

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215043	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/02/2024
NAME OF PROVIDER OR SUPPLIER Kensington Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3000 McComas Avenue Kensington, MD 20895	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>31145</p> <p>Based on observation and staff interview, it was determined that facility staff failed to treat each resident in a dignified manner by pulling a resident down the hallway backwards. This was evident for 2 (#48, #4) residents observed during random observations on 2 of 3 nursing units during a complaint survey.</p> <p>The findings include:</p> <p>On 9/25/24 at 2:27 PM observation was made in the hallway of licensed practical nurse (LPN) #7 pulling Resident #4 down 2 hallways backwards. LPN #7 pulled Resident #4 from the dining room to the end of the hallway, turned the corner and pulled Resident #4 down towards the end of the Potomac hallway where his/her room was located.</p> <p>On 9/26/24 at 11:33 AM observation was made in the hallway by the Chesapeake unit of geriatric nursing assistant (GNA) #30 pulling Resident #48 down the hallway backwards and placing Resident #48 in the activity room. The surveyor walked up to GNA #30 to ask what the resident's name was and she looked at the resident and said, I don't know his/her name. Resident #48 blurted out the name.</p> <p>On 10/2/24 at 9:10 AM an interview was conducted with Staff #13. Staff #13 was informed of the observation and confirmed it was a dignity issue and she shook her head.</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34484</p> <p>Based on medical record review and interview, the facility staff failed to notify a resident's physician for a change in status (Resident #10). This was evident for 1 of 51 residents reviewed during a complaint survey.</p> <p>The findings include:</p> <p>Review of Resident #10's medical record on 9/26/24 revealed the Resident was admitted to the facility on [DATE] and transferred to the hospital on 6/23/24. The Resident did not return to the facility.</p> <p>Further review of Resident #10's medical record revealed the facility staff documented the Resident's blood pressure as 73/49 mmHg on 6/4/24 at 10:39 AM. Review of the nurse's notes and assessments on 6/4/24 revealed the facility staff failed to notify the physician of the low blood pressure.</p> <p>Low blood pressure occurs when blood pressure is much lower than normal. This means the heart, brain, and other parts of the body may not get enough blood. Normal blood pressure is mostly between 90/60 mmHg and 120/80 mmHg.</p> <p>Interview with the Director of Nursing on 9/30/24 at 10:50 AM confirmed that the physician should have been notified for a documented blood pressure of 73/49 mmHg and there is no documentation of notification in Resident #10's medical record.</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18819</p> <p>Based on complaint review, environmental observations, and interview, it was determined that the facility staff failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This was evident on 2 of 2 nursing units observed during a complaint survey.</p> <p>The findings include:</p> <p>1) Review of complaint MD00201103 on 9/25/24 at 10:00 AM revealed allegations that Resident #17's room was unsanitary, the toilet seat was in disrepair, the room was malodorous, and the floor around the resident's bed was soiled and sticky.</p> <p>The following environmental concerns were observed during the survey:</p> <p>The surveyor observed room [ROOM NUMBER] on 9/25/24 at 9:30 AM. The bathroom inspection revealed that the toilet seat had 2 metal bolt covers that appeared covered with a dark substance and rust. The porcelain toilet bowl was soiled with dirt also. room [ROOM NUMBER] restroom lacked toilet tissue and hand towels. On the floor, in front of Resident #17's bed was observed general dirt and food particles. The 2 resident closet compartments were observed to be in disrepair and the doors would not function (open and close).</p> <p>The facility administrator was made aware of the findings at the exit conference.</p> <p>31145</p> <p>2) On 9/25/24 at 11:26 AM observation was made of Resident #4 lying in bed. The bottom sheet had several holes on the right side of the sheet by the head of the bed. The left side of the sheet was soiled with a tan liquid. There was a brown molding strip under the white windowsill that was hanging down approximately 5 inches that was 3 feet wide. The white window blinds were soiled with a tan material. The inside of the radiator, which was blowing cool air in the direction of the resident's bed had black, white, and gray material attached to the bottom, back, top, and sides of the inside. There was a 1 inch by 1 inch piece of laminate missing from the corner of the over the bed tray table. The lamp on the nightstand had a silver base with an attached approximate 12-inch-tall rod that was broke, which made the lamp crooked, and it was leaned over to the right. The cream-colored lamp shade was dirty with brown material.</p> <p>On 9/25/24 at 11:35 AM the surveyor asked the corporate nurse Staff #13 to come in the room with the surveyor. The surveyor showed Staff #13 all the areas of concern. When asked what the material was in the radiator, Staff #13 stated, it appears to be mold. It is grayish. When Staff #13 was asked if she agreed with the concerns in the room, she stated, I don't disagree.</p> <p>3) On 9/25/24 at 11:40 AM observation was made in the Potomac unit hallway of the base molding on the corner by the staffing board that was pulled away from the wall approximately 8 inches long.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4) Observation was made on 9/26/24 at 12:20 PM in the dining room of Resident #49 sitting in a wheelchair. The vinyl on the right armrest was cracked throughout. Observation was made of Resident #50 who was also in the dining room and was in a wheelchair. The vinyl on the right armrest was cracked and missing at the top left front of the wheelchair.</p> <p>5) On 9/26/24 at 12: PM observation was made in Resident #2's room of 2 linoleum tiles that were cracked in the corners and missing part of the tile that was on the floor in front of the bathroom door. The drywall was peeling off the wall by the radiator approximately 3 inches by 8 inches. The left closet door was cracked in the middle with an area 3 inches by 3 inches.</p> <p>6) On 9/30/24 at 9:26 AM observation was made of Resident #39's room. The door to the nightstand was missing. The laminate on the left side of the footboard was missing from the top left corner approximately 3 inches, down the left side perimeter to the bottom of the footboard along the edges and around the bottom left corner.