STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215013	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St. Mary's Nursing Center Inc	21585 Peabody Street Leonardtown, MD 20650

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 30440 Based on observations and interviews with facility staff, it was determined that the facility failed to ensure residents were treated with respect and dignity when requesting assistance and by failing to ensure a Foley drainage bag was covered. This was found to be evident for 2 out of 40 (Resident #47 and Resident #461) sampled residents reviewed during the survey. The findings include: 1.) On 11/19/22 at approximately 9:00 AM a record review was conducted by the surveyor for sampled residents residing on the second floor. While at the nurse station the surveyor visibly observed and audibly heard Resident #47 call light alarm at 9:09 AM, and Environmental Services Staff (EVS) #7 went into the resident room. The call light was off prior to Staff #7 exiting the room. Staff # 7 went across the hall into the kitchen and began wiping down counter areas. Moments later GNA # 8 walked the hallway pushing a linen cart and EVS #7 approached the GNA. After the two staff talked for a few moments, GNA #8 walked down the hallway with the linen cart past Resident #47's room. The surveyor went into the resident's room and asked if s/he received assistance, and the resident stated I told the housekeeper (EVS #7) that I urgently needed the bedpan. The surveyor walked out of the room to alert the staff and simultaneously, the resident put his/her call light on again. The surveyor asked GNA #8 who was in the hallway if she was aware that the resident requested assistance and she stated, that is a control thing, the resident always put his/her call light on. The Unit Manager (UM) Staff #9 appeared on the unit within moments and went into the resident room at approximately 9:15 AM to assist the resident. The surveyor remained at the nurse station to continue the chart review and at approximately 9:26 AM, Resident #47's call light was visibly observed and audibly heard. GNA #8 was at the nurse station and stated to the surveyor, you see, s/he put his/her call light on again. The surveyor at this time motioned GNA #8 to accompany her to the resident room to see what the resident needed. The surveyor and GNA #8 entered Resident # 47's room, and the resident stated, I used the bedpan and am finished, and I would like to get cleaned up. The UM #9 was made aware of the concerns at that time at approximately 9:39 AM. The DON was made aware of the observations and concerns on the same date at 12:30 PM and stated that the facility will investigate the concerns. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility provided the survey team with a copy of their investigation on 11/21/24 and upon review it revealed the abuse allegations were unsubstantiated. The facility provided 1:1 training to GNA #8 with the staff development coordinator to include customer service, verbal abuse, call bells and professionalism. The training was successfully completed on 11/21/24 per the facility's investigation. 21859 2.) A Foley drainage bag, or urinary drainage bag, is a medical device used to collect urine from a catheterized resident. The drainage bag is usually worn on the leg or attached to a bed. During observation rounds on 11/18/24 at 8:54 am, Resident #461 was noted to have a Foley drainage bag attached to his/her bed. The Foley drainage bag was uncovered and contained an amber colored liquid. The bag was attached to the door side of the bed. Resident #461's door was open, and the Foley drainage bag was visible from the hallway. On 11/19/24 at 8:25am, Resident #461 was again observed in bed with Foley drainage bag visible from hallway without a privacy bag. On 11/19/24 at 8:40am, the surveyor interviewed the Licensed Practical Nurse (LPN) #27. She stated the resident's Foley drainage bag should be covered and she would get the resident a privacy bag.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50573 Based on observation and interview, it was determined that the facility failed to ensure the facility was in good repair. This was evident for 5 resident rooms observed on the 4th floor nursing unit during the survey. The findings include: On 11/20/24 at 08:31 AM, an observation of room [ROOM NUMBER] revealed that the A bed (the bed closest to the entry door) had several vertical, abraded wall markings. These markings varied in length and width which resembled scratch-like marks behind the headboard of the bed. On 11/20/24 at 01:51 PM, an observation of room [ROOM NUMBER] revealed that the A bed (the bed closest to the entry door) had several vertical, abraded wall markings. These markings varied in length and width which resembled scratch-like marks behind the headboard of the bed. On 11/20/24 at 01:52 PM, an observation of room [ROOM NUMBER] revealed that the B bed (the bed closest