shall: (a) Be responsible for the control of the operation on a 24-hour basis, and (b) With the exception of §8(3) of this regulation,	S 100		

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STATEMENT OF DEFICIENCIES AND PI.AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/OLIA IDENTIFICATION NUMBER:	()(2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CIIY, STATE, ZIP CODE
NORTHWEST HEALTHCARE CENTER	4601 PALL, MALL ROAD BALTIMORE, MD 21215

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S 100	Continued From page 2 serve full•time. (3) With tl')e Department's approval, an administrator may serve on a less than full-time basis for a maximum of two nursing facl\ltles, one of which shail have a licensed capacity of 35 beds or fewer. (4) The Department shall consider the following factors when deciding whether to approve an administrator to serve on a less than full-time basis: (a) Geographic location of the facilities; (b) Ownership of the facilities; (c) Organizational structure of the facilities; (d) Size of the facllities; and (e) Background and experience of the administrator. This Regulation is not met as evidenced by: Refer to CMS 2567 F600	S 100	See Ftag 600	9/19/19
S 580	10.07.02.18 C Nursing Services - Care 24 Hours a Day .1B Nursing Services. 'e:-1':lursm!:feai' '2l4"11ioufs'at:f"af, ife administrator shall employ sufficient and satisra'ctol)' licensed nursing service personnel	S 580		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CIIY, STATE, ZIP CODE
NORTHWEST HEALTHCARE CENTER	46D1 PALL MALL ROAD BALTIMORE, MD 21215

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S 580	Continued From page 3 and support personnel to: (1) Be on duty 24 hours a day; (2) Provide appropriate bedside care; and {3) Ensure that a resident: (a} Receives treatments, medications, and diet as prescribed; (b) Receives rehabilitative nursing care as needed; (c) Receives proper care to prevent pressure ulcers and deformitles; {d} Is kept comfortable, clean, and well-groomed; (e) Is protected from accident, injury, and infection; (f} Is encouraged, assisted, and trained In self-care and group activities; and (g) Receives prompt and appropriate responses to requests for assistance. This Regulation is not met as evidenced by: Refer to CMS 2567 F58D	S580	See Ftag 580 \	9/19/19
S 61o	10.07.02.1B F Nursing Services - Charge Nurses' Daily .18 Nursing Services. F. Charge Nurses' Dally Rounds. The charge	S 610		

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Office of Health Care Qualit\

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDEN11FICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHWEST HEALTHCARE CENTER	4601 PALL MALL ROAD BALTIMORE, MD 21215

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S 610	Continued From page 4 nurse or nurses shall make daily rounds on all nursing units for which they are responsible, performing such functions as: (1) Visiting each resident; (2) Reviewing clinical records, medication orders, resident care plans, and staff assignments; and (3) To the degree possible, accompanying physicians when visiting residents. This Regulation Is not met as evidenced by: Refer to CMS 2567 F580	S610	See Ftag 580 \	9/12/19
S 740	10.07.02.20 E Nursing Services - Responsibilities of DON .20 Nursing Services - Director of Nursing. E. Responsibilities of the Director of Nursing. The responslbilitles of the director of nursing shall include: (1) Assisting in the development and updating of statements of nursing philosophy and objectives to define the type of nursing care the nursing home shall provide; (2) Preparation of written job descriptions for nursing service personnel; (3) Planning to meet the total nursing needs of residents to be met and recommending the stgl'imentlC:lf·".:f'!;i°t1ffieleift-:.Yfi:JtniJer-:.of'si:ljrervisoJY: and support personnel for each tour of duty;	S740		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPUER/CLIA IDENTIFICATION NUMBER;	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2.15346	A BUILDING: _____ B. WING _____	C 07/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHWEST HEALTHCARE CENTER	4601 PALL MALL ROAD BALTIMORE, MD 21215

.(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PR CEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CciRRECTIVEACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(IC5) COMPLETE DAIE
S 740	Continued From page 5 (4) Development and maintenance of nursing service policies and procedures to implement the program of care; (5) Participation in the coordination of resident services through appropriate staff committee meetings on issues relating to: (a) Pharmacy; (b) Infection control; (c) Resident care policies; (d) Quality assurance programs; and (e) Departmental meetings; (6) Cooperation with administration in planning the orientation program and the staff development program to upgrade the competency of personnel; (7) Ensuring that nursing personnel understand the philosophy and meet the objectives; (8) Participation in planning and budgeting for nursing services; (9) Establishment of a procedure to ensure that nursing service personnel, Including private duty nurses, have valid and current Maryland licenses; (10).Execution of resident care policies unless delegated to the principal physician or medical director; (11) Participation In the selection of prospective admissions to ensure that the nursing home ' s	S740		

FORM APPROVED

Office of Health Care Quam,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPUER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215346	A. BUILDING: _____ B. WING _____	C 07/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHWEST HEALTHCARE CENTER	4601 PALL MALL ROAD BALTIMORE, MD 21216

(X4)1D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (81,CH DEFICIE;NCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PI.AN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE. CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 740	Continued From page 6 staff Is capable of meeting the needs of all residents admitted; (12) Coordination of the Interdisciplinary resident care management efforts; and (13) Supervision of certified medicine aides to ensure that the aides act within the limitations and restrictions placed on them. This Regulation Is not met as evidenced by: Refer to CMS 2567 **F5B0** F600	**S740**	See Ftag 580 SeeFtag 600	9/9/19
S1380	10.07.02.32 8 Clinical Records .32 Clinical Records. B. Contents of Record. Contents of record shall Include: (1} Identification and summary sheet or sheets including: (a}Resident's name; (b} Social Security number; (c) Armed forces status; (d) Citizenship; (e) Marital status; (f) Age; (g) Sex;	S1380		

STATEMENT OF DEFICIENCIES ANO PI.AN OF CORRECTION	(X1) PROVIDER/S\JPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215346	A.BUILDING: _____ B.WING	C 07/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHWEST HEALTHCARE CENTER	4601 PALL MALL ROAD BALTIMORE, MD 21215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF QEFICIENCIES (EACH DEFiCIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVEACT.ION SHdUu:5 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(Xli) COMPLETE DATE
S1380	Continued From page 7	S1380		

(h) Home address; and

(i) Relfgion;

(2) Names, addresses, and telephone numbers of referral agencies, Including:

{a) Hospital from which admitted;

(b) Personal physiclan;

(c) Dentist;

(d) Parents' names or next of kin; and

(e) Resident' s representative;

(3) Documentation of the:

{a) Needs of the resident;

(b) Establishment of an appropriate initial and ongoing treatment plan; and

(c) Care and services provided;

(4) Authentication of hospital diagnoses, based on a:

(a) Discharge summary;

(b) Report from the resident' s attending physician; or

(c) Transfer form;

(5) Consent forms when required, such as:

Office of Health Care Qualill

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPUER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215346	A. BUILDING: _____ B. WING _____	C 07/15/2019

NAME OF RDVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHWEST HEALTHCARE CENTER	4601 PALL MALL ROAD BALTIMORE, MD 21215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH.OEFICiENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PIAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	{I(5) COMPLETE DATE
81380	Continued From page B (a) Administration of investigational drugs; (b) Burial arrangements made in advance; (c) Release of medical record Information; and (d) Handling of fin.ances; (6) Medical and social history of the resident; (7) Report of physical examination; (8) Diagnostic and therapeutic orders; (9) Consultation reports; (10) Observations and progress notes; (11) Reports of medication administration, treatments, and clinical findings; {12) Discharge summary including final diagnosis and prognosis; (13) Assessments done by various disciplines; and (14) Interdisciplinary care plan. This Regulation is not met as evidenced by: Refer to CMS 2567 F842	81380	See Ftag 842	9/13/19

Northwest Healthcare Center

Maryland Department of Health and Mental Hygiene
Office of Health Care Quality
7120 Samuel Morse Drive, Second Floor
Columbia, Maryland 21046-3422

Provider Number **215346**

Dear Laura Norman,

Enclosed you will find Northwest Healthcare Center's Plan of Correction pertaining to the deficiencies obtained during the recent survey that was conducted March 11, 2019.

This Plan of Correction constitutes our allegation of compliance with the federal and state requirements participation in the Medicare and Medicaid program.

Sincerely

Meir Preis LNHA
3/25/19

MARYLAND
Department of Health

*Larry Hogan, Governor · Br vd **K.** Rutherford, Lt. Governor · Robert R. Neall, Seaeta,y*

March 19, 2019

Meir Preis, Administrator
Northwest Healthcare Center
4601 Pall Mall Road
Baltimore, MD 21215

PROVIDER#: 215346
RE: NOTICE OF CURRENT DEFICIENCIES

Dear Mr. Preis:

On March 11, 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* .'ORRECTION (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.

IL ALL A'UON (P OMPLiAN

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, 7120 Samuel Morse Drive, Second Floor Columbia, Maryland 21046 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. JNF RMAL DTSP[illegible] RESOLUTION

In accordance with 488.33 **J,** 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, 7120 Samuel Morse Drive, Second Floor Columbia, Maryland 21046. This request must be sent within 10 days of your receipt of the CMS fo1m 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 fax at 410-402-8234.

Sincerely,

Laura Norman
Health Facilities Survey Coordinator
Long Term Care

Enclosures: CMS Form 2567
State Form

cc: File II

STATEMENT OF DEFICIENCIES AND PI.AN OF CORRECTION	(X1J PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215346	A. BUILDING _____ B WING _____	C 03/11/2019

NAME OF PROVIOER OR SUPPLIER	STREET ADDRESS; CITY, STATE, ZIP CODE
NORTHWEST HEALTHCARE CENTER	4601 PALL MALL ROAD BALTIMORE, MD 21215

(X4J ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY LSC IDENTIfYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COIAPIETION DATE
F 000	INITIAL COMMENTS On 3/11/19, a survey was conducted at this facility by the Office or Health Care Quality to Investigate complaint #MD00137857. Activities included the audit of the residents' personal funds records maintained by the 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		
F 568 SS=B	Accounting and Records of Personal Funds **CFR(s): 483.10(f)(1**0)(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 avallable to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced **by:** Based on the review, on 3/11/19, of the residents' personal funds records, including individual resident's account statements, transaction reports, and trial balances, this	F568	F **tag-568** **Corrective action:** All residents or responsible parties will be will be properly furnished their quarterly statements for the quarter ending 3/31/19 beforeApril,; 30, 2019, Identify **others with potential to be affected:** The residents with an resident account have potential to be affected	3/29/19

IABORI\TORY DIRECTOR'S OR PROVI0 UPPUER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE 3/25/19

Any deficiency statement end1n9 with en asterisk (') denotes a deflclenc:y which tho Institution may be excused from correcting providing II 1s determined that other safeguards provide sufficient protection to lhe patients. (See Instructions.) Except for nursing homes, the findings staled above ere dlscloaable 90 days following lhe dale of survey whether or not a plan of correction Is provided. For nursing homes, the above findings and plans of correction are dlsclosable 14 days fQllowlng the dale these documenls are made available lo lhe facility. If deficiencies are ciled, an approved plan of corracUon Is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PI.AN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IDENTIfICATION NUMBER.	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215346	A BUILDING _____ B.WING	C 03/11/2019

NAME OF PROVIDER DR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHWEST HEALTHCARE CENTER	**4601 PALL MALL ROAD BALTIMORE, MD 21215**

(X4)ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCEDTO THE APPROPRIATE DEFICIENCY)	IXS) COMPLETION DATE
F 568	Continued From page **1** facility failed to maintain a system that ensures a full and complete accounting of the residents' personal monies entrusted to this facility. Findings include: 1. As of 3/11/19, there was no evidence that statements of each resident's personal fund account had been appropriately furnished for the quarters ending 6/30/18, 9/30/18, and 12/31/18.	F 568	**Measures to prevent reoccurrence:** The regional director of finance will reeducate the business office manager on ensuring all of the residents quarterly statements are properly furnished timely. **Monitoring of corrective actions** for **residents affected residents:** An audit will be completed quarterly for the following two quarters to ensure quarterly statements distributed appropriately. The results will be presented at QAPI for review and comment.	