</p> <p>On 10/2/24 at 9:10 AM all environmental concerns were discussed with Staff #13.</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>31145</p> <p>Based on review of a facility reported incident, medical record review, facility documentation review, and staff interviews, it was determined the facility failed to honor a resident's wishes to not change position which resulted in a staff member pulling a resident's contracted fingers which resulted in a fractured finger. The failure to honor a resident's wishes while assisting in bed mobility resulted in actual harm to Resident #2. This was evident for 1 (#2) of 20 residents reviewed for facility reported incidents.</p> <p>The findings include:</p> <p>Review of facility reported incident MD00195473 on 9/26/24 at 8:22 AM revealed Resident #2 was admitted to the facility in June 2023 with diagnoses that included hemiplegia and hemiparesis following a cerebral infarction affecting the left non-dominant side, type 2 diabetes mellitus, chronic kidney disease, and contracture of the muscles with multiple sites.</p> <p>The MDS (Minimum Data Set) is part of the Resident Assessment Instrument that was Federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned based on those individualized needs, and that the care is provided as planned to meet the needs of each resident.</p> <p>Review of Resident #2's admission MDS assessment with an assessment reference date of 6/13/23, Section G, Functional Status, documented A: Bed mobility - how a resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture as (3) extensive assistance with (2) which was one-person physical assist. Section G0400 functional limitation in range of motion, upper extremity, documented, impairment on one side, lower extremity - impairment on 1 side.</p> <p>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.</p> <p>Review of Resident #102's initial activities of daily living care plan (ADL), that was created on 6/12/23 documented, has ADL self-care performance deficit, requires assistance with ADL disease process with interventions, assistance required with ADL's may fluctuate based on time-of-day, mood, pain, or fatigue. Adjust and document as indicated. Report significant changes to charge nurse. There was nothing documented on the initial care plan as to how many staff were required to help the resident with bed mobility.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The facility reported incident documented that the assigned GNA (geriatric nursing assistant) came to Resident #2's room on 8/10/23 at 3:00 PM and wanted to turn the resident while the resident was in bed. The resident stated that he/she told the GNA I am comfortable facing the wall, I don't want to be turned. The resident stated that the GNA ignored his/her request and proceeded in pulling his/her left contracted fingers to turn him/her, and the resident heard a pop at the pulling site. The facility documented on assessment, swelling was noted to the left second and third metatarsals of the left hand and the resident reported that the area was painful.</p> <p>Review of the progress notes in Resident #2 medical record dated 8/11/23 at 12:54 PM documented the resident verbalized mild pain of 4 on a pain scale of 1 to 10. Tylenol was offered but refused, however a stat (immediate) x-ray was ordered. The results of the x-ray that was done at the facility were negative for fracture. The x-ray documented, hand arthritis w/contraction. No fracture.</p> <p>An 8/13/23 at 11:54 AM a physician's telehealth visit documented that the patient was aware of x-rays and that there was no fracture but was insistent on going to the emergency room (ER) for evaluation. The note documented that the resident was alert and oriented and did not want to follow up with the PCP (primary care physician) but wanted to go the ER instead. The resident was transported to the hospital at 12:40 PM.</p> <p>An 8/13/23 physician's telehealth visit documented, resident returned from ER after transfer this morning. Reason for visit is finger injury. Diagnosis is closed non-displaced fracture of proximal phalanx of left index finger. A splint is placed on the index finger.</p> <p>On 9/26/24 at 9:33 AM an interview was conducted with the Director of Nursing (DON) who stated that the GNA that was involved in the incident, GNA #31, was initially suspended and then terminated.</p> <p>Review of GNA #31's personnel file revealed an Employee Corrective Action form that documented on 7/8/22 GNA #31, used foul or abusive language, conduct issues. It was reported to the DON by one of the residents that GNA #31 was verbally abusive. On 2/14/23 an employee corrective action form documented GNA #31, was written up for falsification of documentation. On 8/16/23 an employee corrective action form documented, termination. Safety/carelessness violation: resident abuse to police - after 3 days suspension, decided to terminate.</p> <p>On 9/26/24 at 12:49 PM an interview was conducted with Resident #2. Resident #2 was showing the surveyor his/her left-hand fingers and stated that he/she was receiving electric therapy to those fingers and stated that therapy was helping and that his/her left hand and left leg were doing pretty good. Resident #2 stated to the surveyor, my fingers were broken by an aide here. The aide grabbed and pulled and tried to roll me over. I said you can't do it that way and he said you are going to go, meaning roll over. I went to the hospital, and they said they were broken. Resident #2 was asked if the aide was by himself or if he had help. Resident #2 stated the aide was by himself and the bed was against the wall. It happened between 10 and 11 in the morning. He was rough with me all the time. He was hardheaded and said it was his way or the highway. The resident was asked if he had any pain because the surveyor did not see that the resident received pain medication. Resident #2 stated, yes, I had pain, and I still do when it rains. I don't believe in taking pills. I will take Tylenol every once in a while, but I don't believe in it. Resident #2 was asked why he insisted on going to the hospital when the facility told him/her that the x-ray was negative. Resident #2 stated, because my fingers hurt.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/26/24 at 1:40 PM the Nursing Home Administrator (NHA) was interviewed and stated she was the RN supervisor at that time. The NHA stated, I remember that employee. That was not his first incident. Not only the way [resident #2 name] described it but he had previous incidents. The NHA stated that Resident #2 stated something about him (GNA) trying to turn Resident #2 a certain way and the guy said, no, that is how I am going to turn you. He has had incidents in the past, so this was the last thing and that is why he was terminated. Residents complained about the GNA's approach to them and how he talked to them. The NHA stated, we did not know if the resident tried to hit the GNA first.