

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215084	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/30/2024
NAME OF PROVIDER OR SUPPLIER Patapsco Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 9109 Liberty Road Randallstown, MD 21133	

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 - Many</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42782</p> <p>Based on observation staff and resident interviews, it was determined that the facility failed to provide residents with an environment that promotes a dignified existence. This deficient practice was evidenced in 10 (Resident #2, #42, #48, #71, #76, #26, #85, #281, #34, #15) 21 resident's reviewed for dignity during the survey.</p> <p>The findings include:</p> <p>1. On 09/16/24 at during observation rounds the surveyor observed Resident #42 in bed wearing a hospital gown. The surveyor observed clothes in a white trash bag on top of the resident's armoire and clothes were inside of the armoire.</p> <p>On 09/17/24 at 9:15 am the surveyor observed Resident #42 in bed wearing a hospital gown.</p> <p>On 09/18/24 at 2:46 pm the surveyor observed Resident #42 in bed wearing a hospital gown.</p> <p>On 09/18/24 at 2:51pm during an interview with LPN #16, the surveyor asked what the protocol was for getting residents dressed and out of bed (OOB) daily. LPN #16 verbalized some of the residents have physical therapy and they wait for therapy to come to assess them. The residents who want to get up, the staff get them out of bed and that Resident #42 prefers to stay in bed because they are blind. LPN #16 and the surveyor then went to the resident's room & the surveyor asked the resident if they want to get dressed and get out of bed. Resident #42 verbalized they wanted to get dressed and get OOB. The resident also asked could the staff turn the television on so they could listen to it.</p> <p>On 09/19/24 at 8:43 am during an interview with Director of Nursing #2 the surveyor asked about residents getting OOB daily. DON #2 verbalized the facility uses a get up list according to their shower list. Night shift is responsible for getting some of the residents up by 8 am. Day shift is supposed to get the resident's up by 10 am. The Get Up list and the shower book are separate.</p> <p>2. On 09/20/24 at 10:46 am the surveyor went to Resident #2's room and observed urine and stool inside a plastic bag inside the pail of the bedside commode. Geriatric Nursing Assistant (GNA) #34 was in the resident's room providing Activities of Daily Living (ADL) care. The resident verbalized the GNA's would get angry when they had to empty and clean the pail so he/she put the bag in the pail.</p> <p>(continued on next page)</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 09/20/24 at 10:57 am during an interview with LPN Unit Manager #24 the surveyor asked if it was the facility's protocol to put plastic bags inside the pail of the residents' bedside commodes. LPN Unit Manager #24 verbalized that is not the protocol. They have seen some of the GNA's use plastic bags inside the pail of the bedside commode. They usually discard the entire bag.</p> <p>On 09/23/24 at 10:11 am the surveyor observed a plastic bag over the pail of the bedside commode of Resident #42.</p> <p>50385</p> <p>3. On 9/16/24 at 08:49 AM, an observation of Resident #48's room was made. The resident was seen on their bed in room only wearing incontinence brief with no blanket or sheets covering the resident. The door to the resident's room was open, and the privacy curtain was not pulled. The floor of the room was scattered with articles of clothing and toilet paper with a brown substance on it. [NAME] substance also on the resident's hamper.</p> <p>On 9/16/24 at 08:52 AM, an interview was conducted with Geriatric Nursing Assistant (GNA) #25. When asked who was taking care of Resident #48, GNA #25 stated he was and that he will take care of cleaning the resident and getting him/her up.</p> <p>4. On 9/16/24 at 8:30 AM, an observation of Resident #71's room was made. The floor in between the two beds was covered in urine. Once the surveyor entered the room the resident stated, be careful, the floor is covered in urine because I have to pee on the floor. When asked why the resident must urinate on the floor, the resident states that the staff does not provide a urinal to him in a timely manner. Resident observed to be wearing a soiled incontinence brief. There was a urinal by the sink in the room out of reach for the resident to use.