

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215054	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/11/2024
NAME OF PROVIDER OR SUPPLIER Towson Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 509 East Joppa Road Towson, MD 21286	

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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26190</p> <p>Based on observation, interview, and record review, the facility failed to maintain the cleanliness of the ice machine filter and drip pan for one of two ice machines at the facility. This failure had the potential to cause contamination of the ice which could have a negative impact on all 104 residents currently residing at the facility.</p> <p>Findings include:</p> <p>During an observation on 10/10/24 at 4:15 PM in the kitchen, the [NAME] Symphony Plus' (a small ice machine) filter grate on the right side of the machine was noted to be covered in yellow tinged dust, and the drain pan was covered with rust and white colored substances.</p> <p>During an observation and interview on 10/11/24 at 10:00 AM, the Kitchen Dietary Manager (DM) confirmed that the filter grate was dusty and that the drain pan was covered with rust and white colored substances. The DM stated the maintenance department was responsible for the ice machine's filter management, and the kitchen staff was responsible for cleaning the drain pan. The DM could not locate a schedule for cleaning the drain pan.</p> <p>During an observation and interview on 10/11/24 at 10:30 AM, the Maintenance Director (MD) confirmed that the ice machine's filter grate was dirty/dusty. The MD stated that he cleaned and serviced the small ice machine shortly after he arrived at the facility during September 2023. The MD stated the ice machine was due to be cleaned this month. The MD was unable to produce a maintenance log for the ice machine.</p> <p>During an interview on 10/11/24 at 1:15 PM, the Administrator confirmed that she was not aware of a facility policy that addressed maintenance of the kitchen equipment.</p> <p>Review of an undated manual titled, [NAME] Symphony Plus Ice and Water Dispenser Installation Guide revealed, . Cleaning . Recommended Cleaning Intervals . Exterior as needed . Drain Pan/Drip Pan Weekly .</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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30622</p> <p>Based on observations, interviews, and record reviews, the facility failed to 1.) complete wound care in a manner to prevent cross-contamination when they did not use proper barriers during wound care for three of three residents reviewed for wound care (Resident (R) 91, and R82, and R298), and 2.) ensure peripheral inserted central catheter (PICC) dressings were changed and/or remained intact for one of one resident (R298) reviewed for PICC lines out of total sample of 24. These failures had the potential to increase contamination and the spread of infection.</p> <p>Review of the facility policy titled, Wound Care, dated 10/01/23 revealed, . (5) use disposable cloth (paper towel is adequate) to establish a clean field. Place all items to be used during the procedure on a clean field. Arrange supplies so they can be easily reached . (7) Position resident. Place a disposable cloth next to the resident (under the wound) to serve as a barrier to protect the bed linen and other body sites .</p> <p>Review of the facility policy titled, Central Venous Catheter Care and Dressing Changes, dated 03/2022 revealed, . (1) Perform site care and dressing change at established intervals or immediately if the integrity of the dressing is compromised . (3) change the dressing if it becomes damp, loosened or visibly soiled and: (a) at least every 7 days for transparent semi permeable membrane (TSM) dressing . immediately if the dressing site appear compromised .</p> <p>Findings Include:</p> <p>1. Review of R91's Face Sheet, located under the Clinical tab of the electronic medical record (EMR), revealed R91 was admitted to the facility on [DATE] with diagnoses that included infection of intervertebral disc (Pyogenic), lumbar region and spinal stenosis.</p> <p>Review of R91's quarterly Minimum Data Set (MDS), located in the EMR located under the Clinical tab and with an Assessment Reference Date (ARD) of 09/03/24, revealed R91 had a Brief Interview for Mental Status (BIMS) of 15 out of 15, indicating R91 was cognitively intact.</p> <p>Review of R91's Orders, located in the EMR under the Clinical tab, revealed a treatment order for R91's sacral wound. The order indicated, . Treatment: 1. Cleanse with 0.125% Dakins solution. 2. Pack with silver alginate, barrier cream on periwound to base of wound. 3. Secure with bordered foam .</p> <p>Review of R91's Care Plan, dated 10/09/24 and located in the EMR under the Clinical tab, revealed R91 had actual skin breakdown related to multiple wounds. Interventions included, . Administer pain medication as ordered, encourage increase physical mobility within my capacity limits, and observe for signs and symptoms of wound infection and intervene accordingly .