</p> <p>On 9/26/24 at 1:57 PM a call was placed, and a voice mail message was left for GNA #31. As of 10/2/24 at 3:30 PM, GNA #31 had not returned the surveyor's call.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>31145</p> <p>Based on reviews of facility reported incidents with documentation and interview, it was determined the facility failed to report allegations of abuse within 2 hours of the allegation to the regulatory agency, the Office of Health Care Quality (OHCQ). This was evident for 5 (#11, #6, #2, #20) of 22 facility reported incidents reviewed during a complaint survey.</p> <p>The findings include:</p> <p>1) On 9/23/24 at 11:15 PM a review of facility reported incident MD00203077 was conducted and revealed Resident #11 was at the hospital and reported to the hospital social worker that he/she had been hit in the head by a staff member at the nursing facility.</p> <p>On 2/28/24 at 12:30 PM the facility became aware of the incident from the hospital social worker. The facility reported incident initial report form typed in that the Director of Nursing (DON) filled out the form and submitted it to OHCQ on 2/28/24 at approximately 1:30 PM, however the DON was unable to provide the surveyor with an email confirmation of when the form was sent to OHCQ. Review of the ASE Complaint/Incident Investigation Report documented that the report was received on 2/29/24 at 8:49 AM, which was not within 2 hours of receiving a report of suspected abuse.</p> <p>On 9/23/24 at 12:53 PM an interview was conducted with the DON. The DON stated he looked back through his email confirmations and could not find them. The surveyor informed the DON that it was important that he kept his email confirmations of when the reports were submitted, and the DON replied, absolutely.</p> <p>2) On 9/23/24 at 11:30 PM a review of facility reported incident MD00204934 was conducted and revealed on 4/22/24, at approximately 11:40 AM, a call was received from Adult Protective Services and the staff who called reported that Resident #11 had called to report that he/she was abused by a staff member over the weekend.</p> <p>There was no name or information given about the staff. Resident #11 cannot speak verbally because of a disease process but was able to use his/her phone to type and communicate his/her needs. Resident #11 stated that the incident occurred on Sunday, 4/21/24. Resident #11 stated that the staff spit on him/her, but declined to mention any names, when asked.</p> <p>Review of the facility's investigation revealed the staff became aware of the incident on 4/22/24 at 11:40 AM. Review of the Facility Reported Incident Initial Report Form had a blank for the date/time the report was submitted to OHCQ. There were no email confirmations.</p> <p>On 9/23/24 at 12:53 PM an interview was conducted with the DON. The DON stated he looked back through his email confirmations and could not find them.</p> <p>3) On 9/23/24 at 1:38 PM a review of facility reported incident MD00207915 documented that on 7/19/24 at approximately 13:45 (1:45 PM) Resident #6 complained of pain to the right second finger and the resident mentioned that a male had pulled his/her hand.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A 7/19/24 nurse practitioner note documented in Resident #6's medical record that the resident was seen in the room with right wrist swelling with pain and bruises. Patient stated that somebody did that to [him/her]. Nursing notified and investigation is in process. Patient was able to wiggle all the fingers and move the hand but complained of pain during the process.</p> <p>Review of the facility's investigation failed to produce an email confirmation as to when the facility first sent the report to OHCQ. The ASE form documented the date 7/19/24, however there was no time, therefore it could not be confirmed if it was within 2 hours of suspected abuse.</p> <p>On 9/30/24 at 12:55 PM an interview was conducted with the DON. He stated that he did not have the email confirmation, and he will pay attention to that going forward.</p> <p>4) On 9/26/24 at 8:22 AM a review of facility reported incident MD00195473 revealed on 8/10/23 at 3:00 PM the assigned geriatric nursing assistant (GNA) came to Resident #2's room and wanted to turn Resident #2 while he/she was in bed. Resident #2 stated that he/she told the GNA I am comfortable facing the wall, I don't want to be turned. Resident #2 stated that the GNA ignored his/her request and proceeded in pulling his/her left contracted fingers to turn him/her, and he/she heard a pop at the pulling site. On assessment, swelling was noted to the left 2nd and 3rd metatarsals of the left hand and resident reported that area was painful.</p> <p>Review of the facility's investigation failed to produce an email confirmation as to when the initial report was submitted to OHCQ.</p> <p>On 9/26/24 at 9:33 AM an interview was conducted with the DON. The DON stated, the way the confirmation pops up on the computer screen, I did not print the receipt for the form that was sent.</p> <p>34484</p> <p>5) On 9/23/24 a review of facility reported incident MD00199332 was conducted and revealed a written statement documented on 11/8/23 from GNA #43 that on 11/5/23 GNA #43 was notified Resident #20 called police on GNA #43 so GNA #43 gave the police a statement on 11/5/23 and he reported the police notified GNA #43 to stay away from the Resident.</p> <p>Review of the Facility Reported Incident Initial Report Form documented the initial report was sent to OHCQ on 11/8/23 at 4:00 PM, which was not within 2 hours of an alleged abuse.</p> <p>Interview with the Administrator on 9/25/24 at 9:11 AM confirmed the facility staff failed to notify OHCQ on 11/5/23 when the police were called to the facility for alleged abuse by Resident #20.</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34484</p> <p>Based on record review and interview it was determined that the facility failed to have a process in place to ensure that a baseline care plan was provided to the resident and resident representative within 48 hours of admission to the facility (Resident #40). This was evident for 1 of 3 residents reviewed for baseline care plans during a complaint survey.