</p> <p>On 9/18/24 at 3:45 PM, an observation of Resident #71 was made. The resident was observed in bed. The bed was placed in the middle of the room against the second bed closest to window. The resident was observed with a torn incontinence brief lying in bed. The resident stated that the staff do not give him a urinal and must urinate in bed. No urinal was observed in the room.</p> <p>On 9/18/24 at 3:46 PM, an interview was conducted with Geriatric Nursing Assistant (GNA) #25. When asked why the resident was unkempt and why s/he was in the middle of the room? he stated, [S/he] is not even my resident [s/he] does not belong on this unit, they just moved [him/her] here until they clean [his/her] room. When asked if he has tried repositioning the resident since he/she was brought over, he stated, Yes I helped move [him/her] over and we moved [him/her] 3 times since [s/he] came over. When asked why his/her incontinence brief had not been changed, he stated, I don't know.</p> <p>5. On 9/18/24 at 4:31 PM, an observation of Resident #76's room was made. There was a strong odorous smell coming from the cabinet in the room which had a warped side wood panel. Administrator #1 moved the cabinet and a puddle of yellow liquid was seen. A family member who was present at the time of the observation stated that some residents come into [Resident # 76's] room and try to pee in the trashcan next to the cabinet but sometimes pee on the cabinet.</p> <p>50457</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>6. On 09/16/24 at 9:36 AM, during an observation of Resident #281, both the resident and their family member reported that staff failed to offer or provide clean towels, wash clothes, and bed linens. The resident's family member stated that they must bring clean linens from home for Resident #281.</p> <p>On 09/16/24 at 9:36 AM, the surveyor observed a purple towel placed behind the resident's head and another purple towel draped across the resident's lap. The resident's family member reported that they had brought the purple towels from home. The surveyor also noted clutter on the resident's bedside table, side dresser, and sink. Further observation revealed that a shared toilet between room [ROOM NUMBER] (resident #281's room) and room [ROOM NUMBER] was clogged with a mixture of yellow, brown, and red substance along with toilet paper.</p> <p>7. On 09/16/24 at 9:40 AM, the surveyor entered room [ROOM NUMBER] to conduct an initial observation of Resident #26 and Resident #85. Resident #26 pointed to a closed door and asked the surveyor to look inside the toilet room. The surveyor observed a clear plastic trash bag, and a towel placed directly behind the door. When asked about the items, Resident #26 explained that they had to placed them to prevent leakage from the clogged toilet into their room. Upon opening the door. The surveyor again observed a clogged toilet with a mixture of yellow, brown, and red substance along with toilet paper. Resident #26 stated that they reported the clogged toilet the day previous, but it had not been addressed.</p> <p>8. On 09/16/24 at 10:09 AM, the surveyor observed a mostly empty linen cart on the [NAME] Cove Unit. The bottom shelf had a blanket, the second shelf had 2 fitted sheets, an open personal protective equipment gown package, and an unopened pack of briefs, and the top shelf had three sheets, two open boxes of gloves, clear plastic cup, and one brief.</p> <p>On 09/16/24 at 10:20 AM, the surveyor observed a mostly empty linen cart on the Promenade Unit. The bottom shelf had two gowns, the second shelf had three towels and one washcloth, and the top shelf had two open packs of briefs, one unopened pack of briefs, and a container of sanitation wipes.</p> <p>On 09/16/24 at 10:30 AM , the surveyor informed both the Administrator #1 and DON #2 about the two empty linen carts, residents reports of no available linens, and the clogged toilet in room [ROOM NUMBER] and 21 on the [NAME] Cove Unit.</p> <p>50458</p> <p>9. On 09/16/2024 at 8:00 AM during observation rounds, Resident's (#34's) wheelchair was observed on the left side of the room by with three blue pads soiled with a yellow and brown colored substance on it. The room smelled of urine and feces. On 09/16/2024 at 8:45 AM, this observation was relayed to RN Staff #15. She stated that someone would take care of the concern.</p> <p>Observation on 09/16/24 at 10:25 AM revealed the soiled blue pads were still on the wheelchair.