to the window) had several vertical, abraded wall markings. These markings varied in length and width which resembled scratch-like marks behind the headboard of the bed. On 11/20/24 at 02:04 PM, an observation of room [ROOM NUMBER] revealed that the A bed (the bed closest to the entry door) had several vertical, abraded wall markings. These markings varied in length and width which resembled scratch like marks behind the headboard of the bed. On 11/20/24 at 02:05 PM, an observation of room [ROOM NUMBER] revealed that the A bed (the bed closest to the entry door) had several vertical, abraded wall markings. These markings varied in length and width which resembled scratch-like marks behind the headboard of the bed. On 11/20/24 at 02:46 PM, an interview with the Facilities Director (Staff #23) revealed that staff can fill out a maintenance slip if they found a maintenance concern which maintenance staff check every hour. The surveyor asked if he was aware of any maintenance concern on the 4th floor and he indicated that he was not. During the same interview, Staff #23 indicated that the facility has had issues with the walls behind resident bed headboards as the staff push the bed up to the wall and when raising and lowering the bed, cause scratches on the wall. He said that they have tried to initiate a solution before but that it has not worked. On 11/22/24 at 12:00 PM, at the time of exit, the surveyor reviewed the concern regarding the facility's failure to ensure that the facility was in good repair.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 49148 Based on record review and interview with staff it was determined that the facility failed to ensure a resident was offered the opportunity to participate in their care planning process by being invited to their care plan meetings. This was evident for 2 (Resident #12 and #31) out of 4 residents investigated for care planning during the survey. The findings include: A care plan is used to summarize a person's health conditions, specific care needs, and current treatments and outlines what needs to be done to plan, assess, and manage care. This helps to evaluate the effectiveness of the resident's care. 1.) On 11/18/2024 at 11:44AM, during an interview conducted with Resident #31, the Surveyor was informed that the resident was unaware of care plan meetings and would like the opportunity to participate in their plan of care. On 11/20/2024 at 8:57AM, a review of Resident #31's electronic and paper medical record failed to reveal a care plan meeting in which the resident was invited since 7/11/2023. Further review failed to reveal an explanation as to why Resident #31 did not participate in the development of the resident's care plan. On 11/20/2024 at 9:15AM, during an interview conducted with Social Worker #20, the Surveyor discovered that care plan meetings are held quarterly, and that Resident #31 had not been invited to any care plan meetings since 7/11/2023. Social Worker #20 stated that she could do better with inviting the residents to their care plan meetings. 50573 2.) On 11/19/24 at 11:05 AM, an interview with Resident #12 revealed that he/she was unaware of any care plan meetings for his/her plan of care. On 11/19/24 at 02:22 PM, review of Resident #12's medical record revealed the last documentation of a care plan meeting was 3/24/24. The resident's most recent Minimum Data Set (MDS) Assessment had an Assessment Reference Date (ARD) of 10/16/24. The Minimum Data Set (MDS) is an assessment of the resident that provides the facility information necessary to develop a care plan, provide the appropriate care and services to the Resident, and modify the care plan based on the Resident's status. The assessment reference date (ARD) is the specific end point of look-back periods of resident status for the MDS assessment process. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/20/24 at 09:14 AM, during an interview with Social Worker (Staff #20) about care plan meetings, she indicated she could do better with inviting the residents. Further interview revealed she does not document when a resident is invited to the care plan meeting. During the same interview, the surveyor asked about Resident #12's involvement with care plan meetings. She was not able to provide documentation of him/her being invited to the care plan meetings. On 11/22/24 at 12:00 PM, at the time of exit, the surveyor reviewed the concern regarding the facility's failure to ensure residents are invited to participate in care plan meetings.