</p> <p>During an observation on 10/09/24 at 10:59 AM, Licensed Practical Nurse (LPN) 1 prepared to complete wound care for R91's sacral wound. LPN1 placed the following wound care supplies on R91's bed: normal saline (NS), Dakin's solution, silver alginate, 4x4 gauze pads, gloves, and a bordered foam dressing. LPN1 did not place her supplies on a clean field and failed to place a barrier under R91 to protect the bed linens.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 10/09/24 at 11:46 AM, LPN1 stated the policy was to keep supplies in the original container until they were used. LPN1 stated she was not aware of a policy for using a clean field for wound care supplies or placing a barrier under the resident prior to providing wound care. LPN1 stated she had not received education regarding using a clean field.</p> <p>2. Review of R298's Face Sheet, located in the EMR under the Clinical tab, revealed R298 was admitted on [DATE] with diagnoses that included diffuse large B cell lymphoma and immunodeficiency, unspecified.</p> <p>Review of R298's admission MDS, with an ARD of 10/06/24 and located in the EMR under the Clinical tab, revealed R298 had a BIMS of 15 out of 15, indicating s/he was cognitively intact.</p> <p>a. Review of R298's Orders, located in the EMR under the Clinical tab, revealed no orders for PICC line dressing changes.</p> <p>Review of R298's Care Plan, dated 10/01/24 and located in the EMR under the Clinical tab, revealed R298 had a (single lumen) central line catheter related to his/her chemotherapy. Interventions included, . change dressing, injection caps and extension tubing weekly .</p> <p>During an interview and observation on 10/10/24 at 9:48 AM, the dressing on R298's PICC line was observed to be loose and was dated 09/27/24. R298 stated facility staff did not change the dressing. S/he stated it was last changed at the hospital.</p> <p>During an interview on 10/10/24 at 9:58 AM, Registered Nurse (RN) 1 stated R298 had been going to the hospital on a weekly basis for lab drawings, treatments, and PICC line dressing changes. RN1 stated the facility staff were only flushing the PICC line. RN1 confirmed R298's PICC line dressing had not been changed since 09/27/24.</p> <p>During an interview on 10/10/24 at 10:43 AM, the Director of Nursing (DON) and Administrator stated PICC line dressings should be changed once a week. The DON verified R298 was receiving dressing changes at the clinic when s/he went for chemotherapy. The DON stated the facility nursing staff should have identified the dressing had not been changed since 09/27/24. The administrator verified R298 went for a chemotherapy treatment on 10/03/24, and the dressing should have been changed at that time. The Administrator stated the oncology clinic preferred to change the dressing themselves and not have the nursing home staff change PICC line dressings.</p> <p>b. Review of R298's Orders, dated 10/03/24 and located in the EMR under the Clinical tab, revealed, . 1. Cleanse wound with normal saline. 2. Apply Silver alginate to the base of the wound. 3. Secure with bordered gauze .</p> <p>During an observation on 10/09/24 at 11:38 AM, LPN1 was observed completing wound care for R298's left lateral thigh wound. LPN1 placed the following wound care supplies on the bedside table without using a clean field: NS, gauze pads, and bordered gauze. The bedside table was not cleaned prior to placing the dressing supplies on the table.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 10/10/24 at 12:00 PM, the DON stated the proper procedure while providing wound care was to place all wound care supplies on a clean field prior to beginning the treatment. The DON stated a paper towel could be used as a clean field. The DON stated her expectation was for all nurses to use a clean field for their wound care supplies.</p> <p>3. Review of R82's quarterly MDS, with an ARD of 08/24/24 and located in the EMR under the Clinical tab, revealed R82 was admitted to the facility on [DATE] with unspecified intellectual disabilities. It was recorded that R82 had a BIMS of 99, which indicated severe cognitive impairment. The MDS revealed R82 had one stage three pressure ulcer that was not present upon admission/readmission.</p> <p>Review of R82's Orders, dated 09/19/24 and located in the EMR under the Clinical tab, revealed, . 1. Cleanse wound with normal saline. 2. Apply Santyl to wound base, Calcium alginate, skin prep peri wound. 3. Secure with bordered foam .</p> <p>Review of R82's Care Plan, dated 09/20/24 and located in the EMR under the Clinical tab, revealed R82 had actual skin breakdown. Interventions included, . administer pain medication as ordered, treatments as provided, and wound evaluation weekly to determine progress or deterioration of wound .</p> <p>During an observation on 10/09/24 at 2:40 PM, LPN2 prepared to complete wound care for R82's right lateral foot wound. LPN2 placed the following wound care supplies on the resident's bed: NS, gauze pads, Santyl, and a bordered foam dressing without using a protective barrier.</p> <p>During an interview on 10/09/24 at 2:49 PM, LPN2 stated she should have used a protective barrier for her wound care supplies.</p>