</p> <p>On 9/16/24 at 12:30 PM, the surveyors, Director of Nursing (DON) and the Administrator went to the resident's room and the blue pads were still in the wheelchair and noted the flies were flying in the room over the blue pads. Resident #34 stated no one had been in his/her room to remove the soiled blue pads.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>10. On 9/16/2024 at 8:15am, during observation round Resident (#15) was observed lying in bed with an incontinent brief on. The resident was uncovered and his/her room door opened and the resident could be seen from the hallway. There was a large blue pad lying on the floor that was also saturated with a yellow substance that smelled like urine. On 9/16/2024 at 8:30am, The Charge Nurse Staff (#15) was made aware of the findings. She stated she would take care of it now.</p> <p>On 9/16/2024 at 12:30am, the Director of Nursing (DON) and the Administrator were notified of the findings. The DON stated the resident room was cleaned every day.</p> <p>On 9/19/2024 11am during a follow up observation, a blue pad again was observed on the floor saturated with urine. Staff (#13) was made aware and removed the saturated pad.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</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** 21859</p> <p>Based on observations, staff and residents' interview, it was determined the facility failed to provide safe clean homelike environment. This deficient practice was discovered on 5 units of 5 units observed during the survey.</p> <p>The findings include:</p> <p>1. During a facility tour on 9/18/24 at 11am the laundry room was noted to have three laundry dryers with bath linens. The Laundry Aide staff #27 stated he was waiting for the linens to dry. When questioned about surplus of linen he stated there was not enough linens to send to every unit to meet the PAR (Periodic Automatic Replenishment) level. A par level is the minimum number of linens a floor and/ or facility should have on hand at any given time.</p> <p>On 9/18/24 at 11:30am, observation of the second-floor linen closet revealed there were no towels, washcloths, gowns or pillowcases.</p> <p>During interview with Resident #73 on 9/18/24 at 12:50pm, s/he stated there was not enough linen in the facility, the linen is removed from the bed washed and replaced. During an interview with staff # 52 and staff # 53 on 9/18/24 at 2pm revealed there was not enough linen to complete morning care, and they had to frequently wait for laundry to be washed and dried to complete care.</p> <p>During interview with the Administrator on 9/18/24 at 3:30pm, she stated extra linen was ordered; however, the linen continues to disappear.</p> <p>On 9/23/24 at 10am, during a tour the linen closet on the second-floor linen was observed to be stocked with new linens.</p> <p>42782</p> <p>2. On 09/23/24 at 4:38 am two surveyors were doing observation rounds on Promenade unit when the surveyor's noticed an alarm going off. When the surveyor's reached the nurse's station, LPN #39, RN #40, and GNA #41 were at the nurse's station. The surveyor asked if they heard the alarm and what was going on. GNA #41 verbalized there was water going into room [ROOM NUMBER] from upstairs. The surveyors went to room [ROOM NUMBER] and observed water coming through the sprinkler above the light fixture over the sink in the ceiling. The surveyor observed water trickling down the wall in the bathroom behind the commode. There was water on the floor in the bathroom and inside the resident's room. The surveyors went to the Liberty unit and observed a very large puddle of water outside of room [ROOM NUMBER]. GNA #42 was standing at the end of the hall looking at the resident who occupied the room. The resident was trying to figure out what was going on. The surveyor asked GNA #42 if they would assist the resident. GNA #42 verbalized there were no towels or blankets to help absorb some of the water on the floor.</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 - Many</p>	<p>On 09/23/24 at 5:00 am Administrator #1 went to Liberty unit and assisted the resident away from the water outside their room. Administrator #1 verbalized maintenance had been notified of the problem and would be coming to rectify the situation.</p>