Office of Health Care Quamv,

STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION	(?(1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY ' COMPLETED
	215346	A IIUILDING: _____ B.WING	C 03/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COOE
NORTHWEST HEALTHCARE CENTER	4601 PALL MALL ROAD BALTIMORE, MD 21215

(X4)1D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE **APPROPRIATE** DEFICIENCY)	(XS) COMPLETE DATE
S 000	Initial comments On 3/11/19, a survey was conducted at this facility by the Office of Health Care Quality to investigate complaint #MD00137857. Activities included the audit of the residents' personal funds records maintained by the 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)	S000		
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	**86505**	See F tag 568	3/'Jq/1,

OHCQ
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (XBlDAlE

STATE FORM 6899 — 295U11 — 3/25/19

If cantlnUBUon **sheet** 1 of 1

MARYLAND
Department of Health

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

August 15, 2019

Michael Moranz, Administrator
Northwest Healthcare Center
4601 Pall Mall Road
Baltimore, MD 21215

Provider#: 215346
RE: Notice of Deficiencies as a Result of Revisit, Imposition of Denial of Payments for New Admissions under Federal Regulations, Loss of NATCEP

Dear Mr. Moranz:

On July 30th through August 1, 2019, a revisit survey was conducted at your facility by the Office of Health Care Quality, to verify that your facility had achieved and maintained compliance for those deficiencies cited during the survey completed on May 24, 2019. We had presumed, based on your allegation of compliance that your facility was in substantial compliance as of July 8, 2019. However, based on our revisit we found that your facility is not in substantial compliance with the requirements for participation.

All references to regulatory requirement(s) contained in this letter are found in Title 42, Code of Federal Regulations.

I. lMPOSlTlON OF REMEDIES

As a result of our finding that your facility is not in substantial compliance, the following remedy (ies) will be imposed:

Imposition of denial of payment for new admissions, effective August 24, 2019.

If substantial compliance is not achieved by November 24, 2019, the CMS Regional Office and/or the State Medicaid Agency may terminate your provider agreement that date.

Please note that this notice docs not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should CMS determine that termination or any other remedy is warranted, CMS will provide you with a separate formal notification of that determination.

IT. AUTOMATl ONSEQUENCES AS A RESULT OF IMPOSITION Of DENIAL OF PAYMENT FOR NEW ADMISSIONS

The Federal regulations at 42 CFR §483.151 (b)(2)(iii), 42 CFR §483.151 (b)(3)(i), (ii) and (iii), and 42 CFR §483.151 (e) require that any nursing facility that has been subject to an extended or partial extended survey, a denial of payments for new admissions or a Civil Money Penalty of not less than $5,000.00, must have the approval for their nurse aide training and competency evaluation program (NATCEP) withdrawn for a period of two years. As a result of the imposition of denial of payment for new admissions effective August 24, 2019, your facility is prohibited from operating a nurse aide training program for two years from the last day of the survey. See §483.151

As a result of the survey findings the Center for Medicare and Medicaid Services (CMS) and the Maryland State Medicaid Agency have authorized us to inform you that Medicare and Medicaid payment for all new admissions to your facility will be denied effective August 24, 2019. This action is required by sections 1819 (h)(2)(B)(i), 1819 (h)(2)(D), 1919 (h)(3)(B)(ii), and 1919 (h)(3)(C)(i) of the Social Security Act. In addition, you are advised that, should you remain out of compliance, your provider agreement will be tem1inated by CMS and the Maryland State Medicaid Agency on November 24, 2019. Please note that the denial of payment for new Medicare admissions includes Medicare beneficiaries enrolled in Medicare managed care plans. It is your obligation to inform Medicare managed care plans contracting with your facility of this denial of payments for new admissions.

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures goverp.ing this process are set out in 42 CFR §498.40, et – You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAD E-Pile) at hlln·://drib.·file.hh·.gov no later thnn sixty (60) duys nftcr 1· · iving lhi · 1 ··Lto r. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted to:

Chief Counsel
Office of the General Counsel
801 Market Street
Suite 9700
Philadelphia, PA 19107

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically

or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, **S.W.**
Cohen Building - Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for hearing should identify the specific issues and the findings of fact and conclusions oflaw with which you disagree, 42 CFR §498.40(b)(l). It should also specify the basis for contending that the findings and conclusions are incorrect, 42 CFR §498.4D(b)(2). You may be represented by counsel at a hearing, at your own expense.

Should we take action to terminate your participation in the Medicare program, we will advise you of your appeal rights as a result of that action. Please note that those appeal rights are separate and distinct from the appeal rights cited above.

You will be notified separately by the Maryland Medicaid State Agency regarding their application of the remedies in this letter.

III. 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. Resident Roster. 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 the documents are released to the public.

IV. ALLEGATION OF COMPLIANCE

If you believe the deficiencies identified in form CMS 2567 have been corrected, you may contact Laura Norman, Survey Coordinator 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.

If upon a subsequent revisit or by other means, we verify that the facility is in substantial compliance, we will recommend to CMS that the remedy (ies) be terminated. However, if the seriousness of noncompliance changes from the survey findings, the remedies selected may change. If this occurs, you will be advised of any change.

V. 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 me, Margie Heald, Deputy Director, Office of Health Care Quality, 7120 Samuel Morse Drive, Columbia, MD 21046-3422. This request must be sent within 10 days of your receipt of the CMS 2567.

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

VI. LICENSURE A TION

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 and credible evidence of compliance 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 Laura Norman at (410) 402-8003.

Sin 'rely.

,wQ

Hi ·hard Proctor
Director of Strategic Planning
Office of Health Care Quality

Enclosures: CMS 2567
State Form

cc: Ginger Levesque, CMS RO
Jane Sacco
Ruby Potter
Stevanne Ellis
Ronda Washington
Claire Pierson, Esq.
Jill Callan, MBoN
File II

MARYLAND
Department of Health

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

August 16, 2019

Michael Moranz, Administrator
Northwest Healthcare Center
4601 Pall Mall Road
Baltimore, MD 21215

RE: REVISION TO STATEMENT OF DEFICIENCIES FOR MAY 24, 2019 SURVEY

Dear Mr. Moranz:

Based on the Centers for Medicare and Medicaid Services (CMS) Region III1s review of the complaint survey that concluded May 24, 2019, our Office has been directed to revise the Statement of Deficiencies (Federal Form CMS 2567) regarding F558, F656, and F684 that were cited at a scope and severity of "D". Specifically, we have been instructed to delete the F558 federal citation and revise language for F656 and F684 federal citations.

As a result of this revision, the Statement of Deficiencies (State Fann) has also been revised.

Please reenter your facility's plan of correction including compliance dates onto this revised statement of deficiencies, sign and return to this Office within 10 days of the receipt of this letter. Upon its return, this revised, completed and signed statement of deficiency will become the document released to the public.

If you have any questions, please contact, Laura Norman, Survey Coordinator at 410-402-8003.

incerely y ur..

Richard Proctor
Director of Strategic Planning
Office of Health Care Quality

cc: Claire Pierson, Esq
Michele Clinton, Survey Branch Manager, CMS RO III
Stevanne Ellis
File II

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MAME OiO PROV\01:1\ Oli.SUPPliER	STIIEET ,\00R£SS, CITY. STATE.ZJPCODE
NORTHWEST HEALTHCARE CENTER	4I01PAU. MALI. RO'-D BALTIMORE, M021215

(JC ◀)ID pf!EAX To\li	SUMIJARV ST.\T!MEllT CF Ol!FICll:NC: ES tEACttOEFICIEtlC'I IIJSTee Pfl.EC!DeD av FUU. AECIMI0!\V Cl\\sc IOENTlfOOG lllfQRI.U."TION)	ID PREFIX TAG	PROVI>!A 9 Pl.>JI CW COIUl2CT10ff {f!ACHCOAAECTIVE,\CTIOtlSHOIA.D II! CROSS-,Cl!l'VliHteD T0 *IIIE* ,.,,l'R0PAIATE DEFICEtlCYl	(X5) COMPLETION DATE

F 000 INITIAl. COMMENTS

F000

'The statcmcnt.s: made on this plan of co1Tcclion are oot an admis.sion co and do not constilllle an agreement with the **alleged** deficiencies.

To remain in compliance with rJrrat and state regulations, lhe center **hJS** taken or Will ••Ice the actions set forth in this plan ofconeclion. 1'he plan OI correction cons11tutes the center's allegation of substantial compliance such lhat alleced deficiencies cited have been or will be corrected by lhc d111e or datC5 indicated,

q-C'j'-l.011

On July 30, 2016 th10t19h August 1, 2019 a revtsll survey was cgnductad at this facility by tha OfficeofHeallh caniouanty. The censuswas79 11nd lhe lk:anslKI bad capacity Is 91.

SUrvay acUvlUes consisted ot a review or resldenls' medical ffiC!lrds, obsel'Vlltlon, lnlervlaw of lhe raclnty staff, and a ravlaw or admllllslraliva records and resklenl care policies televanl lo Idenlilied dellllan\ praclices,

The suNay ldanllfled non-compliance with Federal and Stale requirements of 42 CFR Part 483, Subpart **B,** and Raqukemenls for long Tann care.

F641 Accuracy of Asseumen\s
SS.:::O CFR(s): 4B3.20(g)

F641

Corrective Action:

'f- 'f-'2.01,

§483.20(9) Accuracy of Assessmenl5.
The assessmenl muslacctJralel renact lha resldml's slalus.
Thls REOUIREMENT Is not melas evidenced by;
Based on medical reconi revlaw and stall tnteNlew II was determlned the facility staff falled to en.sure lha\ lha ln£ormalion used lo complete th1t Minimum Data Sel (MOS) comprehensive assessments for nulrlllomll status was accurate for Resident #1. This was evident for 1 11f:! resldenls **reviewed** lor MOS accuracy during lhls ravlsil survey.

1he findings Include:

The Minimum Data S11l(MDS) **Is a** comprehenslva assessment ol lha resident

I. **Resident** Arteclcd:
Res# I MOS corrected 10 reflect current nulfltional a c:.ssmenL

2. Identify Others with Potential tu **be aCTedi:d:**
Others have the potential to be affected by lhis dcfic!cn1 pnclice. The MDS lead completed **a** I00ro audit or the past 30 days of avalua1ions ID identify those with sicrul'icanl weight chan1c 10 com:ct the MDS accuracy.

3. Measures to prevent reoc1mrrcnce \ StaffDevclopmcnt Coonlinator In• serviced the MDS Coordinators regarding Accura1e **codins** of the MDS.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE

Executive Director

(X6) DATE 9/20/19

deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused fr safeguards provide sufficient protection to the patients . (See instructions for Survey

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F 64'1 ConUnued Fnim page 1

completed by lhe racilily staff. The MOS Is a mulli•disciplinarian tool that allows many (acel5 of he re.sldenl'& care (cognition, behavior, tnoblAty, acUvilies or daily li'ing, ac.ciclenls. aclMUas, weight, pain and medicaUons to name a few] lo be addressed. The MOS assessment Is part Or a broaderRAI (Raslden! Assessment Instrument) process. Tho RAI p,ocess lies the assessment and care plan lo Iha dellvel)I Or care lo meel Iha needs or tho resklenL

MOS coordinalors are nurses lhal are lasked lo ensure lhal patient servicing Is well documented espedalty during Iha assessmant phase In laciiiUes thal are accredited or offer Medicaid or Medicare servlcos.

A cara plan Is a guide !hat addresses lhe unique needs of each resident II Is used lo plan, **assess** and evaluate \he effectiveness of the resident's care.

Medical record rc11lew on 811/19 ravealed Resident #1 was a long•lerm care resident with diagnoses that Included Dementia and Depression.

A care plan lnillated *on* 11/15117 addrused Iha polenlial fer allera\Jon In nutrient **Intake related** lo cognıUve Impalrmenl, medıcatıons and **weıght** loss

A Welghl Change note dal!!d 7/10/19 reported lhe resident eJperienced a significant weight loss. The DiellUan recommended Iha addit;oo **of a** Magic: Cup (nutrilional supplement lhal C8'1 be eaten as a pudding er frozen as an ks cream, served wllh maals or In botween meals lo booi;l nutritional lnlalle) and Ensure Plus lo **aide** In

F 641

4. Monitoring rar Compliance MOS lead Coordinator will complete weekly 11udiu ordu: cu1Tenlly completed wcs.smcnLS 10 monilor fer etcura1c coding in relation lo v.-cii;ht cbangcs (Scclion IC.oflhc MDS). The QA Director will monitor compliance monthly X 1 monlhs and repo" findinss lo QA.

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NORTHWEST HEALTHCARE CENTER	GOt PALL MALL ROAD BALTIMORE, MD 21215

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Further ravlew or lha medica:I record revealed orders da\ed 7H2/t9 for Ensure PhJ5 and a Magic Cup twice a day *as* meal supplem1mls.

Re\/lew ol lh& weigh\ summaiy revealed lho resident weighed 144 pounds en 6/5119, 135 pounds on 7/5/19 and 136 on 7124/19. Further review ol lhe care plan ravealed an ln\en,enUon was .dd&d on 7/30/19 lnsll'\lcUng slaff lo oblain weel\\y weights due lo a slgniftcanl weight loss for 1 month.