</p> <p>The findings include:</p> <p>The baseline care plan is given to residents within 48 hours of their admission and details a variety of components of the care that the facility intends to provide to that resident. In addition to the baseline care plan, residents are also expected to receive a list of their admission medications. This allows residents and their representatives to be more informed about the care that they receive.</p> <p>Review of Resident #40's medical record on 10/1/24 to investigate a complaint regarding lack of communication to the Resident's representative on admission to the facility revealed the Resident was admitted to the facility on [DATE] from the hospital.</p> <p>The medical record review failed to reveal evidence that the facility offered the Resident and their representative a summary of the baseline care plan that included initial goals, physician orders, therapy services, dietary services, and social services within 48 hours of the resident's admission to the facility.</p> <p>Interview with the Regional Nurse on 10/1/24 at 1:27 PM confirmed the facility staff failed to provide a summary of the baseline care plan to Resident #40 and their representative within 48 hours of the resident's admission to the facility.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>34484</p> <p>Based on medical record review and interview it was determined the facility staff failed to ensure a resident's plans of care included individual resident care needs and interventions to assist each resident in reaching their highest practicable level of wellbeing. This was evident for 1 (#24) of 51 residents reviewed during a complaint survey.</p> <p>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.</p> <p>The findings include:</p> <p>Review of Resident #24's medical record on 9/23/24 revealed on 5/21/23 the Resident left the facility without notifying staff to go to a family member's house.</p> <p>Further review of Resident #24's medical record revealed a nurse's note on 5/25/23 at 4:00 PM that stated, While doing my round, resident was observed sitting alone by the Gateway dining room exit door. He/she requested writer open the door for him/her to exit but was reminded that as per MD order, he/she cannot go out unaccompanied.</p> <p>Review of Resident #24's care plans revealed no care plan that the Resident is at risk for elopement to provide interventions for the Resident.</p> <p>Interview with the Director of Nursing on 9/25/24 at 9:05 AM confirmed the facility staff failed to develop a care plan for Resident #24's risk for elopement.</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34484</p> <p>Based on medical record review and interview, the facility staff failed to have quarterly care plan meetings for residents and responsible parties). This was evident for 7 (Resident #5, #9, #10, #17, #4, #1, #2) of 51 residents reviewed during a complaint survey.</p> <p>The findings include:</p> <p>Once the facility staff completes an in-depth assessment (MDS) of the resident, the interdisciplinary team meet and develop care plans. Care plans provide direction for individualized care of the resident. A care plan flows from each resident's unique list of diagnoses and should be organized by the resident's specific needs. The care plan is a means of communicating and organizing the actions and assure the resident's needs are attended to. The care plan is to be reviewed and revised at each assessment time of the resident to ensure the interventions on the care plan is accurate and appropriate for the resident. Care plan meetings are held each quarter and as needed.</p> <p>1. Review of Resident #5's medical record on 9/26/24 revealed the Resident was admitted to the facility on [DATE].</p> <p>Further review of Resident #5's medical record revealed the facility staff failed to have any quarterly care plan meetings from admission in July 2022 until July 2024.</p> <p>Interview with the Director of Nursing on 9/26/24 at 2:06 PM confirmed the facility staff failed to have quarterly care plan meetings for Resident #5 from admission in July 2022 until July 2024.</p> <p>2. Review of Resident #9's medical record on 9/27/24 revealed the Resident was admitted to the facility on [DATE].</p> <p>Further review of Resident #9's medical record revealed the facility staff failed to have any quarterly care plan meetings from 4/19/23 until discharge on [DATE].</p> <p>Interview with the Director of Nursing on 9/30/24 at 8:20 AM confirmed the facility staff failed to have quarterly care plan meetings for Resident #9 from 4/19/23 until discharge on [DATE].</p> <p>3. Review of Resident #10's medical record on 9/26/24 revealed the Resident was admitted to the facility on [DATE].</p> <p>Further review of Resident #10's medical record revealed the facility staff failed to have any quarterly care plan meetings from admission 1/25/24 until discharge on [DATE].</p> <p>Interview with the Director of Nursing on 9/26/24 at 2:09 PM confirmed the facility staff failed to have a quarterly care plan meeting for Resident #10 from admission until discharge on [DATE].</p> <p>4. Review of Resident #17's medical record on 9/26/24 revealed the Resident was admitted to the facility on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Further review of Resident #17's medical record revealed the facility staff failed to have any quarterly care plan meetings from 2/15/23 until 9/25/24. After surveyor intervention, the facility staff held a care plan meeting on 9/26/24.</p> <p>Interview with the Administrator on 9/26/24 at 10:56 AM confirmed the facility staff failed to have a quarterly care plan meetings for Resident #17 from 2/15/23 until 9/26/24.</p> <p>31145</p> <p>5. On 9/24/24 at 1:44 PM a review of complaint MD00209234 revealed Resident #4's responsible party (RP) complained that communication from the social work department dropped off in early 2024 after the social worker left and issues that the RP had pertaining to Resident #4's care went unanswered.</p> <p>On 9/25/24 at 12:33 PM an interview with Resident #4's RP was conducted. Resident #4's RP stated that he has not had a care plan meeting with the facility regarding Resident #4. The RP stated he used to talk to the previous SW but has not had any resolution to his issues. The RP stated it has been very frustrating trying to get things done for his sibling.</p> <p>Review of Resident #4's medical record revealed Resident #4 was admitted to the facility in April 2023. There was documentation of a care management strategies meeting on 9/19/23. There were no meetings after that.</p> <p>6. On 9/24/24 a review of complaint MD00209271 revealed Resident #1's responsible party (RP) had been trying to have Resident #1 return to his/her home state since January 2024. The RP alleged that the facility had not done their due diligence in coordinating a discharge plan and had not had care plan meetings.