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 51490 Based on complaint, review of medical records, and staff interview, it was determined that the facility failed to transcribe a physician's order that directed nurses to obtain a wound care consult for a resident. This was evident for 1 (Resident #313) out of 40 sampled residents reviewed during the survey. The findings include: Review of complaint MD00211390 and Resident # 313's medical record on 11/20/24 at 1:55pm revealed the following: A change in skin note dated 10/5/24, which stated moisture associated skin damage between buttocks. A new order was given by the physician to turn the resident every 2 hours and obtain a wound care consult. Further review of the medical record on 11/20/24 at 3pm failed to reveal a wound consultation was done. During interview with the Director of Nursing on 11/21/22 at 2pm she stated the nurse failed to carry over the order for the wound consultation; therefore, it was missed. During interview with the Quality Assurance Nurse on 11/21/24 at 2:10pm she stated all nursing staff were re-in serviced on the transcription of physician orders.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 50573 Based on observation, record review, and interviews, it was determined that the facility failed to ensure: 1) a resident's safety was maintained during a transfer. This was evident for 1 of 2 residents (Resident #6) reviewed for accidents and 2) an order for seizure precautions on a resident were correctly maintained. This was evident for 1 of 2 residents (Resident #21) reviewed for position and mobility. The findings include: 1) Review of Resident #6's medical record on 11/19/24 revealed the resident has resided at the facility for several years, was alert and oriented with a A Brief Interview for Mental Status (BIMS) of 15, and able to verbally communicate. Resident #6 was dependent on staff for mobility transfers. A Brief Interview for Mental Status (BIMS) is a tool used to screen and identify the cognitive condition of residents in a long-term care facility. The BIMS assessment uses a points system that ranges from 0 to 15 points. A score of 13-15 indicates cognitively intact. On 11/19/24 at 08:10 AM, an interview with Resident #6 revealed she/he recently had a fall that resulted in hospitalization . Further interview with the resident revealed that the GNA, who she/he did not identify during the interview, spun her/him too fast during a transfer from the toilet in the bathroom. On 11/19/24 at 02:32 PM, review of the resident's medical record revealed a progress note dated 11/15/24 at 09:51 AM completed by Staff #21 that indicated Resident #6 fell during a transfer from the toilet with the Geriatric Nursing Assistant (not identified in the note) present on the previous day around 6:50 PM. Further review of the progress note revealed the resident was sent to the emergency room . On 11/19/24 at 03:07 PM, an interview with Licensed Practical Nurse (Staff #21) revealed she did not witness the fall, but indicated that Geriatric Nursing Assistant (Staff #17) witnessed it and was the GNA assisting her during the transfer. On 11/20/24 at 09:00 AM, review of the fall investigation regarding Resident #6 provided by the facility that was requested by the surveyor revealed a document titled Resident #6 fall 11/14/24 that was typed and signed by the Director of Nursing (Staff #2) dated 11/15/24 which indicated the Unit Manager (who was unidentified on the document) interviewed Resident #6 that read, Resident states that she 'spun me around too fast. ' Further review of the same document at the same time revealed that, . the cushion on Resident #6's wheelchair hangs about 2 inches off of the base of her wheelchair which could have caused an illusion of how far back the resident was sitting in her wheelchair. On 11/20/24 at 09:47 AM, an interview with the Director of Rehabilitation (Staff #29) revealed that the resident has had periods of being a 1 person assist during mobility transfers and periods of a 2 person assist during mobility transfers due to his/her complex medical diagnoses. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the same interview, the surveyor requested notes from the resident's therapy sessions from her/his most recent case load (active therapy) that she indicated the resident had been discharged from in September of 2024. On 11/20/24 at 10:15 AM, review of the therapy session progress notes provided by Staff #29 revealed a Treatment Encounter Note dated 7/24/24 at 3:00 PM completed by Physical Therapy Assistant (Staff #30) with a topic of transfers that said, res stated that GNAs do not give [him/her] enough time that they rush [her/him] On 11/20/24 at 03:30 PM, an interview with Geriatric Nursing Assistant (Staff #17) about Resident #6's recent fall in the bathroom revealed that she/he was transferred to the wheelchair with both wheels locked. She indicated that the resident had been standing in front of the wheelchair using the hand rail. Further interview revealed that Staff #17 then unlocked both wheels of the wheelchair and moved to the back of the wheelchair where she pulled the wheelchair towards her which made the wheelchair move backwards. Further interview with Staff #17 on 11/20/24 at 3:30 PM revealed that the resident started leaning forward and she attempted to grab the resident by the gait belt that was on the resident's at the time. Staff #17 indicated she was unaware if the resident was trying to move but that the resident ended up on the floor. During the same interview with Staff #17 on 11/20/24 at 3:30 PM, a surveyor present during the interview indicated to Staff #17, if she maintained the safety of the resident for the entirety of the transfer, how did the resident end up falling, and she indicated that she should have maintained the safety of the resident during the transfer. On 11/22/24 at 12:00 PM, at the time of exit, the surveyor reviewed the concern of the facility's failure to ensure a resident's safety was maintained during a transfer. 