Review of the quarterly MDS assessment dated 7/19/19, revealed racilily staff enlered a weigh! In Section K Swallowing/Nulritlon Status or 135 pounds. Slaff !ndlcalad lri scclioo K0300 lhallhe '8S\danl was on a prescribed weight-loss regimen. Review of lhe phy&lcian's orders **lailad** lo reveal an order for a prescribed weight loss dilll.

During an interview \'lilh the surveyor on 811/1e al t:59 PM tho MOS Coordinator slated section Kor the MDS Asseumenl was completed by lha Oielilian. The suiveyor inquired Ir there was an order lor a weight loss dial rar Reslden\ #1, Toe MOS Coordinator confirmed (ha\ an order would be requir d for a weight loss diet and aclmowledged lhe resident's weighl loss was unintentional, noLprescribed. The MOS Coordlnalor amended lhe quarterly MOS assessme;il, dated 7/19119 to renecl lhe te!ilden\ was not on a prnscribed weight loss regimen.

In lnlervlew with the surveyor on 8/2119 al 1:53 PM the Dielilian acknowledged the entry In the MOS assessmenl In Section K

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NORTHWEST HEALTHCARE CENTER	**4101** PALL MALL 110110 BALTIMORE, MO 21215

	SUM IAAV S'T,\TEJ,IEl'tT OF OEFICIEI-ICIES (EAC!-t o!,1c1e1cv IJ'JST !'!c PRECED!!D BY FULL rleGULAT Y Oli LSC IOEt,ill'Wlu ltiFORW.TIOII ▶	10 PIIEFtlt T-'G	PROlllOERS PI.AN OF COMECTION {EACH CORRECTIVE ACTION St!O\J\.D BE CRCSS,R!:FEIIENa:O TO THE **APPROPRIATI:** OEfICIENCYI	(X3)[COMPLETI:N DATE
F 641	Continued From page 3 Swallcwing/Nuliilion Status mgartling Ille proscribed welght loss was a coding error.	F 641		
(F 656} SS=O	Davelop/Jmplemenl Comprehensive Care Phm CFR(s); 4B3.21(b)(1) §4B3.21(b) Comprehensive Cara Plans §4B3.21(b)(1) lho lacllity must develop and Implement a comprehensive person-cantered care plan ror eac;h raslde11l, consistent wilh the resident rights set forth at §483.10(c)(2) and §483.10{c)(3), lhallncJudas measurable ob)ec.lives nnd Umelrames to meel a resident's medical, nursing, and menial and psychosocial need, that are Identified In lhe comprehensive assessment. The comprehensive care plan must describe the lollav.ing - (i) The services that are to **be** furnished to altaln or maintain the resldenl's highest praclicable physical, menlal, and psychosocial wall-belng **as** required under §483.24, §483.25 Of §483.40; and (ii) My sesvlces thal would olheMise berequlred under §4B3.24, §4B3.25 or §483.40 but ere not provided due ta the res!denl's exorcise ol rtghls under §483.1O, Including Iha righl lo refuse lrealmenl under §4B3,1□(cl(6). (iii) Any specialized services or speciaHzed rehabll1tative services the nursing lacility will provide as a resull of PASARR , ommendations.If a facilily disa9rel!s wilhlhe findings or Iha PASARA, ll musl Indicate its raUonale in lhe resident's medical record. (i•,)In cansullaUon wilh Il1B resident andlhe resident's rnpresenlalive(s)- (A) ihe resident's goals ror admissionand di!slrad outcomes. (BJ The resident's preference and potential ror future discharge, Fatilities must document whether lh!! rnsldenl's desire lo return lolha	(F **656)**	Corrccllv,: Action: I 1. Correc:lian for resident affeclcd I Res # 3 and Res 114 had their Care pion updated in accordance with smoklng evalua.tions. 2. Idtnllfy others with polt'ntial lo br nrfccled: The Dircc1or ofnur5ing will complete 11n audit cf current residents 10 ensure the residents ciU'c plons ore accum1ely rr:flccilng ibe residents smoking Sl\rc1y bt1scd off of the comprcbcnsivc residents needs 3. Measures lo prevent rc-occurrcncc: The direcror of nursini; will educ ale the licensed nurses, MOS Ccotdinalor and llte social worker 10 ensure 1he smoking asscssmcnl is complclcd accunuely, The rcsidenls care plans arc eccun,tely rcnec1ing lhe residents smolting safely based oil'of the.comprehensive: residen\'s needs.	9-9-2019

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NORTHWEST HEALTHCARE CENTER	0111 PALL MALL ROAD BALTIMORE, MD 21215

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{F 656) Continued From page 4

community was **assessed** and any rele1Ti11S la local conlatl agencies and/or olher appropriate entitles, for this purpose.

(C) Discharge plans In lhe compn hensive care plan, as approp,iale, In accordance wilh lha requirements sel forth In paragraph (c) ol lhls secUon.

This REQUIREMENT ls not met as evidenced by:

Based on medical record review and stall Interview it was delennined lhe facility staff **railed** lo develop and Implement Individualized cam plans ror residents to address smoking saroty, based on a comprohensive assessment of the rasldenls' needs, This was true !or 2 out or the 4 residents (Resident #3 and Resident #4) reviewed for accuracy In care plan developmenl during this complalnl survey.

The Ondings include;

The r.1inimum Dala Set (MOS) **Is a** comprehensive assessment ol lhe resident compleled by lha racililly slalf. The MOS **Is a** multl,disdptlnarian tool lha\ allows many **racel.!** or lhe resident's care {cognition, behavior, mobllllly, acliviUes of daily living, accidents, aclivlUes, weight, pain and medications 10 name **a few]** lo be addressed. The MOS assessment Is part Or a broader RAl (Resident Assessment Instrumenll process, The RAI proc!Ss lies lhe assessment and care plan lo the delivery or care lo meet the needs ol lhe residenl.

A care plan Is a guide that addresses lhe unique needs al each resident. ti Is used to plan, assess and avaluale the effecliveness of lha reslden t's care.

{F 656)

4. **Monitoring** for the Carrecllvc **acUon:**
The: direclarofnursing will pcrfonni

for 1wo rnonlhs of new

11n 11udil weekly 4 and then

mon1hly
o dmls ions, niodmlts and rcsidcnis w11.h **change** in condition who smoke: 10 C'OSurc lhnl lhc rc.sidcnls c:111c plans an: accunnely rcOcctlng lhc residents smoking safely bll5cd off of the residem's needs. The findings of 1hc audiLS will be presented DI QAPI for the OC'III 90 days for review 11nd comsncnL

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tll,I.IE Or PROVIDER Of\SUPf'UER	STREET ADOAE5S, CITY,. STATE. ZIP COi)!!
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(F 656) Continued From page 5 {F 6561

1) Medical record review on 7130/19 r1111eated Resident #13 was a long-term care resident who was identified as a smoker.

A earl? plan Initiated an 10117/1B addre!!ed Resident tl3's desl1e lo smoke and lndicaled lhe resident was assessed as an Independent smoker. The care plan Indicated the resident was al risk for potential for bums related lo her/his hisJory or smcklng. lnlervanUons direclsd staff lo supe,vise lh& rasldenl during all smoke break and lo rocus on obseivalion or lhe reslden!'s hands during weekly skin checl\s to ensure (here were no bums.

A Smoking assessment dated 5/2119 noted the reslden! required an ap1on and was lo be supervised whHe smoking.

The inconslstenc:les In the assessment and care plan were discussed wilh the Regional Cllnlcal Nurse Consu!tanlon 7130/19. The care plan was tevised on 7/30/19and lha lnrormalton regarding lhe polen al ror bums and lhe need ror supervision was removed.

2) MDdic:ill tecord review on 7130/19 revealed Resident #4 was a long•lerm care residonl who had a diagnosis of Unspecified Calaracl.

Review of the quarterly MOS assessment dated 4/23/19 Section I Diagnoses revealed lhe dii!gnosls of unspecrned cataract and revisw of Section 8 1000 Vision revealed facllily staff coddd lhe resident as visually impaired.

Review of lhe Smoking Assessment daled 5123/19 revealed lhe resident's visual Impairment

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NORTHWEST HEALTHCARe CENTER	4&01 PALL MALL ROAD (BALTIMORE, MO 21215

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(F 656)	Conllnued Frcrn page 6 vras nol,enected In Iha smoking assessmanl The Inconsistencies In lhe assessment were discussed with the Reglonal cnnlcal Nurse Consultant on 7130/19. **The assessment was revised** on 7/30/19 to reRecl theresident's visual lmpalrmenL	{F 656}		
{F 684) ss:o	Quatity..9f Cc!f!l\ CFR(s): 483.26 $ **-483.25** Qua ty of care Quallty of care Is a fundamenlal principle that appfies to all treatment **and care** provided lo facRily resldents. **Based on the** comprehensive assessment of a **resident,** the facllily must ensure lhal reslden\s receive treatment and careIn accordance with professional standards of practice, the comprehensive person-centered care plan, and lhe **resklen\s'** choices. This REQUIREMENT is nol met as evidenced by: **Based** on medical record review and slaff lnterview it was determined the facility railed to:1} lmplement a plan lhal addressed the nulriUonal status fOf a resident (Resident #2) Who **e)(Jleriern:ed** severe weight loss **based** on a comprehensive assessment of the resldenrs needs and slatus; 2) transcribe physician's orders to obtain weekly weights far residents who experienced significant weight loss (Re&idenls #1, #5, -NS). This was evident for 4 of 5 residents reviewed for weight loss during lhls complaint Investigation. The findings included; 1) The facllily failed to Implement a plan lo address conUnued weight loss for Resident #2 based on a comprehensive assessment of lha	(F **684}**	1lF684) ,Corrective Action: 1. Res. #1 #2, #5 and #6 were reass Jq and care plans updated to address weight loss. Resident #1, #2, #5 and #6 had weight orders obtained. Resident #2 no longer receives enteral feeding per their wishes. Resident #2 receives nutrition and supplements orally per their wishes. 2. Identify others who may be affected: Other residents with tube feedings were not affected. Residents wilh significant weight loss had the potential to be affc:clcd by not having weights ordered. These residents were audited to ensure weight orders and plan of care were addressed to meet their nutritional goals.	

C "TATEMENT OF DEFICIENCIES ,No Pt.AN OF CORRECTION	{JIil PI10VIOER/SUPPLIERICLIA IDEIITIFICATION NUMIIER	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____	(Xl) DATE SURVEY COMPLETED
	215346	B WING	R-C QB/0112019

NAME OF PROVIOER OR SUPfLIER	STREET ADORI!.SS, CITY. 511.TE, 21P COOE
NORTHWEST HEALTHCARE CENTER	4601 PALL MALL **ROAD** BALTIMORE, MD 21215

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{F 684} conllnued From page 7

resident's lndlvlduallzed needs.

Medical record review en 8/1/19 revealed Resident #2 was e long-term care resident with diagJKJses lhal Included Oysphagla (diffccully swallowing), Cachexla (a "wasling" disorder thal causes exlreme weight loss and muscle wasting, and can include loss of body fat), and Depression. The resident received nulrilion via a feeding tube.

A Nutrillonal Assessment dated 7/2119 reported the dieUllan had a lengthy discussion with Resklent #2 who wished to continue wilh his/her dlel which included tube feedings and a regular PO (by mouth) dlet despite the high risk for aspiration (Inhalation or food or drink Into the lungs). Il was noted that lhe resident continued to discoonecl his/her lube feeding during lhe nlghl

A Care Plan lnlUated Ofl 7/2119 addressed a nutritional problem related to severe malnutrition and dr-5phagia (difficulty swallowing). Inlerveolions included educate and reinforce the importance of maintaining the diet ordered, encourage compliance and discuss the consequences or refusa obesltyfmalnutrition risk factors, provide and serve diet as **ordered,** and pr0vlde and serve supplements ils ordered. The goal is for the resident to tolerate tube feeding and accept grealer than 75% or the feeding. A care plan lnlUaled on 7/5119 addressed the resident's need fer tube feeding relaled to dysphagla (difficulty swallowing).

A review or the weight record revealed the following measurements in pounds for Resident #2:

{F **684}**

3. **Meamre to prevent reoccurrencc:**
The Quality Assurance nurse will educate the Dietitian and licensed nurses on ensuring residents with significant weight loss will have frequency of weighls identified and plan of care re-addressed. Education ofweighl policy will be included.
The Qualily Assurance nurse will re-educate the Dietitian lo re-assess residents that are non-compliant with their diet and who had a significant weight loss for their needs and preferences to ensure they arc being met,

4. **Monitoring** of c ti;,ctions'i r **residents affected:**
The Director of Nursing will perfonn anl audit weekly x four, and then monthly over the neitt two months to ensure residents with a significant weight loss have Physician n tification, orders for weights, and care plan updated to renect treatment plan. The findings will be reported lo QAPI for the next 90 days.