</p> <p>On 9/24/24 a review of the medical record for Resident #1 revealed Resident #1 was admitted to the facility in January 2023 following a 3 month stay in an acute care facility due to an accident.</p> <p>On 9/24/24 at 12:28 PM an interview was conducted with Resident #1's RP who stated that Resident #1 was in an accident and in the hospital for 3 months and had been at the nursing facility since 2023. She stated, we were having a hard time getting the discharge process moved along. Resident #1's RP stated that she had been talking to the previous SW #11, but after he left the current SW assistant had been thrust into the position and nothing was getting done. The RP stated, we got guardianship in April 2023. During that time period I was not having care plan meetings. We finally had a meeting a couple of weeks ago because the Ombudsman got involved.</p> <p>Review of care plan sign-in sheets revealed there was a care plan meeting on 3/15/23 and 6/1/23. There were no care plan meetings after 6/1/23 until 9/20/24.</p> <p>Review of Resident #1's care plans revealed a discharge care plan that was initiated on 11/20/23 that documented Resident #1 along with the RP wished for Resident #1 to be discharged back to Washington State with family when care was up to par for discharge. As of 9/24/24 the care plan had not been updated or evaluated with current interventions.</p> <p>On 9/26/24 at 2:06 PM the DON confirmed that there were no documented care plan meetings.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>7. On 9/26/24 at 8:58 AM Resident #2's medical record was reviewed and revealed Resident #2 was admitted to the facility in June 2023.</p> <p>Further review of the medical record failed to produce evidence of care plan meetings. On 9/26/24 at 1:15 PM the DON and social work assistant were asked if they could produce care plan sign-in sheets.</p> <p>On 9/26/24 at 2:06 PM the DON brought back SW notes for the surveyor and confirmed there was no evidence of care plan meetings.</p> <p>This issue was discussed at the exit conference with the Corporate Administrator and Nurse.</p>

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<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Plan the resident's discharge to meet the resident's goals and needs.</p> <p>31145</p> <p>Based on complaint, medical record review and staff interview it was determined the facility failed to develop an individualized discharge plan and update a discharge care plan for a resident admitted to the facility for rehabilitation. This was evident for 1 (#1) of 27 residents reviewed for complaints.</p> <p>The findings include:</p> <p>On 9/24/24 a review of complaint MD00209271 revealed Resident #1's responsible party (RP) had been trying to have Resident #1 return to his/her home state since January 2024. The RP alleged that the facility had not done their due diligence in coordinating a discharge plan.</p> <p>On 9/24/24 at 12:28 PM an interview was conducted with Resident #1's RP who stated that Resident #1 was in an accident and in the hospital for 3 months and had been at the nursing facility since 2023. She stated, we were having a hard time getting the discharge process moved along. Resident #1's RP stated that she had been talking to the previous SW #11, but after he left the current SW assistant had been thrust into the position and nothing was getting done.</p> <p>On 9/24/24 at 2:29 PM a review of the medical record for Resident #1 revealed Resident #1 was admitted to the facility in January 2023 following a 3 month stay in an acute care facility due to an accident.</p> <p>Review of Resident #1's care plans revealed a discharge care plan that was initiated on 11/20/23 that documented Resident #1 along with the RP wished for Resident #1 to be discharged back to Washington State with family when care was up to par for discharge. As of 9/24/24 the care plan had not been updated or evaluated with current interventions.</p> <p>Further review of Resident #1's medical record failed to produce documentation that an active discharge plan was in process.</p> <p>On 9/25/24 at 9:18 AM an interview was conducted with the Director of Nursing (DON) and Nursing Home Administrator (NHA) regarding the discharge issue. The NHA stated, the Ombudsman sent me an email and stated that the family wanted to transfer to Washington State. They said they were having difficulty making arrangements. I asked [Staff #12] to set a zoom call. This was a couple of weeks ago. Both the DON and NHA stated they were not aware of the discharge issue.</p> <p>On 9/25/24 at 9:51 AM an interview was conducted with Staff #12, social work assistant who stated she was working with the previous social worker when the family asked to start a discharge plan, however there was no documentation in the medical record to support the discharge planning. Staff #12 stated she did do a care plan meeting, it was her first without a director, however there was no documentation of that meeting. Staff #12 stated that for Resident #1, she has not put her notes in the system yet. Her notes are through her emails.</p> <p>On 10/2/24 at 3:15 PM the Corporate Nurse was made aware.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34484</p> <p>Based on review of complaint, medical record review, and staff interview, it was determined the facility failed to provide care to meet the needs of a resident's physical, mental, and psychosocial health This was evident for 5 (Resident #7, #8, #10, #24, #3) of 51 residents reviewed for quality of care during a complaint survey.</p> <p>The findings include:</p> <p>1. The facility staff failed to administer Methadone as ordered for Resident #7.</p> <p>Review of Resident #7's medical record on 9/25/24 revealed the Resident was admitted to the facility on [DATE] with a diagnosis of opioid dependence. Opioid dependence is a chronic disease that occurs when someone regularly uses opioids, leading to a strong internal drive to use them.</p> <p>Further review of Resident #7's medical record revealed the Resident was ordered on 4/30/24 by the physician to receive Methadone 10 mg 3 tablets in the morning for pain. Methadone is a medication used to treat Opioid Use Disorder.</p> <p>Review of Resident #7's Medication Administration Records for July and August 2024 revealed the facility staff failed to administer Methadone as ordered on the following dates: 7/8, 7/9, 7/10, 7/11, 7/12, 7/13, 7/14, 7/15, 7/16, 7/17, 7/19, 8/11, 8/12, 8/13, and 8/14/24. The ordered for Methadone was discontinued on 8/14/24.</p> <p>Interview with the Regional Nurse on 9/26/24 at 2:50 PM confirmed the facility staff failed to administer Methadone as ordered by the physician for Resident #7.