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for 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>50904</p> <p>Based on a review of facility investigative material and interview with facility staff, it was determined that the facility failed to ensure that residents remained free of abuse. This was evident for 1 (Resident #151) out of 2 residents reviewed for abuse during the survey.</p> <p>The findings include:</p> <p>The facility's investigation related to facility reported incident MD00198074 was reviewed on 09/24/24 at 12:10 PM. The review revealed that the facility incident report indicated that on 10/03/23, a nurse that was assigned to the floor had made an allegation to the Director of Nursing of staff-to-resident abuse. The incident also stated that Geriatric Nursing Assistant (GNA) #57 was in the hallway collecting all the trays, and Resident #151 had a plate full of food. He/she was taking it down the hallway and the GNA #57 asked the resident, Can I have the plate please, and h/she ignored the GNA. GNA#57 repeated herself and grabbed the plate. Then, the resident took a handful of food and put it down GNA #57's shirt. The GNA said that it was her instinct to get the resident off her, so she pushed the resident off and the resident fell .</p> <p>The alleged incident occurred on 10/03/2023 and the Director of Nursing, DON was notified at 01:31 PM while the Administrator was informed at 2:00 PM and the initial report was sent to the state agency. On the same day, the facility also notified the law enforcement agency, ombudsman and physician. The GNA was suspended immediately pending further investigation and was terminated verbally on the same day. GNA#57 was also reported to the board of nursing. The final investigation report was sent to the State agency on 10/10/2023.</p> <p>On 09/24/24 at 1:10 PM in an interview with Human Resource Manager Staff #32, when surveyor asked why GNA #57's employment was terminated, she stated that GNA #57's employment was terminated because of a substantiated allegation of abuse. She stated that termination of the alleged staff member was done verbally after the staff admitted that she pushed the resident. She also added that a termination letter was not given because the investigation was completed almost immediately after the incident, and she provided a copy of the timesheet for that day which revealed that GNA #57 clocked out at 2:30PM on 10/03/2023 and did not work afterwards.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42863</p> <p>Based on surveyor review of a facility reported incidents, review of medical records, and family and staff interviews, it was determined that the facility failed to report and submit facility related incident reports (FRI) to OHCQ related to injury of unknown origin, serious bodily injury, elopement, misappropriation of resident property and potential employee related abuse towards a resident within the required two-hour framework and failed to submit a follow up investigation report within 5 days. This was evident 9 (Resident #131, #133, #117, #78, #104, #89, #144, #145, #139) out of 38 facility reported incidents reviewed during the survey.</p> <p>The findings include:</p> <p>The OHCQ is the agency within the Maryland Department of Health charged with monitoring the quality of care in Maryland's health care facilities and community-based programs. Allegations of abuse, serious bodily injury, and misappropriation of resident property are to be reported to the OHCQ in a timely manner (within 2 hours for the initial report and within 5 working days for the final report).</p> <p>1. On 09.20.24 at 09:49 AM the surveyor reviewed MD00203928 related to Resident #131. On 09.23.24 at 09:39 AM the administrator stated that she would look for the documentation related to the Resident #131's documented left breast hematoma.</p> <p>On 09.20.24 at 11:00 AM the surveyor reviewed the reviewed the electronic medical record and reviewed the change in condition completed on 02.27.24 and 03.05.24 related to the resident's left breast hematoma of unknown origin. Resident # 131 was originally found to have left breast hematoma on 02.27.24 via a change in condition progress note and reported still present on 03.05.24. The initial facility incident report was dated 03.25.24 which was beyond the required timeline for submission and final facility incident report was dated 04.02.24.