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NORTHWEST HEALTHCARE CENTER	4&01 PALL MALL ROAD BALTIMORE, MD 21215

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{F 684)	Continued From page B **3120/29· 10D.4** 4/10/19- 97 **5122119-82** **6'5/19-BO** 6/28/19- 77.6 7/5119-76 7/24119- 76 7/31- 7 .6 A Behavior Note dated 7/23/19 reported that at the beginning of the shift lhe writer noted the tube feeding was not In place. The writer noted the resident refused tube reedlngs several Umes and when the writer altempled lo place the raedlng tube the resident **slated** s/he did not want It. It was also reported that the resident was hoarding Ensure and not consuming IL A physician's order dated 7/23/19 directed slaff to weigh the resident weekly. A Dietitian's Weight Warning note dated 7/29/19 al 4:05 PM reported the resident had significant weight loss over the past 6 monlhs as previously documented. IL ls also noted lhal per the medical record lhe resident continues to lnlerm1"enUy refuse gaslrlc rube leedlng and Is hoarding Ensure supplement In his/her room. The Dietilian noted the resident had been repeatedly educated by staff lo keep the tube feeding running throughout the nlghl On 7/30/19 staff lnlliated a care plan that addressed significant weight loss for Resident #2. The goal was that lhe resident would allow tube feeding to be administered ss ordered and to obtain weekly weights until stable. Review of the Medication and Treatment Administration records on 811/19 revealed the	(f **664}**		

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NORTHWEST HEALTHCARE CENTER	-41!11 PALL MALL ROAO BALTIMORE, MD 21215

(IC-4) 10 PREFIX TAG	SUMMAAY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED IJY FIJIL REGUIATORY OR ISC IOEHTIFYING INFORtMTION)	ID PREF!){ TAG	PR0"1DER'S PLAN Of COAAECTION (EACtt CORRECTIVE ACTION SHOULD BE CROSS,REFERENCED1'D THI!:APPRDPI\IATE OEFICIEHC'()	, , CDW'LETIDN DATE
(F 684}	Continued From page 9 lube reeding was signed off except on 7/20119 and 7129/19. Staff entered a code 9 on lho$e cales which according lo the key code indicated the nurse was to enter a progress note In the medical record. Review of the medical record failed to reveal a progress note on 7/20119 or 7/29119 lhaladdressed the resident's refusal of the tube reeding. Medical record ravlew faffed lo reveal documentation that Resident #2 was not receiving 100% of his/her tube **reeding.** Review of the July 2019 Medication Administration Record re11ealed facility staff signed off Ensure supplement as administered. There was no Indication the resident rerused or partially consumed lhe supplements. During an Interview with lhe surveyor on 8/2119 al 1:53 PM lhe Dietitian &lated the resident's refusal of the lube feedings was an ongoing behavior. The surveyor noted that the review of the medical record failed lo show the resident was conslstenUy refusing or only recel\/lng partial Infusions of the tube feeding and ensure supplement It Is um:lear if the resident was meeting lhe goal or accepting at least 75% of the feeding as facllity staff did not Indicate In the medical record how much or the feeding the resident was receiving daily. 2a) The facllily failed lo tranSC1ibe a physician's oofer lo oblain weekly weighls ror a resident who experienced unplanned weight loss, Me<lical reaird review on 011/19 revealed Resident #1 was a long-term Cafe resident with diagnoses that Included Demenlla and	(F 684)		

"TATEIAENTOF DEFICIENCIES ;,o PINI OF CORRECTION	(ll1) PROVI0ERISUPPUERICllA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(1(11DATE SURVEY COMPLl;T!:O
	215346	A. BUlIOING _____ S.W1NG	R·C 08/0112019

NAME OF PR0VI0Eft OR SUfPUER	STREET ADDRESS, CITY, STATE. ZIP OOOE
NORTHWEST HEALTHCARE CENTER	460' PALL MALL ROAD BALTIMORE, MD 212i5

(X JID PREFIX YAO	SUIN.IAI\Y STATEMENT OF OEFICll:NCIES tE'ACH DEFICIENCY MIJST IIE !'RECEDED BY FUU. REGULATOR'(OR LSC IDENTIFYIHG INFORMATION)	ID PREFIX T,I.O	PROVIOER'S PLAN Cl' CORRECTION (EACH CORRECTIVE ACTION SHOUID BE CROSS•REFERENCEO TO THEIJ'PROPRIATE OEFICIENCY)	llU! COI.Cl'l.fTIOtl DATE
{F 684)	ConUnued From page 10	{F 684}		

Depression.

A care plan initiated on 11/15/17 addressed the po\entla\ for alteration In nutrient Intake related to cognllive Impairment, medications and weight loss.

A Weight Change note dated 7/10/19 reported the resident e1epetlenced a significant weight loss. The DieUtian recommended the addition of a Magic Cup (nutritional supplement that can be ealen as a pudding or frozen as an ice cream, served wilh meals or In between meals to boost nutritional lnlake) and Ensure Plus lo aide in weight slablliz.aUon.

Further review or the medical record revealed orders dated 7/12119 for Ensure Plus and a Magic Cup lwice a day as meal supplements.

Review of the weight summary revealed the resident weighed 144 pounds on 6/5119, 135 pounds on 7/S119 and 136 on 7124119. A physician's order dated 7129/19 instructed staff to obtain weekly weights until stable. Review of lhe Medication and Treatment Administration Records revealed this order was not transcribed. Further reVieW of the care plan revealed an InteivenUon was added on 7130/Hl Instructing staff to obtain weekly weights due lo a significant welghl loss for 1 monlh.

2b) Medical record review on 7131/19 revealed Resident #5 was long-term care raslden t with diagnoses that Included but were not limited to Anemia and Dyspha9la (difficulty swallowing).

A Care Plan note dated 6125/19 reporte<I the resident had a need for monitoring due to the

ATEMENT OF OI!FICIE.NCIES JIO Pl.Ml OF CORRECTION	(Xt) PR01110£R/SUPPLIER/CIJA IDENTIFICATION ffUMIIER	(Xll MULTIPLE CONSTRUCTION A. BUILIIING _____	(Xl) DATE SURVEY COMPLETEO
	215346	8WING	R•C 08/01/2019

HAM!: OF PROVIDER OR SUI'PUEA	STREET AOORESS. CIIY, STATE. ZIP COOE
NORTHWEST HEALTHCARE CENTER	-4601 PAU. MALL ROAO BALTIMORE, MD 21215

(X4) 10 PREFIX TAG	SUIAMARY STATEMI!tIT OF DEFICIENCIES (EACH DEFICIEHCY' I,1UST BE PRECEOEtl eV FULL REGULATORY OR LSO IOEIITIFYIIIG IWFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COfIRECTION IE/,CH CORRECTIVE ACTION SKOIJLD BE CROSS REFERENCED TO THE APPROPRIATE DEfICIENCY)	' ' COMPI. ET'ION D.\Tf
{F 684)	Continued From page 11 poteollal for alteration In nutrient Intake and utilization. The plan contained an Intervention lhat directed staff to obtain weekly weights until stable. Re11iew of lhe weight record revealed a weight loss of 19 pounds over a 4-monlh period (JfT/19-7124I19). A Weight Change Nole dated 6126/19 reported lhe resident had a 10% weight loss In the past month. Il was noted that cnIlcal Illness and dysphagia likely conlributed to lhe weight loss. The plan was to pravida double portions al meals, rortified Jcods and a magic cup three times a day. AWelghl Warning Nole dated 7/29/19 reported the resident had a slight **decrease** In weight but was overall stable, The medical record contained a physician's order rorweekly walghls until stable. This order was not transcribed lo lhe Medication orTreatmentAdmlnistration Record. A No"ficatlon Nole dated 7130/19 reported lhe resident's responsible party and physician were notified ab0t1I the resident's weight loss. 2c) Medical record review on 7/31119 revealed Resident #6 was a long-term care resident with diagnoses lhat Included but were not limited to Schizophrenia and Unspecified Psychosis. A Care Plan Initialed on 517/18 addressed the need lo monitor the resident for the potential ror alteration In nutrient Intake and utillzaUon related lo a hi5lcry or unintended weight loss. A Care Plan In!Uated on 5/9/19 **addressed** unplanned/unexpecled weight loss related to poor food Intake and expressed paranoia about her/his faod being poisoned. Interventions included alert the dieUcian If consumption is poor for more lhan	{F 884}		

1,'TEMENTOF DEFICIEHCll:S 'IDPLAN OF CORRECTION	(XI) PROVIOER/SUPl'LIERJCUA IDENTIFICATIONNUMBER	fX21MULTIPl.E CONSTRUCTION	(XIl OATE. SURVEY COMPLETED
	215346	A. BUILOIHG _____ B Wlt/G	R-C 08/01/2019

NAME OF PROVIDER DR SUPPLIER	5TREET ADDRESS, CITY, SIATE, ZIP COOE
NORTHWEST HEALTHCARE CENTER	**41501** PALL MALL ROAD BALTIMORE, MD **21215**

(X-4) IO PREFIX. TAG	SUMt.IAAV STATEMEUT OF OEFJCIENCIES (EACH OEFICIENCY MUST BE PRECEDED av FLU REGUIATORV OR L5C IDENTIfYING INFORMATION)	10 PRI:FIX TAG	PROVIDER'S PLAN Of COIUIECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REF'ERENCeo TO TItEAPPROPRIAIE DEFICIENC'()	COl.'.P1ETJD/1 **Oo'ITE**
{F 6B4)	Continued From page 12 48 hours, Ir weight declifte persists, contact the physician and dietician immediately and weekly wefghls x4. **A** Weight Warning note dated **5129/19** reported lhe Re::.iident had a previously documented weight loss over the past 3 monlhs. It was noted lhe Resident had been reporting slhe was not ealing as s/he fel-ood was being poisoned. The resident's psyc otropic medfcallons were readjusted. Il was further noted lhe resident was eating 76-100% of meals and regaln1ng welghl. The medical record conlalned the following weight measurements in pounds for Resident #6: **6/19119-167** **6126119- 166** 7/5/19- 153 718/19-158 7/9/19· 158 7/23/19· 153.4 **7/29/19-152** A Weight Change Note dated 7/B/19 reported the Resident was again noled to have significant weight loss. Recommendations included liberalizing the resident's **die** adding Ensure Plus three times a day and obtain weekly weights to track adequacy of lntake. A Weight Wamlng note daled 7/29/19 reported the Resident had conlinued weight loss and food Int.aka was variable. The medical record contained a physician's order to obtatn weekly weights. This order was not lranscribed to the Medication or Treatment Admlnlslralion Record. Review of the Task docurnenlalion or meal percentages revealed the resident was noted to	(F 684}		

"-·r11TEJ,IEfIT OF DEFICll;NCIES PIAN OF CORRECTION	fltl) PRDVIOERISUPPUERICLIA IOEHT1FICATION NUMBER	r.lULTIPLE CONSTRUCTION	(Xl) DATE S\JRVEY COMl'Ll!TED
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NAME Of PROVIDER OR SUPPUER	STREeT AOORESS. CITY, STATE, ZIP cooe
NORTHWEST HEALTHCARE CENTER	4601 PALL MAlL ROAO BALTIMORE, MD 21215

pC◀l10 PREFIX TAG	SUMMAAV STATEMENT OF DEFICIENCIES (EACH OEl'ICIENCV MUST BEPRECEDED BY FUU. REGULATORY OR LSCIDENTIFYING INFORMATION)	10 PFIEFLX TI\G	PRO\lIUER'S PI.AN Of CORRECTION (EACH CORRECTI\IEACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEfICIENCY)	(XS) COMPIEIK>ff CATI
	l			
{F 68-4)	Conlinued From page 13	(F 684)		
	, have consumed 7Bo/a· 100% of his/her meals from the period 7/2119 to 7/30/19 except on 7/3/19 and 7/10119, 7/29/19, and 7/30/19 when il was noled s/he consumed 51%-75% of the dinner meal On 7/27119 ll was noted lhe resident consumed 0%· 25% or lhe dinner meal.			
	ourtng an Interview with the surveyor on 7/31/19 al 2:12 PM the Dietitian stated the Resident was currently refusing psychiatric medications and had resumed paranoid idealions about food being poisoned. The sur.,eyor asked ror clarificaUon regarding lime frames for reporting meal rerusals, l the definition of poor consumplion, and ' parameters for weight decline as lhls was not clear in lhe care plan.			
	The Reglonal Cllnlcal Nurse Consultant presented a revised care plan that noted lhe dleliUan was lo be notified for meat consumption of less than 50% for 3 **days** or less than 25% in **one day.**			
	The faUure lo transcribe physicians' orders far restdents experiencing unintended weight loss was discussed wllh the Director of Nurslng and 1 Regional Clinical Nurse Consultant on B/2/19.			
{F 921)	Safe/Funclional/Sanilary/Comfortable Environ	(F 921)		
SS.:O	CFR(s): 4B3.SO(l)			
	§4B3.90(i) Olher Environmental Conditions , The facility must provide a safe, runcUonal, sanilary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observalion and lnleNlew wilh facllity ' slaff, II was determined lhe racility failed lo			