2) On 11/19/24 at 08:40 AM, an initial observation of Resident #21 revealed he/she was in bed that had partially covered bedrails on both sides on the bed with a cushion, revealing about 12 inches on the bedrail side closest to the head of the bed with no cushion. On 11/19/24 at 02:48 PM, an observation of Resident #21 revealed she/he in bed with the bedrails in the same condition as noted in the initial observation. On 11/20/24 at 1:00 PM, review of Resident #21's medical record revealed that he/she has an active medical diagnosis of epilepsy (a chronic brain disorder that causes seizures, which are episodes of abnormal electrical activity in the brain). Further review of Resident #21's medical record at the same time revealed an active order dated 10/16/23 for, 2 padded side rails at HOB for seizure precautions. On 11/20/24 at 01:55 PM, an observation of Resident #21 revealed he/she in bed with the bedrails in the same condition as the two previous observations, partially cushioned bedrails on both sides with about 12 inches closest to the head of the bed with no cushion. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/20/24 at 01:57 PM, an interview with Geriatric Nursing Assistant (Staff #19) in Resident #21's room revealed that the seizure precautions for the resident are the cushions on the bedrails. The surveyor noted to Staff #19 during the interview that the bedrails are partially covered. On 11/21/24 at 08:13 AM, an interview with the 4th floor Unit Manager (Licensed Practical Nurse, Staff #18) revealed that the seizure precautions for the resident are the seizure pads on both bedrails. The surveyor indicated to Staff #18 that the bedrail appears to be covered partially. Staff #18 indicated that the cushion padding should be covering the entire bedrail. On 11/22/24 at 12:00 PM, at the time of exit, the surveyor reviewed the concern of the facility's failure to ensure a resident's seizure precautions were correctly maintained.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 51490 Based on observation, interview, and documentation review it was determined that the facility staff failed to ensure the walk-in refrigerator temperatures were documented accurately. The findings include: An initial environmental kitchen food services inspection was conducted on 11/18/24 at 8:20am. The walk-in refrigerator temperature logs were not found/observed hanging near the refrigerator. The Dietician staff #13 (who oversees the kitchen) was asked about the temperature log, and she responded, the logs were kept in a book on the side of a table located near her office. During review of the walk-in refrigerator temperature log on 11/18/24 at 9am revealed the refrigerator temperature was documented as 42 for the morning of 11/18/24; however, the thermometer located inside of the refrigerator was reading 38 degrees. The Dietician stated the thermometer inside of the refrigerator is the correct temperature. She stated the thermometer located on the outside of the refrigerator is sometime inaccurate. During a follow-up inspection of the kitchen by the surveyor of the walk-in refrigerator on 11/21/24 at 8:40am, the surveyor observed the outside thermometer on the walk-in refrigerator to be blinking and not registering a temperature. The inside thermometer read 39 degrees. Review of the walk-in refrigerator temperature logs on 11/21/24 at 8:45 am revealed the following documented temperatures: 11/18/24 pm temp 45 11/19/24 am temp 45 11/19/24 pm temp 44 11/20/24 am temp 45 11/20/24 pm temp 40 11/21/24 am temp 45 During an interview with the cook staff #33 on 11/21/24 at 8:50am, she was asked if she knew what the walk in temperature for the refrigerator should be; She stated, yes. It should be 40 or less. When asked did she document the temperature of 45 degrees this morning? She stated yes. I documented the temperature that was located on the outside of the refrigerator instead what the thermometer that was in the refrigerator. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview with the Dietician staff #13 on 11/21/24 at 9:15am stated the dietary staff are documenting the incorrect temperature that is displayed on the thermometer outside of the walk-in refrigerator instead of the thermometer inside of the walk-in refrigerator and she would be addressing it.