</p> <p>2. On 09.19.24 at 11:00 AM the surveyor reviewed MD00195697, related to Resident #133. The Resident #133 eloped from the facility through a resident window on 08.16.23 on or about 9:30 PM. The Resident #133 was a [AGE] year-old, BIMS of 15, and who had been receiving intravenous (IV) antibiotics via an IV (PICC) line. The resident was ambulatory, alert and oriented times three according to the medical at the time of the elopement. However, the initial facility incident report (FRI) was submitted to OHCQ via email on 08.17.23 by the former administrator, staff # 5 which was beyond the required timeline for submission. The final facility incident report was submitted on 08.23.23 at 10:56 PM by staff #5 per the documentation provided by the facility on 09.24.24 at 08:42 AM.</p> <p>3. On 09.21.24 at 4:00 PM the surveyor reviewed MD00206525, related to Resident #117 who currently resided in the facility. The resident accused GNA # 60 of throwing a food tray onto the resident's overbed table and called the resident a derogatory name on 06.08.24. The accusations were substantiated, and the employee was terminated. The facility incident report was not submitted to OHCQ until 06.11.24 by the current administrator.</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 - Many</p>	<p>The surveyor discussed the concerns related to the late submission of facility related reports with the administrative staff on 09.24.24 and 09.25.24 as well as during the surveyor exit interview on 09.26.24.</p> <p>49304</p> <p>4. The facility's investigation related to facility reported incident MD00201088 was reviewed on 9/26/2024 at 7:26 PM. In the investigation, it stated staff found Resident #78 unresponsive. Further review of the initial report documented 12/31/23 at 2:00 PM as the date and time when staff became aware of the incident, 12/31/23 at 3:00 PM as the date and time the administrator was notified of the incident, and 1/1/24 at 5:00 PM as the date and time the initial report was submitted. The initial report was submitted 27 hours after facility staff found the resident unresponsive.</p> <p>On 9/27/24 at 1:26 PM in an interview with the Administrator she stated the latest the incident should have been submitted to the state agency was 12/31/24 at 5pm and confirmed the initial report was submitted 1/1/24 at 5pm. When asked if it was submitted in the required 2 hour time frame, she stated, No.</p> <p>5. On 9/26/24 at 5:52 PM MD00199215 facility investigation was reviewed. In the investigation, it stated staff found Resident #78 unresponsive. The initial report documented 11/5/23 at 10:30 PM as the date and time when staff became aware of the incident, 11/6/23 at 10:00 AM as the date and time the administrator was notified of the incident, and 11/6/23 at 9:15 PM as the date and time the initial report was submitted. The initial report was submitted 23 hours after facility staff became aware of the incident.</p> <p>6. On 9/17/24 at 11:48 AM in an interview with Resident #104's resident representative he/she stated Resident #104's top and bottom dentures have been missing for about one year.</p> <p>On 9/17/24 at 2:10 PM review of the medical record revealed Resident #104 with a documented Brief Interview for Mental Status (BIMS) of 1 out of 15, which indicates the resident has severe cognitive impairment. Further review revealed the resident has multiple diagnoses including dementia. Continued review of the medial record revealed a care plan that documented Resident #104 had the potential for oral/dental health problems related to edentulous (having no teeth) status. Documented interventions included to monitor/document/report as needed any signs and symptoms of oral/dental problems needing attention and to provide mouth care.</p> <p>On 9/18/24 at 1:25 PM in an interview with Geriatric Nursing Assistant (GNA #60) she stated she is Resident #104's GNA and confirmed Resident #104 used to have dentures on the top.</p> <p>The Unit Manager (UM#24) and the Director of Nursing (DON) were interviewed on 9/23/24 at 9:37 AM. During the interview, the UM#24 stated the resident did have dentures when he started about 1 year ago and that the GNAs would clean the dentures. Furthermore, the DON stated when she started working at the facility, facility staff confirmed that Resident #104 had dentures. The DON confirmed that Resident #104's missing dentures were not reported to OHCQ.</p> <p>50457</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 - Many</p>	<p>7. On 09/17/24 at 12:52 PM, during the review of MD00208860, the report revealed that an alleged incident involving abuse of Resident #89 occurred on 8/10/24. The incident was never reported to the state agency.