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HORnlWEST HEALIHCARE CENTER	.CGat PAIL MALL RO.\D BALTIMORE, MO 21215

(X◀)liJ P/1!fll(TAO	SUMMARY STATEMEHT OF OEFICIENCIES (EACH OEFIC1£NC'I' IAUST BE PRECEOf.D B'I'flltl REGUL>.TORV OR L5C IOEITTIFY1Nu INFO!Ul>.T10NI	ID P/IEFIX TAG	FR0Vl!lER'SFWI OF COMECTIOII (EACH COAAECTJVE ACTION SHCU\.D BE CROSS·REi'EIIEIIC:CO TO llf!:APPR0PRl4Tc. OEFIC1£PICY)	(I<S) CV.TE
{F 921)	Continued From page 14 maintain an environment lhal was sara, sanltilry, comrortable and functional for lhe residents, stalf and visitors. "This deliclenl praclica had lhe potential to affect all res!denls. The findings Include: The suiveyor noled upon enhance lo lhe racilily on 7130/19, 7/31'19 end B/1119 lhe strong odor of urine. Room 4: the strong odor ol unno was present on 7/30119, 7131/19 and 8/1/19, Observation on 7/30/19 or !he Terrace Unit re11aaled an unoccupied wheelchafrwes In lhe hallway. The seal and back or the c;halr had cracks which posed a risk for lnfeclion and Injury. Housekeeping Slal/#11 look Iha chair to lhe rehabiHlaUon department for repair. Sun1eyot lour or the lacilily on 7131/19 at 3:1D PM re11ealed the following concerns: Terrace Unil Shower Room: the curtain rod was not sec;ured lo the wall, There were cracks around Lhe rod on lhe ri,;ihl side. Several rrun mos were visible. Terrace UnU Shower Roorn: Iha wheels on lhe shower chair were rusty which posed a rlskror injury lo residents. Terrace Unll: there was an odor orunnecomlng from lhe bathrooms near Iha shower. 1he com:ems wen, discussed wilhlhe Admlnistialoron 7131119 at 4:DD PM.	{F 921)	The unoccupied wheelchair wilh the c ckcd seatb3ck was removed and repaired. The Tmucc Unit Shower Room rod was secured lo the wall. The cracks around lhe rod on lhe right side were rcp.iircd. Boy Ciry Pcsl Conlrol lre ted lhc orca for fruit flies. Tltc showcc ch.air wi1h rusty wheels found in the Terrace Unit Shtiwcr Room was rcmovl!d. The b,uhrooms near the shower on lhe Tcnac:e Unil have 1heir floors replaced, c;le;ined and Wllltcd. 2. ldentlry other **areas** wlth the paltnU1l *lo* **be aITcdcd:** Environmcnu1l rounds of the building ""ill be rou1incly made eoch shift to identify sources or odor. A wheelchitir invcnlory has been created to identify and record the whce\chairi; in lhc building Shower chnits will be idi:ntHicu 1md logged. A log of shower rooms and b:ilhrcoms will be crc:ur.d to focilttate tracking their cleanliness, ;, l\leasuru 10 Prevent r occurrcoce:	0...'l--.zi,11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	!XI I PR!IVIOERISUPPlIERJCU.i. IOEtlllfiC>.TIOtl H\JMeEI\, 21SJ4&	(X2) MULTIPLE COIISTAUCTIOO ,-,BUILOldG \Vi/T.,	(lO) DATt! SUIIVJ!Y COMPIETEO R·C OB/0112O19

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS. CITY, STATE, ZIP CODE
tlORTHWEST HEALIHCARE CEHTER	AMII PALL MALL ROAD BALTIMORE, MD 21215

	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)	COMPLETION DATE
(F 921)	Continued From page 14 maintain an environment lhal was sare, sartlta,y, comCortable and functional ror the residents, staff and visllcrs. Thls deficient practice had lhe polential lo effecl an residents. The findings lnclud1;1: The surveyor noted upon entrance la the facnity on 7/30(19, 7131/19 and 811(19 \he strong odor or urino. Room 4: the strong odor o!urine was present on 7/30/19, 7/31/19 and B/1/19. Observation on 7/30f19 or Iha Terrace Un!t revealed an unoccupied wheelc:halr was InIha tiallway. The seal and back ulU1e thalr nad cracks which posed a risk fot InfacUan and Injury. Housekeeping Slatt #1 look the ch.ilr lo the rehabilitation department **ror** repair. Swveyor tour oClhe facility on 7/31119 al :l:10 PM revealed lhe following concerns: Terrace Unit Shower Room: the curtain **rod was** nol secured lo the waU. There were cracks around 1he rod on lhe right 5fde. Several fruit mes were visible. Terrace Unit Shower Room: the whools on lhe shower chair were rusty which posed a risk ror Injury lo resldenls. Terrace Unll: there was an odor of urinecomlng from the bathrooms near lhe shower. Tho concerns were discussed wilhlhe Adml;iislrat!lr on 7/31/19 al 4:00 PM.	(F 921)	The use or uir filters will **be** employed to reduce odors. MaureS5cs identified 10 be soiled wilh urine will be replaced. Hampers with plnslir: liners will be usei.110 callc:cl soiled clothing. Hampers will ncl be used in the: hallways, A wheelchair log will be u ed lo records lhc rou,inc and regular clc:ining and moinlcnnnee cf whcclcht1irs. Wheel chairs nol in good n:p.iir will be disc11rded. Shower room chairs will be monilorccl routinely for cleanliness and suitobiluy for use:. Tho c deemed un5uit ble will be n:phiccd. Shower rooms will be monitored no less 1ha11 twicc u shift lo assure lhi:y arc clcnn odor free and i.n good repair. The Maintenance Director will prcp re II loc indicutin& the regular inspection, nd maintenance or whcclchnirs. The log will be reviewed, The QA.l'l Conumuec: meeting for lhc neitl 90 da>-s 4. Monltnring of Corrtcllve Actions: A weekly aud1l x 4 weeks and lhcn	9-9-2019

TA1EIAE/IT □ OEFICIE/ICIES D PI,\N 01' CORAECllliN	(XI) PROVIDEIUSUPI'UERICLIA 10£/ITIFICATIOtl NUMBER 215JA6	1:01MIJI.TIPLE CONSll'IUCTIOtl .,_ lIUll,OlllG -·-—-·· B WtJG	(IO) DATE SUIW£V C:OW'LETED R-C DB/0112O19

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NORTttWEST HEALTHCARE CENTER	&01 PA.LI. MAI.L ROAD BALTIMOAI; MO 21215

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{F 921}	Continued From page 14 maintain an environmenl lhat was sale, =,anltary, comrortable and funclianal for lhe resldants, slalf and visl(ors. This deficlenl pracllco had the potential lo affect all resldenls. The findings include: The surveyor noled upon entrance to lhe facillly on 7130119, 7/31/19 and B/1119 tho strong odor of urine. Room 4: the strong odor ol urine was present on 7/30119, 7/31/19 and B/1/19. Obseival!on on 7/30/19 or lhe Terrace Unll re11ealed an unoccupied wheelthalr wa=, lnlha haUway. The seal and back cf the chair had cracks which posed a risk *l0t* Jnreclion and lnjul'/. Housekeepk,g Siar< #1 took !he chair lo lha rehabililation department re,repair. Surveyortcur orlhe faciiily on 7/31/19 al:l:10 PM r1111ealed lhe following concerns: Terrace Unil Shower Room: the curtain rod was nol secured lo lhe wan. There were cracl\s around lhi! rod on lhe righi side. Several fruit 111es were visible. Terrace Unil Shower Room. lhe wheals on lhe shower chair were rusty which po5ed a riskier Injury to residents. Terrace Unit· !here was an odor or urine coming from the bathrooms near Ule shower. The concerns were discussed wilhtha Adminls(raloron 7/'.31119 at 4:00PM.	(F 921}	monlhly audi1 it 2monlh3 of reports of urine odors will be mainlilined by the Director of EnYimnmcnllll ScrvicCS" ond the resuhs oftm findings will be prescnltd 10 the QAPI Commiuce for rhc ncxl 90 days. The EnvironmenllII Services Director will develop o weekly clconln,g schedule for whcclchai,s end present the proof or clc11nin11 la lhc QAP(Committc11 for the ntxl 90 days.	9-c;--7.0i'I

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FORM APPROVED

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NORTHWEST HEALTHCARE CENTER	**C&D1 PALLMALLROAD BALTIMORE, MO 21215**

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	On July 30, 2016 thraughAogust 1, 2019 a re'llsll survey was conducted al this facility by lhe Otrrce al Health Care Quallly. The cansus was 79 and the ncansed bed pacity Is 91. survay acHvttles consisted ol ll review of residents' m cal recon:ls, observallon. Intel\liew of lh• fadllty staff, and**a niview** of admlrislrnlivc rsoirtls and reslda ol care **policies** relevant to idsnlified daRcient prac:Uces. The survey Identilied non-compUancewith Federal and State requlremenls Or 42 CFR Part 483. Subpart B, andRequiramerils ror Long Term **Care.**			
s 100	10.07.02 09 A·B Adminlstratlan and Resident Cara 09 Adrninlstrallan and Resident Care. A. Rupons'bi,ly. (1) The licensee shall be ,esponslble lor the overa11 c.onducl of the comprehensive caf9 lacili\y or exlender:f care racll:tyand ror camphance With applicable laws and regu!alions (21Tue adminlslralor shall be1esponslble !or the lmp!mienlaUon ond enlorcemenl ct all provisions of \he Pallenl's BUI er Rights Regulallons under COMAR 10.07.09 B. De\agaticn to Adminlslralor. (11Toe llc11ns1111, I! not c1cU119 **as an** admlnlslnltor, shall appolnl as admlnlsllatar a respoJ1slbte penton who Is	S 100	Refer to f-641	-9-2019

REGULATORY DIRECTOR & OB SIGN — SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Executive Director — 1/20/19

FORM — 1111 — IIIO'Nll — continuation sheet 1 of 8

STA1l!MEtlT OF OE,,.:telCt.ES Atll>PIA/1 IF rotU•ECllOtl	(11 PAOVldERISUPPUERICUA !Mt.'11IFICll,Otl IIUl,IOfR 2151&4&	11 MUITIPll; COOSTlt!CTION r. BUIU>UO _____ I.WNCi	1n) CATE SURVEY COl.l?LETEO R-C 08/01/21)19

IWIE OF PRO\nOEI\ OR :SUI'P\IER	STl!EET AIIOR!!S5, CITY, STATc. ZIP CODE
NORTHWEST HEALTHCARE CENTER	Got PALL MALL ROAD BM.TIMORE, MO 2U15

	SUP,IMAIIV STAJENEI/T OF DEJICI (EACll WICIE/ICY MUST DEPRECEDED BY FUU. RECiUU.TDRY CA LSC10EfiTV'lltlG FQAM.t.111111)	10 PREFIX TAG	PRDVIOER"S I'LAN Of CORRECTIOII (1:AC!f COMECTM: N.TION SliOlll.O 11£ CIIOS5-AEFEA£11CEIIWll« APPll0PAIA1&: DEFICIE.NC'IJ	
s 100	Continued F1om page 1 (a) Qualified by lr.tning ano e.wperianca; and (b) Ucensad by Ille Board of Examlnars of Nur$1ng Home Admlnislralors for Iha State. (2) Tha adm111islralor shall (a) Be respons,ble lor Ihe conlrol of lhc cpelilllon on **a** 24-hOtJr **basis;** and (b) Wilh lhe exceplian al **§8(3)** of lhls mgulatiGn, serve fiJlf,time. (:l) Wilh Iha Oepar1menl • s approval, an administrator may **sel'\/e** en **a less** than fLlll•lime basis ror a mal!lmum of IWo nursing facilities, one or whk.h shall have a licensed capacity ol 35 beds or fewer. (4) The Oepanmenl shall consider the following factor:. when dacldin!l whelhar to appravo an adminislralor to **serve** on a less Ihan full,lime basis: ta) Geographic localicm ol the lac:ililias; (b) Ownership ol the raciHUes; (c:) Organizational s1,uc1u1e ol lhe facilities, (d} Size ol Ihe facilities; and (al Background and experien of \ha administrator. This Regulation ls not mal as evidenced by Reier to CMS 2567 F921	S 100		