</p> <p>2. The facility staff failed to administer medications as ordered by the physician for Resident #8.</p> <p>Review of Resident #8's medical record on 9/26/24 revealed the Resident was admitted to the facility on [DATE] at approximately 10:00 PM and discharged on [DATE] at 7:45 PM.</p> <p>Review of Resident #8's July Medication Administration Record for July 2024 revealed the Resident did not receive the following medications on 7/18 and 7/19/24:</p> <p>a) Topiramate 50 mg two times a day for seizures</p> <p>b) Sucralfate 1 gm/10 ml give 10 ml before meals and at bedtime for GI ulcer</p> <p>Interview with the Director of Nursing on 9/27/24 at 9:14 AM confirmed the facility staff failed to administer medications as ordered by the physician for Resident #8.</p> <p>3. The facility staff failed to administer eye drops as recommended by the eye doctor in a timely manner for Resident #10.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #10's medical record revealed the Resident was admitted to the facility on [DATE] and had diagnosis to include bilateral dry eye syndrome.</p> <p>Further review of the Resident's medical record revealed on 3/22/24 the Resident was seen by the eye doctor and ordered to continue artificial tears 3-4 times daily and lid scrubs one time daily.</p> <p>Review of Resident #10's March and April administration records revealed the facility staff did not begin administering the artificial tears and lid scrubs as recommended until 4/16/24.</p> <p>Interview with the Director of Nursing on 10/1/24 at 2:00 PM confirmed the facility staff failed to administer eye drops as ordered for Resident #10 in a timely manner.</p> <p>4. The facility staff failed to accurately assess Resident #24's risk for elopement.</p> <p>Review of Resident #24's medical record on 9/23/24 revealed on 5/21/23 the Resident left the facility without notifying staff to go to a family member's house.</p> <p>Further review of Resident #24's medical record revealed a nurse's note on 5/25/23 at 4:00 PM that stated, While doing my round, resident was observed sitting alone by the Gateway dining room exit door. He/she requested writer open the door for him/her to exit but was reminded that as per MD order, he/she cannot go out unaccompanied.</p> <p>Review of Resident #24's Wandering Observation Tool for 5/22/23, 11/22/23 and 6/11/24, the facility staff inaccurately documented No for Does the resident have a history of elopement?</p> <p>Interview with the Director of Nursing on 9/25/24 at 9:05 AM confirmed the facility staff inaccurately assessed Resident #24's risk for elopement on 5/22/23, 11/22/23 and 6/11/24.</p> <p>31145</p> <p>5. Blood pressure is a measurement of the pressure that the blood places on the arteries as it is moving through the arteries. The top number is the systolic pressure (SBP), which is a measurement of the pressure when the heart pumps the blood out into the arteries. The bottom number is the diastolic pressure (DBP) which is a measurement of the pressure when the heart is between beats (resting).</p> <p>On 9/24/24 at 10:40 AM a review of Resident #3's medical record revealed Resident #3 was admitted to the facility in August 2024 with diagnoses that included but were not limited to hypotension, hypoglycemia, adrenocortical insufficiency, and aftercare following surgery on the digestive system.</p> <p>Review of Resident #3's August 2024 physician's orders revealed an order for Midodrine 5 milligrams (mg) 3 times per day for hypotension (low blood pressure). Hold for SBP above 120.</p> <p>Midodrine is a medication used to treat low blood pressure. Midodrine works by causing blood vessels to tighten, which increases the blood pressure.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #3's Medication Administration Record (MAR) documented on 8/30/24 at 6:00 AM that Resident #3 had a blood pressure of 130/70. The MAR documented the nurse's initials which indicated the medication was administered. The medication was administered when the blood pressure was outside of physician ordered parameters which documented to hold when SBP above 120. The SBP was 130. The nurse failed to follow physician's orders.</p> <p>Review of Resident #3's care plan, has hypotension that was initiated on 8/28/24, had the intervention, administer medications per medical provider's orders. The care plan was not followed.</p> <p>On 10/1/24 at 9:32 AM an interview was conducted with Staff #13 about the Midodrine being administered when outside of parameters and failure to follow the care plan related to medication administration.</p> <p>On 10/2/24 at 11:42 AM Staff #13 came back to the surveyor and stated she confirmed the error with the Midodrine.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34484</p> <p>Based on medical record review and interview, the facility staff failed to provide treatment/services to prevent/heal pressures ulcers (Resident #40). This is evident for 1 of 3 residents reviewed for pressure ulcers during a complaint survey.</p> <p>The findings included:</p> <p>A pressure ulcer also known as pressure sore or decubitus ulcer is any lesion caused by unrelieved pressure that results in damage to the underlying tissue. Pressure ulcers are staged according to their severity from Stage I (area of persistent redness), Stage II (superficial loss of skin such as an abrasion, blister or shallow crater), Stage III (full thickness skin loss involving damage to subcutaneous tissue presenting as a deep crater), Stage IV (full thickness skin loss with extensive damage to muscle, bone or tendon) or Unstageable Pressure Ulcer (full thickness tissue loss in which the base of the ulcer is covered by slough and / or eschar in the wound bed).</p> <p>Review of Resident #40's medical record on 10/1/24 revealed the Resident was readmitted to the facility on [DATE] from the hospital with a Stage III pressure ulcer to the sacrum.</p> <p>Further review of Resident #40's medical record revealed the Resident's sacral wound was assessed by the Wound Nurse Practitioner on 3/3/24 and documented measurements of the wound.</p> <p>Further review of Resident #40's medical record revealed the facility staff failed to reassess the Resident's sacral pressure wound weekly on 3/10/24 and the Resident was discharged to the hospital on 3/15/24.</p> <p>Interview with the Director of Nursing on 10/1/24 at 3:29 PM confirmed the facility staff failed to reassess Resident #40's sacral wound on 3/10/24 to determine the wound's status.</p>		