PRINTEO: 08/l5/20t9
FORM APPROVED

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AME OF PROVIDER OR SUPPLIER
NORTHWEST HEALTliCARE Ct;NTER

SlREET N)CRfS , CITY, tr;.IE,W';:ooe
4801 PALL MALL "0-'0
BALTIMORE:, MO 21115

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SHl	10.07.02.20 E Nursing Sel'llces • Responslbllilles arooN ,20 Nursing SeNicus • Obactor or Nursing, E. ReSJ)onsi filles ol lhe Oirector of Nursing. The raspansibililies or lhe director of nursing shaN fn lUde: (1) AsslsUng (n lhe dev!!lOpmenl andUpdaUng ol statements ol nu l"g philosophy and objectives to define the type *ell* nursing care lhe nursing home !han p1ovide, (2) Preparation ol wrillen lob de.scripHons fct nursing service personnel, (3) Planning to meet the total nursing needs cf residents to be mat and recommending lha assignment cl a sufficient number of supervisory and suppart pmonoel for eacti lour or duty, (41Deveklpment and maintenance or nursing servic11polici!!s and procedures lo hnplemenl U1e program 1J/ !:lire; (5) Participalion in lhe coon:linaUon ol rasldent services lhraugh appropriate sli'ltt commltlee meelings onissues relating lo {a) Pharma<:y, (b) lnleclion conlrcl. (c) Resldent care policies, (d) Quality assurance programs; and (e) Oepart:nental mee ngs,	57◀0	Refer to f.556	1-7-2019

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STATE FORM ,•,,

Offiee 01Health Care Ooatilv

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NORTHWEST HEALTHCARE CENTER	'601 PALL MALL ROAD BAlllMOAE, MD 21215

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S *1 0.*	Continued From page 3	S7-40		
	(6) Cooperation with admlolstration In planning lhe orien\alian program and U,e stall dewlapmenl program to upgrade the c:ompetency or personnel;			
	(7l Ensuring lha\ nursing persoMel undorsland lha phWosophy and meet lh!! objectives;			
	(8) Participation Inplanning andbudgeling ror nursing setvices;			
	(9) EslabUshmenl of a procedure lo ensure lhal nursing servlce per.so Me.!, including privalo duly nurses, haYe valid and currant Maiyland ilcanses;			
	(10) ExecuUon or resident care policies unless dalegaled lo lha principal physician or medical director;			
	(11l Participation in lhe selection ol prospective admissions lo ensure lhal the musing home• s staff is tapable or met!llng the needs al aU resldenls admllled,			
	(12) Coatdination of the lnlt!rdisciplimny resident care management efforts; end			
	(13) Supervision of certined medicine aides lo ensure lha.I the aides act within the hmitalions and reslricticns placed on lhem.			
	Thi$ Reg\Jla\ion Is no\ mal as evidenced by; Re*let* lo CMS 2567 F6B4 F655			
S 760	10,07.02,20 G Nun;ing SeNices ·Daly Rooods OON	5760	Rerer to **F-6811**	-9-2019

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PI.WI: 0 PIIOVICER OR SUPPIJER	STREET AOORESS, CITY, STATE ZIP CODE
NDRTttWEST HEALTHCARE CENTER	4li01 PALL IU.1.L ROAD BALTIMORE.Mb 21215

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s 760	contin:iad From page 4 20 Nulliln g Servicns • Olrcelor ol Nursing. G. DaDy Rounds• Dire tor of Nursing. (1) Although dall,' rounds are prlma!lty the responslbllily of !he charge nurH or nurses, lhe director or assislanl din1ctor ol nursing shall periodically make clinical roundll lo nurslllI! units, ranclomly reviewing cth1lcat tecorqs, medication orders, rasldenl 1;11re plans, and !llatf assignments and visiting resldenl5. (2) Upon raque!t, lhe director or assistant director *ol* nursing *may* accompany physicians vi iling resldenls. This R11gu!aU0n Is nol met as evidenced bt, Refer lo CMS 2567 F6'11 F656	S75D		
S289C	10.07.02.58 Re dent Care Managemenl Syslem .58 Resident Care Management System. A. Each comprehensive care racihly and ext!!11ded care facility shall ostabllsh and maintain a resldont care manag ment system. B. The. resident care management system shall consist or three related components (II Resiclenl slalus assessment and data gathering, (21 Care planning, and (3) Actions in response lo care plan approaches.	52890	Refer to F-6SG	7-9-2019

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S290(	10.07.02.59 Residenl Stalus sessment .59 Resident StallJs Assessment. A. A nursing home shiiH use lhe following lonns and procedures lor tesident assessment as described in the CMS Manual System, Pub. 100-07 State Operations ProVfder CertJlicalion and In lhe CMS Long-tenn Care Facility Rosldenl As5essmenl lns1n1menl 3.0 Users Manual: (1) The Minimum Data Sal (MOS) version es delennined by !ht U.S. 011par1m&nl at Health and Human Services, Cen!ets lat Medicar11 and Medicaid Services, rere,enced in §B or !his regulation. (2) MOS Care Area Assessmenl process; antS (3) Care plans, B. *The* nursing heme shan complele all assessments In accordance wilh lh!! provisions or 42 CFR §463.20, as amended. C. A nur.;ing home certi/ied for parocipalio/1 In Medicafe or Medicaid shaU camplole and electronically submit lhe assessment lo the Quality Improvement end evalual/on sy,1em (QIES) Ass smenl Submlssion end Processing (ASAP) system. lhe assessment shaU (1) Use a standard record layoul forma	S2900	Refer to F-6SG	1-4-2019

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NORTIW',EST HEALTHCARE CENTER	4101 PALL MALL ROAD BALTIMORE. MD 211.15

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S'Z90D	Conti ued From page B \2) Use a data diclionary **as** id11nli6ed by the automa!ed dala processing requirements: ar.d (3) Pass standardized edits as defined by CMS and lhe State. D, A federally certml!d nursing home shaR; (1) Encode a!lsossmenl dala as spetllietl in **lha** CMS Long-tenn Care Facility Rasitlenl Assessment lnsl,urnanl 3.0 User's Manual, and (2) Transmit asses.srnl!nl dala as specified in lhe CMS Long-tetm Ca/It Facility Resident Asse5smen\ Instrument 3.0 Use s Manual except as excluded in §E or this regulation, E. A nun;lng home licensed as a nursing home bul not certified for partlcipalion inthe Medicare or Medicaid P1ogram shaK comply with the CMS Manual Syslem,.Pub, 100-07 Stale Operation., Provtdat Certlricallon. and wllh RAI instrucllDns In lhe CMS Lcing,lerm **Care** Facility Residenl Assessmenl Instrument J 0 **Use(s** Manual, e,cepl lhcl\ data m11y not ba submilled electronlc-.ill,' IO lho Department 1"his Regulation iS not met as evidenced by Rere, \0 CMS 2567 F641	S2900		
S509C	10,07.09.08 A Res. RightslS11cs,gcneral .OB Resident's Rights and Setvicas, A, A nur..ing facil:ty shall pro•Jida care lcr residents In **a** manner **end** In an cnviranmanl lhat	S5090	Refer ta f- 921	1-9-2019

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NORTHWEST HEALTHCARE CENTER

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BALTIMORE, MO 21215

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l\•IARYLAND DEPARTMENT OF HEALTH
OFFICE OF HEALTH CARE QUALITY

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SS W,\Oli AVENUE
CATONSVII.LE, MAR YI.AND 21228

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Oirt:CIOf

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

.ii\ MARYLAND
Department of Health

Jonuorv 16, 2018

Attn: Meir Preis, A.dn1lnlstrator
Nonhwcst He.ilthc.irc Center
4G01 P.111 Mall Roild
O.ltlmorc, **MD 2121S**

Oe.ir Mr. Preis:

This letter isto acJtnowlcdgc tcccipt of anapJJhtatlon to operate Northwc-st Hc.ilthcare Center.

The enclosed license will beIncffc-ct untll OctobN l, 2019, unlessrevoked, It ls vour Juthorltv to malnt3in a comprchcn),ivc c.ire focllity with a licensed cap.lclty of 91 bedsunder the provision of COMAR 10.07.02.

This license is to be dlsplavcd In aconspicuousplJcc. ator ,iear the entrance of your facllity, pl.1lnlv vis.iblc and Nslly read by the publlc.

The d ilnd roombrcJkdown Is attached.

Sincerely,

Margie He.ild,Oci,uty Olrcctor
Officeof Hc.ilth CareQuality

Mtt/cjc

Enclosure: license No, 30·033
Cc: B;llllmo1e City Ht'.Jllh Olf,cet
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Room .indbed b,ealtdown:

CATEGORY	LO(ATION	TOTA
Comp,ehcnsfve C.uc Facility		
	Moln H:.(I	
	Duplex Room>; I. 2, 3. *4,* S, 6, 7, 8, 9, 10, 12, *14,* JS, 16, 20, 22, 24, 26	36 bods
	Trrple Rooms 18	03 bods
	Quad Rooms: 11	04 bods
	Tolol Main Holl	**43 beds**
	Now Wing	
	S.ngle Rooms: 46	01 bods
	Ouptex Rooms: 40,47. 48. 49	08 bods
	Triple Rooms; 41, 42, 43, 44, 4S	IS b<,ds
	Quad Rooms: SO	04 beds
	Tot INew Wing	**28b<ds**
	Tgr ce Unit	
	Siogll' Rooms: 36	01 bed
	Duplex Rooms: 31, 32, 33, 34, 3S, 37	12 beds
	Triple Rooms: 38	03 beds
	Qu3d Rooms: 39	04beds
	Toua1Terr.,cUnit	20beds
	Total Overall	91 beds

lkense Registration N o3 G, <.J.3J Dale license Due I "/ I /'.1

FACILITY LIC£NSUR£ REVIEW-R£NEWAl

Facility Name tv o r1µ.,,, •;1 I\CiruJC. r1:- (.r.\,')E,l-·

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R£ASON FOillJC£NSE:

Two Yearlicense Renewal uJ' Provisional license D Fii.cllity Name Change

BedIncrease O Remaining Por1ion0

THEFOLLOWING FORMS ARECOIIPL£TEO:

Appli 1lon	Yes[No 8	N/A B	
Addresses of Board of OirKtor.s	Yes	No	N/A
Room & Bed Breakdown	Yes	No O	N/A0
·Pnncip'l,/& Rcirer/ehyslc;./	Yes	No !;ii	N/A 0
Director of Nursing	Yes	NoBD	N/ABD
Facility Ownershlp-(Modlcald)	Yes	No	N/A
Ownership & Disclosure	Yes	No	N/A
·r : , : .Que>llonairc	::	NNNooo	NNNN',,,AAAAO
Certlrico1te ofCompliance	Yes		
Ad\lerse legal At:t.Ons	Ye-s		
Chain Homo Office Info	Yes	No	N/A

CURRENT CATE80RYOFBEDS NO.

tZf'comprchenslve Care 1l.

QSpo<lalCore Unll

,fC (To1al)

PROP0S£D CHA.118& CATEGORY OF BEDS(•or-) NO,

B Comprehensive core

Special Core Unit

NewCap:tcity

SI'f.CIAI.SITUATIDNS

IsZoningRequited?	Ye,8	NoB	warvers	Yi,s	NOB
HasZoningbeenapproved? Date____________	vos	No	Restriction onAdmissions	Vos	No
ISMHRPCCONrequired?	YesQ	No O	MandaiedS1affing	Y s☐	NoQ
			Voluntary Admis.slon Celling	YesO	NoO
HasCertlOcatlon been grated?		No	Oe<up.oncy Permit 03tc______________		
Plans Rev.Cat Approval	B	No 8	Date Approved________________		

Commcml$:

SurvcyCoordlnator:.________________ Oate______________________________

OeputyOir«tor:.______________________ Oatc______________________________

SECTION A - LONG TERM CARE FACILITY APPLICATION

APPLICANT INFORMATION

E-mail: LicensureNotices@chs-corp.com

Fax: 513-489-7199

Name of Facility: Northwest SNF LLC dba Northwest Healthcare Center

Telephone No.: 410-664-5551

Location: 4601 Pall Mall Rd. (Street)

Baltimore (City) Baltimore City (County) 21215 (Zip)

Other (Specify)

LEASING ARRANGEMENT (If an entity operates the business under a lease, the following section shall be completed):

Lessee Name(s) and Address(es): OHI Asset (MD) Baltimore - Pall Mall, LLC

Lessor Name(s) and Address(es): 200 International Circle, Suite 3500, Hunt Valley, MD 21030

Expiration Date of Lease: Multi year lease

Applications on behalf of a corporation, association, government unit or agency shall be made by two officers of the corporation, association or governmental unit or agency and names and addresses of their board members shall be submitted.

Administrator: Meir Preis   Administrator License No. R1968

LONG TERM CARE FACILITY TYPE

X Nursing Home Comprehensive Care Facility

Hospital Extended Care Facility

Number of Beds ____

X Room & Bed breakdown attached: Exhibit A

Does facility operate a special care unit?

YES: Type ____

Number of Beds ____

✓ NO

I/We Lynelle Stephens (Please Print)

certify that I am/We are 18 years of age or older and of reputable and responsible character do hereby apply for a license to maintain and operate a facility subject to the provisions of Health-General Article, Title 19, Subtitle 3, Annotated Code of Maryland, and to the regulations adopted there under by the Secretary of Health and Mental Hygiene.

1. Signature of Applicant: [signature]   Title: Corporate Paralegal

2. Signature of Applicant ____   Title ____

Sworn and subscribed to before me this 6th day of December, 2017, a Notary Public for the State of ~~Maryland~~ Ohio

My Commission expires: 04-19-2020

Notary Public: Connie Forgrave

CONNIE FORGRAVE
Notary Public
In and for the State of Ohio
My Commission Expires
April 19, 2020

SEND COMPLETED APPLICATION TO:

FOR OFFICE USE

1 Initial
Renewal
Change of Ownership

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APPLICANT INFORMATION E-mail Licensure Notices@chs-corp.com Fax 513-489-7199

Name of Facility Northwest SNF LLC dba Northwest Healthcare Center Telephone No 410.664.5551

Location 4601 Pall Mall Rd. (Street)

Baltimore (City) Baltimore City (County) 21215 (Zip)

RECEIVED DEC 22 2017

TYPE OF BUSINESS ORGANIZATION
Individual Partnership X Corporation Association Other

TYPE OF CONTROL X Proprietary Voluntary Non-Profit Church Other (Specify)
Government Unit: State City County

LEASING ARRANGEMENT (If an entity operates the business under a lease, the following section shall be completed)
Lessor Name(s) and Address(es) OHI Asset (MD) Baltimore-Pall Mall, LLC
Lessor Name(s) and Address(es) 200 International Circle, Suite 3500, Hunt Valley, MD 21030
Expiration Date of Lease 10th year lease

Applications on behalf of a corporation, association, government unit or agency shall be made by two officers of the corporation, association or governmental unit or agency and names and addresses of their board members shall be submitted

Administrator Meir Preis Administrator License No. A1968

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Exhibit A

Does facility operate a special care unit?
YES Type
Number of Beds
NO

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,.. . , ... _ Title Corporate Paralegal

2. Signature of Applicant Title

Sworn and subscribed to before me this 6th day of December, 2017 a Notary Public for the State of Maryland Ohio

My Commission expires 04-19-2020

Notary Public Connie Forgrave

CONNIE FORGRAVE
Notary Public
In and for the State of Ohio
My Commission Expires
April 19, 2020

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DHMH 125A – Revised 3/16/2010

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Principal Physician (signature) 10·4-17 Date

Principal Physician Information (please type or print)

Name: Karen (First) A. (Middle) Cousins (Last)

Medical License Number: K00604207

Address: 7250 Parkway Dr Suite 500

City: Hanover State: MD. Zip code: 21076

Telephone Number(s): 443-484-1764

DHalNUSG-, .J11UJ111•

SllCTION B-LONG TllRM CAM PROVIDER Al'PLICATION

RELllll' PHY ICIAN AGREEMENT

Name of Facility: Northwest **License #:** 30033

NOTE: Tll,Sta,Dq,,OMnlofH"'1Jlt/lq:,dJll1-rtf•lr<tJtd-Colnr<A. .... i., C.,,.F«llilf J/J.01,02.,,_f.,•pi<pld,Jtto,.,..aol'rl1o<lp,,l .l1rysJ,da,"" • fftllfldnll,ftooJ'fft:t'pmotb w,\,a At,orAtrfJtt"llka41't nottrPOJJeblr...

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Relief Physician Information (please type of print)

Name: HAroLD B, BOB
(First) (Middle) (Last)

Medical License Number: D15872

Address: PO Box 1525

City: Owings Mill **State:** Md **Zip code:** 21117

Telephone Number(s): 4435485700

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My agreement with the Administrator requires that I be on duty 5 days per week and work a minimum of 40 hours per week.

Director of Nursing (signature) /.Q• !1.../7

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The above statement is correct and in accordance with the conditions under which

______________________ is employed by this facility.
(Director of Nursing)

Facility Administrator (signature) 10/4/7
Date of Agreement

DHMH 1297 — Revised 3/17/2016

MI!UIC'AL C.ARE PROGRAM • PROVUl Cl.Ft APP'LICAllON

IMPORTANT: PLEASE READ ATTACHED INSTRUCTIONS BEFORE COMPLETING APPLICATION

,. APPLIC'ATIOHnri::

Medicare

Provider Number 215346

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Requested Enrollment Begin Date

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Group Practice/Facility Name
Northwest SNF, LLC dba
Northwest Healthcare Center
Physician Prefix/Name Last Name First Name

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&t-b te

E-mail/Website Address
:stoltz@chs-corp.com
Suite Number Handicap Access

Zip Code
21215-6414

Provider Type Code
62

Social Security Number

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SECTIOND ..M(DICALCAREPROORAU• PROYIOER »PUCAttON

8) MEDICARE INFORMATION

Name	Medicare Number
Northwest Healthcare Center	215346

9J ALIERNATIVE ADORESSIHfORIMTIOH

Pay to Address

Address

City	State	Zip Code

Correspondence Address

Address

4700 Ashwood Dr. #200

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10) OTHER PRACTICE LOCATION INFORMATION

Please enter other locations where you service Maryland Medicaid recipients. Include all group addresses you are currently practicing under, if applicable. *Please refer to the instructions for appropriate codes.

Practice Address #2	Suite Number	Handicap Access

City	State	Zip code

Telephone Number	* County Code	License Number Expiration Date

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SECTJOHO. UEOICAICAREPROGRAM• PACMO£R APPLICATION

4)PRAClICE INFORMATION

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Type of Practice

HMO Type Category

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Charles R. Stoltz

Print of Type Name of Practitioner, Administrator or Authorized Professional Responsible for the Quality of Patient Care

N/A

Signature of Owner (in the case of a Pharmacy)

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PrD'Mtlf Em:il'ncnt
P.O. Sox17030
Ballinole,MD21203

SECTIONO• PROVIDER APPLICATION' INSTITUTIOII ADDENDUM

Your Fiscal Year End Date: |2-3|

Bed Data

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PROVIDER OWNERSHIP ANO CONTROL DISCLOSURE FORM

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1. Is an officer or director

Stephen L. Rosedale, Charles R. Stoltz and Ronald S. Wilheim,

2. Is a partner

3. MIAd't«to,,n,$1c;-tl t - otS' ..or mOro

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Omega Healthcare Investors, Inc

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See attached list. Exhibit B.

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Facility	LLC	Address	City	Zip9	Phone Number
Anchorage Healthcare Center	Anchorage SNF, LLC	105 Times Square	Salisbury	21801-2808	410-749-2474
Bel Pre Health & Rehabilitation Center	Bel Pre Leasing Co., LLC	2601 Bel Pre Road	Silver Spring	20906-2313	301-598-6000
Blue Point Healthcare Center	Blue Point SNF, LLC	2525 West Belvedere	Baltimore	21215-5203	410-367-9100
BridgePark Healthcare Center	Liberty Leasing Co., LLC	4017 Liberty Heights Ave	Baltimore	21207-7545	410-542-5306
Clinton Healthcare Center	Clinton Nursing, LLC	9211 Stuart Lane	Clinton	20735-2712	301-868-3600
Commons at Cumberland	White Leasing Co., LLC	506 White Ave	Cumberland	21502-3813	301-722-5535
Cumberland Healthcare Center	Winifred Leasing Co., LLC	512 Winifred Road	Cumberland	21502-6396	301-724-6066
Ellicott City Healthcare Center	Ridge (MD) Leasing Co., LLC	3000 N Ridge Road	Ellicott City	21043-3311	410-461-7577
Fayette Health & Rehabilitation Center	Fayette Leasing Co., LLC	1217 W Fayette Street	Baltimore	21223-1938	410-727-3947
Forestville Healthcare Center	Marlboro Leasing Co., LLC	7420 Marlboro Pike	Forestville	20747-4343	301-736-0240
Fort Washington Health Center	Livingston Leasing Co., LLC	12021 Livingston Road	Ft Washington	20744-4210	301-292-0300
Ridgeway Manor Healthcare Center	Edmondson Leasing Co., LLC	5743 Edmondson Ave	Catonsville	21228-1926	410-747-5250
Glynn Taff Assisted Living	Edmondson II Leasing Co., LLC	5741 Edmondson Ave	Catonsville	21228-1956	443-604-4166
Hagerstown Healthcare Center	Dual Leasing Co., LLC	750 Dual Highway	Hagerstown	21740-5909	301-797-4020
Holly Hill Healthcare Center	Holly Hill Nursing, LLC	531 Stevenson Lane	Towson	21286-7607	410-823-5310
Kensington Healthcare Center	Kensington Nursing, LLC	3000 McComas Avenue	Kensington	20895-2316	301-933-0060
Laurelwood Care Center	Laurel Leasing Co., LLC	100 Laurel Dr	Elkton	21921-5328	410-398-8800
Marley Neck Health & Rehabilitation Center	Howard Leasing Co., LLC	7575 E. Howard Road	Glen Burnie	21060-8312	410-768-8200
Northwest Healthcare Center	Northwest SNF, LLC	4601 Pall Mall Road	Baltimore	21215-6414	410-664-5551
South River Healthcare Center	Washington (MD) Leasing Co, LLC	144 Washington Road	Edgewater	21037-1412	410-956-5000
Westminster Healthcare Center	Washington (West) Leasing Co, LLC	1234 Washington Road	Westminster	21157-5854	410-848-0700
Willow Tree Manor	Blue Ridge Nursing, LLC	1263 S. George Street	Charles Town	25414-4384	304-725-6575
Worthington Healthcare Center	Thirty Six Leasing Co., LLC	2675 36th Street	Parkersburg	26104-8024	304-485-7447
Crystal Creek Health and Rehabilitation Center	FLO-GP Leasing Co., LLC	250 New Florissant Rd South	Florissant	63031-6716	314-838-2211
Green Park Senior Living Community	Green Park Leasing Co., LLC	9350 Green Park Rd	St Louis	63123-7211	314-845-0900
Garden Valley Healthcare Center	Granby Leasing Co., LLC	8575 N Granby Avenue	Kansas City	64154-1235	816-436-8575
Maple Wood Healthcare Center	Northeast Leasing Co., LLC	724 NE 79th Terrace	Kansas City	64118-1564	816-436-8940
Battlefield Park Healthcare Center	Flank Leasing Co., LLC	250 Flank Road	Petersburg	23805-9117	804-861-2223
Cedars Healthcare Center	Cedars Leasing Co., LLC	1242 Cedars Court	Charlottesville	22903-4800	434-296-5611