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<p>F 0691</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services.</p> <p>37586</p> <p>Based on record review and interviews, it was determined that the facility failed to ensure that colostomy care was provided to a resident with a colostomy. This was evident for 1 (16) of 1 resident reviewed with a colostomy.</p> <p>The findings include:</p> <p>The Minimum Data set (MDS) assessment is a federally mandated assessment tool that nursing home staff use to gather information on each Resident's strengths and needs. The information collected drives resident care planning decisions.</p> <p>A medical record review was done on 9/23/24 at 11:12 for Resident # 16. Records revealed Resident # 16 had a colostomy. The resident had a diagnosis of malignant neoplasm.</p> <p>A subsequent record review completed on 9/23/24 at 10:51 AM revealed an order summary report of January 1/8/24 which revealed an attending providers orders for 1) colostomy care every shift, initiated on 1/8/24 and discontinued on 2/9/24 at 4 AM, 2) Monitor ostomy site for discoloration, change ostomy every shift and as needed, initiated on 1/8/24 and discontinued on 12/9/24. A continued review showed a MDS assessment, dated 1/11/24, which revealed that Resident#16 is Moderate assistant for staff on toilet/ hygiene.</p> <p>Interview with Resident # 16's family member on 09/23/2024 at 12:01 pm indicated in their complaint that they were told by staff that they would have to purchase the colostomy bags themselves. Complainant cannot remember who she spoke to at the time. Family member purchased 3 boxes Convatec, 1-piece drainable pouch. Family member stated the bottom of the bag was not secured by a clip but stapled instead. Therefore, the bag leaked of feces.</p> <p>The surveyor asked the DON to see the supply clerk who came back later with the boxes of colostomy supplies resident had left in the supply closet. The surveyor counted the bags and there were 28 colostomy bags left. All of the colostomy bags found required a clip to secure the bottom of colostomy bag. There were new bags in the convatec box that had the residents name on the colostomy bags and a bag was stapled shut ready for the next use. Surveyor showed the bag to the DON.</p> <p>(continued on next page)</p>		

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<p>F 0691</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The DON was made aware on 9/23/24 at 12 noon. There was no response.</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18819</p> <p>Based on administrative and medical record reviews and staff interview, it was determined that the facility failed to 1) maintain access to all closed medical records, and 2) maintain accurate electronic medical records. This was evident for 3 (#35, #8, #26) of 51 resident records reviewed for accuracy during a complaint survey.</p> <p>The findings include:</p> <p>1) Resident #35 was admitted from the hospital to the facility on [DATE]. A review of facility reported incident (FRI) MD00177812 on 09/24/2024 revealed details that Resident #35 eloped from the facility on 05/28/2022. Resident #35 did not return to the facility after 05/28/2022. A request for Resident #35's closed medical record was made to the director of medical records on 09/24/2024 at 1:50 PM. An interview with the medical records director proceeded after the medical record request. The medical records director stated that S/he had been in this position for 6 years and that the facility uses an outside vendor to house the paperwork from closed medical records. The medical records director also stated that the facility had a flood on the lower floor where the medical records were stored in 2019 and that several charts had to be disposed of. The medical record director confirmed that Resident #35's closed medical record was not onsite at the facility.</p> <p>On 09/24/2024 at 3:45 PM, the medical records director asked the nurse surveyor if it would be okay to order Resident #35's closed medical record from the offsite vendor. The surveyor confirmed that Resident #35's closed medical record would be required for the complaint survey review. The medical records director stated that S/he would now request an expedited order from the offsite vendor for Resident #35's closed medical record and that it would take approximately 3-5 days.</p> <p>On 10/01/2024 at 10:20 AM, the medical records director informed the survey team that Resident #35's closed medical record could not be located at the offsite vendor storage facility and would not be available for review.</p> <p>2) A review of Resident #35's electronic medical record on 10/01/2024 at 11 am revealed a psychiatric nurse practitioners progress note dated 06/02/2022 at 11:24 AM that indicated Resident #35, and the nursing staff were interviewed. Upon completion of the assessment and interview, the psychiatric nurse practitioner documented a primary diagnosis of Paranoid Schizophrenia and indicated the treatment plan for Resident #35 would be to continue supportive therapy and continue current medications and that the psychiatric team will monitor mood and behavior.</p> <p>In a telephone interview with the psychiatric nurse practitioner and the psychiatric business liaison on 10/02/2024 at 3:38 PM, the psychiatric nurse practitioner was asked to confirm that S/he conducted a psychiatric assessment on Resident #35 on 06/02/2022. The psychiatric nurse practitioner stated that S/he was going into the facility to perform consultations in June of 2022 and not conducting consultations via telehealth (via skype video computer).</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Kensington Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3000 McComas Avenue Kensington, MD 20895	

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The psychiatric nurse practitioner reviewed his/her 06/02/2022 progress note for Resident #35 and stated that S/he asked Resident #35 questions during the consultation. The psychiatric business liaison was asked if S/he could confirm that psychiatric nurse practitioner billed Resident #35 for the 06/02/2022 consultation. The psychiatric business liaison was able to pull up billing records from June 2022 and confirmed that the psychiatric consultation business billed Resident #35 for the 06/02/2022 consultation performed by the psychiatric nurse practitioner. The nurse surveyor then reported that Resident #35 had eloped from the facility on 05/28/2022 and did not return to the facility after that date.</p> <p>34484</p> <p>3) A medical record is the official documentation of a healthcare organization. As such, it must be maintained in a manner that follows applicable regulations, accreditation standards, professional practice standards, and legal standards. All entries to the record should be legible and accurate.