Exhibit B

Petersburg Healthcare Center	South Leasing (VA) Co., LLC	287 E South Blvd	Petersburg	23805-2700	804-733-1190
Sleepy Hollow Healthcare Center	Columbia Leasing Co., LLC	6700 Columbia Pike	Annandale	22003-3450	703-256-7000
Advanced Healthcare Center	Garden Leasing Co., LLC	955 Garden Lake Pkwy	Toledo	43614-2777	419-382-2200
Aristocrat Berea Respiratory Care	Front Leasing Co., LLC	255 Front Street	Berea	44017-1943	440-243-4000
Aristocrat Berea Skilled Nursing & Rehabilitation Center	Front Leasing Co., LLC	255 Front Street	Berea	44017-1943	440-243-4000
Berea Alzheimer's Care Center	Sheldon Leasing Co, LLC	49 Sheldon Rd	Berea	44017-1136	440-234-0454
BridgePort Healthcare Center	Royce Leasing Co., LLC	2125 Royce Street	Portsmouth	45662-4714	740-354-6635
Burlington House Rehabilitative & Alzheimer's Care Center	Springdale Leasing Co., LLC	2222 Springdale Rd	Cincinnati	45231-1805	513-851-7888
Candlewood Park Healthcare Center	Belmore Leasing Co., LLC	1835 Belmore Rd	East Cleveland	44112-4301	216-268-3600
Chardon Healthcare Center	Water Leasing Co., LLC	620 Water St	Chardon	44024-1148	440-285-9400
Cityview Nursing and Rehabilitation Center	City View Nursing and Rehab, LLC	6606 Carnegie Ave	Cleveland	44103-4622	216-361-1414
CommuniCare of Clifton Postacute and Rehabilitation Center	Clifton Care Center, Inc.	625 Probasco Street	Cincinnati	45220-2710	513-281-2464
Columbus Healthcare Center	Clime Leasing Co., LLC	4301 Clime Rd N	Columbus	43228-3406	614-276-4400
Copley Health Center	Heritage (Ohio) Leasing Co., LLC	155 Heritage Woods Dr	Copley	44321-1398	330-666-0980
Crestwood Care Center	Midland Leasing Co., LLC	225 W Main St	Shelby	44875-1412	419-347-1266
Falling Water Healthcare Center	Falling Leasing Co., LLC	18840 Falling Water	Strongsville	44136-4200	440-238-1100
Grande Pointe Healthcare Community	Merit Leasing Co., LLC	3 Merit Dr	Richmond Heights	44143-1457	216-261-9600
Greenbriar Healthcare Center	South I Leasing Co., LLC	8064 South Ave	Boardman	44512-6153	330-726-3700
Greenbrier Healthcare Center	Pearl Leasing Co., LLC	6455 Pearl Rd	Parma Heights	44130-2984	440-888-5900
Hanover Healthcare Center	Avis Leasing Co., LLC	435 Avis Ave NW	Massillon	44646-3555	330-837-1741
Kent Healthcare Center	Fairchild (MD) Leasing Co., LLC	1290 Fairchild Avenue	Kent	44240-1814	330-678-4912
Lake Pointe Health Center	Kolbe Leasing Co., LLC	3364 Kolbe Rd	Lorain	44053-1628	440-282-2244
Northwestern Healthcare Center	Rocky River Leasing Co., LLC	570 North Rocky River Drive	Berea	44017-1613	440-243-2122
Oak Grove Healthcare Center	East Water Leasing Co., LLC	620 E Water St	Deshler	43516-1327	419-278-6921
Pebble Creek	Jarvis Leasing Co., LLC	670 Jarvis Rd	Akron	44319-2538	330-645-0200
Pine Valley Care Center	Brecksville Leasing Co., LLC	4360 Brecksville Rd	Richfield	44286-9457	330-659-6166
Regency Manor Rehabilitation and Subacute Center	Regency Leasing Co., LLC	2000 Regency Manor Circle	Columbus	43207-1777	614-445-8261
Riverside Healthcare Center	King Tree Leasing Co., LLC	1390 King Tree Dr	Dayton	45405-1401	937-278-0723
Suburban Pavilion Nursing and Rehabilitation Center	Emery Leasing Co., LLC	20265 Emery Rd	North Randall	44128-4122	216-475-8880
Wood Glen Alzheimer's Community	Summit (Ohio) Leasing Co., LLC	3800 Summit Glen Drive	Dayton	45449-3647	937-436-2273
Wyant Woods Care Center	Wyant Leasing Co., LLC	200 Wyant Rd	Akron	44313-4228	330-836-7953
Baldwin Health Center	Skyline (PA) Leasing Co., LLC	1717 Skyline Dr	Pittsburgh	15227-1744	412-885-8400

Wexford Healthcare Center	Old Leasing Co., LLC	9850 Old Perry Hwy	Wexford	15090-9311	412-366-7900
Greenwood Healthcare Center	Westridge Leasing Co., LLC	377 Westridge Boulevard	Greenwood	46124-2137	317-888-4948
SouthPointe Healthcare Center	War Admiral Leasing Co., LLC	4904 War Admiral Drive	Indianapolis	46237-9737	317-885-3333
Wildwood Healthcare Center	Sixteenth Leasing Co., LLC	7301 East 16th Street	Indianapolis	46219-2308	317-353-1290
Greenfield Healthcare Center	Green Meadows Leasing Co., LLC	200 West Green Meadows Drive	Greenfield	46140-1014	317-462-3311
Eagle Creek Healthcare Center	Shore Leasing Co., LLC	4102 Shore Drive	Indianapolis	46254-2608	317-347-9051
Allison Pointe Healthcare Center	Eighty Second Leasing Co., LLC	5226 East 82nd Street	Indianapolis	46250-1628	317-842-6668
Bridgewater Healthcare Center	Carey Leasing Co., LLC	14751 Carey Road	Carmel	46033-9084	317-575-2208
Sellersburg Healthcare Center	Old (IN) Leasing Co., LLC	7823 Old Highway #60	Sellersburg	47172-9283	812-246-4272
Rolling Hills Healthcare Center	St. Joseph Leasing Co., LLC	3625 Saint Joseph Road	New Albany	47150-9745	812-948-0670
Wedgewood Healthcare Center	Potters Leasing Co., LLC	101 Potters Lane	Clarksvill	47129-1017	812-948-0808
Indian Creek Healthcare Center	Beechmont I Leasing Co., LLC	240 Beechmont Drive NE	Corydon	47112-1718	812-738-8127
Harrison Healthcare Center	Beechmont II Leasing Co., LLC	150 Beechmont Drive NE	Corydon	47112-1717	812-738-0550
Southwood Healthcare Center	Margaret Leasing Co., LLC	2222 East Margaret Avenue	Terre Haute	47802-3339	812-232-2223
Kokomo Healthcare Center	Lincoln Leasing Co., LLC	429 West Lincoln Road	Kokomo	46902-3508	765-453-5600
Great Lakes Healthcare Center	Lakes Leasing Co., LLC	2300 Great Lakes Drive	Dyer	46311-1917	219-322-3555
Valley View Healthcare Center	Mishawaka Leasing Co., LLC	333 West Mishawaka Road	Elkhart	46517-1921	574-293-1550
Blue Ridge Vista Health & Wellness	CV Operating Co, LLC	5500 Verulam Ave	Cincinnati	45213	513-841-3001
ClearVista Health & Wellness	Kolbe II Leasing Co., LLC	3364 Kolbe Road	Lorain	44053-1628	440-960-7960
Commons at Greenbriar	South II Leasing Co., LLC	8060 South Avenue	Boardman	44512-6108	330-758-8855
Aristocrat Berea ICF/DD	Front Leasing Co., LLC	255 Front Street	Berea	44017-1943	440-243-4000
Advanced Specialty Hospital of Greenbriar	South III Leasing Co., LLC	8064 South Ave, Ste. One	Boardman	44512-6153	330-965-6432
Advanced Specialty Hospital of Toledo	Garden II Leasing Co., LLC	1015 Garden Lake Parkway	Toledo	43614-2779	419-381-0037
Bel Pre (Asset Ownership)					
Ellicott City (Asset Ownership)					
Fayette (Asset Ownership)					
Forestville (Asset Ownership)					
Liberty Heights (Asset Ownership)					
Marley Neck (Asset Ownership)					
Northwest (Asset Ownership)					
OMG Asset Ownership					
South River (Asset Ownership)					
Cityview (Asset Ownership)					
BridgePort (Asset Ownership)					

Columbus (Asset Ownership)					
Northwestern (Asset Ownership)					
Oak Grove (Asset Ownership)					
Health Care Holdings, LLC					
Health Care Lease Facilities, LLC					
HC Real Estate Holdings, LLC					
LaSalle Holdings, LLC					
LaSalle Real Estate Assets, LLC					
DMG LS Leasing Co, LLC					
DMG RE Holdings, LLC					
DMG MSTR LSCO, LLC					
PC MSTR LSCO, LLC					
DMG RE Leasing Co, LLC					
Post-Acute Holdings	Post-Acute Holdings, LLC	1700 Ashwood Dr, Suite 200	Cincinnati	[redacted]	513-489-7100
CommuniCare Health Services, Inc.		1700 Ashwood Dr, Suite 200	Cincinnati		513-489-7100
Health Care Facilities Management, LLC		1700 Ashwood Dr, Suite 200	Cincinnati		513-489-7100
Resident Care Consulting Co., LLC		1700 Ashwood Dr, Suite 200	Cincinnati		513-489-7100
Nurse Practitioner Co	CNP Operating Co, LLC	1700 Ashwood Dr, Suite 200	Cincinnati		513-489-7100

SECTION E STATE AFFIOAVIT

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I ttt1lf)'u,at the A1hulnl,1r.a1hc,.nd procNurw1 ttqulrtmrnh conr■lo«I In COMAR 10.07.02 (Regulations governing Comprehensive Care Facilities and Extended Care f•<llllic,) In the..-u1qf,ninrnadnil11h1r:111h•c and rtshlmf cott polldn.Uy..t,m'I and ochero,i:uilrallon1Itl0<11cncn11tlon,,rrltlen ai,:rttmcnH.,'11h 011h.ldc rnGuttc,/N1nrnlrAni'- committee meetings, staff qualifications and written development program such as inservices, equipment maintenance and disaster preparedness have not been substantively altered, revised, or modified, since the previous survey, or if they have, I have notified the Offirt'of llt11,lth Cuc Qu1111rr.1n wriHnz:.bdonthecfftt1h'cdott'of lhc-cl1.11nJtc-. I rur1hrr «-rtlr)' that t wot notlf)"lhr Omu of JlrJllh CartQu11fl)' If thcf'C • any folutt "substantive changes in facility management and operation." as defined in the instructions forcomp1ctlon o(lhC F«tn'111 affidavit, tltats.J.tt1iflN11lly•frct'f polldoantiprotttfutH ud tlUII nollttulllbr i:,h't'n In t1 thin;bdon"th<' dTtdivc-dllllc-of the (bange.

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Northwest Healthcare Center

Signature of Authorized Official

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Title

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Date

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SECTION F WORKERS' COMPENSATION LAW QUESTIONAIRE

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Section G

AC.0.BD_ CERTIFICATE OF LIABILITY INSURANCE

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SECl'ION I: AOVERSE ACTIONS/CON\'ICl'IONS

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SECTION I: ADVERSE ACTIONS/CONVICTIONS

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SECTION J: Cl1A1N HOME OFFICr: IN FORMATl.ON

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For more information on chain organizations, se 42 C.F.R. 421.404.

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Name of Home Office	First Name	Middle Name	Last Name	Jr., Sr., etc.
Health Care Facility Management	Richard		Odenthal	
Title of Home Office Administrator	**Social Security Number**		**Date of Birth (mm/dd/yyyy)**	
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SECTION J: ClIA!N MOME OFFlCE rNFOR.MA TION

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For more information on chain organizations, see 42 C.F.R. 421.404.

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Name of Home Office	First Name	Middle Name	Last Name	Jr., Sr., etc.
Health Care Facility	Richard Management		Odenthal	
Title of Home Office Administrator		Social Security Number	Date of Birth	
C.00		[redacted]	[redacted]	

RnhC'd lltll/1010

s1:CTION J: CHAtN HOME OFFICE INI+QRMATION (u11t .t,

C. CHAIN HOME OFFICE INFORMATION

1. Name of Home Office as Reported to the Internal Revenue Service

Healthcare Facility Management, LLC

2. Home Office Business Street Address Line 1 (Street Number and Name)

4700 Ashwood Dr. #200

Home Office Business Street Address Line 2 (Suite, Room, etc.)

City/Town

Cincinnati

o 't a-4(

Telephone Number	Fax Number (if applicable)	E-mail Address (if applicable)
513/489-7100		

3. Home Office Tax Identification Number	Home Office Cost Report Year-End Date (mm/dd)
[redacted]	12/31

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- ☐ Leased
- ☐ Operated/Related
- ☐ Wholly Owned
- ☐ Other (Specify)

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(SEO Tags: Northwest Healthcare Center, claim against Northwest Healthcare Center, malpractice of Northwest Healthcare Center, Maryland nursing home lawyer, Baltimore malpractice attorney, Baltimore nursing home attorney, pressure sores attorney, bed sore claim, wrongful death attorney, decubitus lawsuit, nursing home abuse attorney, assisted living attorney, Maryland elder abuse attorney, Baltimore elder abuse attorney, Baltimore elder law attorney, nursing home injury, nursing home abuse attorney, adult protective service lawyer, nursing home abuse lawyer, Maryland Nursing home abuse attorney, Maryland nursing home attorney, Maryland assisted living attorney, Baltimore County attorney, Baltimore medical malpractice attorney, Baltimore nursing home malpractice attorney)