</p> <p>Review of Resident #8's medical record on 9/26/24 revealed the Resident was admitted to the facility on [DATE] and discharged on [DATE].</p> <p>Further review of Resident #8's medical record revealed the facility staff documented vital signs for Resident #8 on 7/20/24 at 12:01 AM and 7/21/24 at 6:03 AM that included temperature, pulse, blood pressure and oxygen saturation even though the Resident was not in the facility and had been discharged .</p> <p>Interview with the Regional Nurse on 9/27/24 at 11:10 AM confirmed the facility staff inaccurately documented vitals signs for Resident #8 who had been discharged .</p> <p>37586</p> <p>4) A medical record view was conducted on 9/24/24 at 10:45 AM. Resident # 26 was readmitted to the facility on [DATE] with a diagnosis of left artificial knee joint infected, bacteremia, and other diagnosis.</p> <p>Medical record review on 1/3/23 revealed resident called 911. EMT responded and the nurse on duty asked why they were there. Resident # 26 complained of right arm pic line being painful.</p> <p>On 1/24/23, Resident rang the call bell, time unknown, resident # 26 complained of her IV site being red and irritated. Nurse assessed the IV site and found it not to be red. Nurse did ask Unit Manager, staff # 33 to verify the results of the IV site and it was not red.</p> <p>On 9/24/24 at 11:15 AM this surveyor had an interview with the unit manager staff # 33. Resident # 26 is receiving</p> <p>(continued on next page)</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Vancomycin for Left Knee infection. Nurse spoke with attending Doctor, who ordered resident # 26 to be sent out with 911.</p> <p>Upon residents return from the hospital, social worker Staff # 11 (no longer with the facility) spoke to resident # 26 and asked why resident called 911 instead of notifying the nurse and resident stated that they never help. Social Worker was then fired by resident # 26 because the resident was unsatisfied with the actions of social work.</p> <p>Resident # 26 returned to the facility 1/9/23 and inquired about personal belongings that were missing. Resident # 26 stated that she/he personal property which includes a wallet, laptop, bag and charger were missing. On 9/24/24 at 10:45 AM the surveyor requested the medical record from the DON (Director of Nursing). The DON stated the medical chart is off site and he will call the offsite Co. and have the chart delivered. DON stated it will take about a week for the chart to come to the facility.</p> <p>On 10/1/24 at aprox 10:30 AM, DON stated the offsite Co. was unable to find the chart for resident # 26 therefore surveyor is unable to see if resident had an inventory sheet proving resident 26 had the computer, bag and charger when resident # 26 was admitted to the facility.</p> <p>DON aware this is a deficiency on 10/01/24 aprox 10:30.</p>		

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<p>F 0850</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Hire a qualified full-time social worker in a facility with more than 120 beds.</p> <p>31145</p> <p>Based on written and verbal complaints, documentation review and staff interview, it was determined the facility failed to obtain a full-time social worker when the certified number of beds exceeded 120 in the facility. Currently the facility was licensed for 140 certified beds. This was evident for 1 out of 1 required personnel and had the potential to affect all residents.</p> <p>The findings include:</p> <p>On 9/24/24 at 1:44 PM a review of complaint MD00209234 revealed Resident #4's responsible party (RP) complained that communication from the social work department dropped off in early 2024 after the social worker left and issues that the RP had pertaining to Resident #4's care went unanswered.</p> <p>On 9/25/24 at 12:33 PM an interview with Resident #4's RP was conducted. Resident #4's RP stated that he has not had a care plan meeting with the facility regarding Resident #4. The RP stated he used to talk to the previous SW but has not had any resolution to his issues. The RP stated it has been very frustrating trying to get things done for his sibling.</p> <p>On 9/24/24 a review of complaint MD00209271 revealed Resident #1's RP had been trying to have Resident #1 return to his/her home state since January 2024. The RP alleged that the facility had not done their due diligence in coordinating a discharge plan.</p> <p>On 9/24/24 at 12:28 PM an interview was conducted with Resident #1's RP who stated that Resident #1 was in an accident and in the hospital for 3 months and had been at the nursing facility since 2022. She stated, we were having a hard time getting the discharge process moved along. Resident #1's RP stated that she had been talking to the previous SW #11, but after he left the current SW assistant had been thrust into the position and nothing was getting done. Resident #1's RP also stated that there were no care plan meetings.</p> <p>On 9/25/24 at 9:51 AM an interview was conducted with Staff #12, who was the SW assistant. Staff #12 stated she had worked at the facility for a year and a couple months. Staff #12 stated, I am enrolled for my bachelor's degree. I am feeling overwhelmed. I have 1 year left plus clinicals. I am doing everybody (all residents) by myself. At the care plan meetings, the Director of Nursing (DON) and I run the meetings. I make calls about care plan meetings to the family. I started doing notification letters in July because I was not aware that that was the way we were supposed to notify family members. Staff #10 is from corporate, and she checks on me 2 times a week. She zoom calls every week. If I have questions I call her.</p> <p>(continued on next page)</p>		

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<p>F 0850</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 10/2/24 at 10:17 AM the Corporate Administrator, that was filling in for the Nursing Home Administrator due to vacation, provided a list of all the social work (SW) staff employed at the facility from January 2022 until current. The facility did not employ a social work director from 1/1/22 to 4/24/22. From 4/25/22 to 12/22/22 the facility had 1 licensed social worker. From 12/13/22 to current, 10/2/24, the facility did not have a licensed full time social worker. There was a typed statement that was given to the surveyor from the Corporate Administrator that read, since then (12/22/22) we have been actively recruiting licensed SW candidates. We have had two licensed applicants accept the job, but both eventually decided not to come aboard. In the meantime, supervision is provided by Staff #10. It was noted that Staff #10 was from corporate and not in the facility on a full-time basis.</p> <p>Cross Reference F657 and F660</p>		