</p> <p>On 09/23/24 at 06:45 AM, the Administrator #1 provided the surveyor with a copy of grievance documents related to the incident involving Resident #89. The Administrator #1 stated that this was the only file concerning the incident and confirmed that no investigation had been conducted. When the surveyor inquired about the reason for not investigating, the Administrator #1 explained that they did not know why it had not been done.</p> <p>8. On 09/18/24 at 2:35 PM, during a review of investigation MD00198955 and review of facility self-report form, it revealed an alleged incident of staff abuse involving Resident #144 occurred on 10/25/23 at 5:00 PM. The incident was reported to the state agency on 10/25/23 at 8:19 PM. Upon further review of the facilities investigation, there were no evidence that the required five-day follow-up report had been completed.</p> <p>On 09/24/24, 09/25/24, and 09/26/24 the surveyor requested the facility's five-day follow-up investigation report involving Resident #144 from the Administrator #1. On 9/26/24 the Administrator #1 explained that the report had been completed by the previous Administrator, but they were unable to locate the follow-up investigation report.</p> <p>9. On 9/20/24 at 12:47 PM, during a review of investigation MD00200065 and review of the facility's self-report form, it was revealed that an alleged incident of staff abuse involving Resident #145 occurred on 11/29/23 at 12:30 PM. The incident was report to the state agency on 11/29/23 at 9:44 PM. Further review of the facility's investigation showed that the follow-up investigation was not submitted until 12/6/23 at 9:24 PM.</p> <p>50904</p> <p>10. A review of intake MD00197034 was started on 09/24/2024 at 9:20 AM revealed that on 09/15/2023, Resident #139's daughter had called the facility and reported to the Administrator that the hospital had informed her that Resident #139 had a fractured rib. The facility also added that on initial investigation no one saw the resident fall and that the resident was currently in the hospital; however, staff were made aware of the occurrence to ensure that it did not happen upon the resident's return. The resident did not return to the facility.</p> <p>A record review of the facility's investigations showed that the resident went to the hospital on 09/11/2023 for being lethargic and hypoxic, however, staff had observed that the resident had bruising and swelling on the face before the hospital transfer. The facility conducted an interview on the staff members who worked with the residents on 09/10/23 and they all stated that they did not observe any bruising or swelling on the face. The facility's staff conducted interviews with the staff members who worked with the resident on 09/11/2023. The following statements were included in the facility's investigation:</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 - Many</p>	<p>Licensed Practical Nurse (LPN) Staff #55 stated that at approximately at 8:15 AM on 09/11/2023 while making his round, he observed Resident #139 lying in bed, alert and easy to arouse He also stated that the resident's left eyelid appeared a little swollen with no sign of distress, breakfast was served and he/she ate about 25% of his/her meal, Geriatric Nursing Assistant (GNA) assisted with Activities of Daily Living (ADL) after breakfast and resident was sitting at the edge of the bed. He added that at 11:40 AM, GNA #56 notified him that the resident was not looking well. He went to assess the resident and found him/her lethargic. He took his/her vital signs. He informed the nurse practitioner who saw the resident and ordered that resident's vital signs be repeated and ordered that resident be transferred to the nearest emergency room via 911.</p> <p>GNA Staff #56 in her statement to the facility on [DATE] stated that while she was helping an agency GNA Staff #25 to receive the report for the shift, they checked Resident #139 and he/she was seen tucked in bed, facing the windows with covers up to his/her shoulder. She added that it was not a little further after breakfast that the nurse told her that he was writing a change of condition on the resident's eye. GNA Staff #56 stated that she went to check on the resident, pulled the covers and noticed that the resident had bruises on his/her eyes, and his/her eyes were also swollen, and his/ her face was sealed shut. She also added that the resident's face was swollen from his/her eyes down to their neck and was not talking or responsive. GNA #56 stated she ran to liberty to get a nurse, and they began care.</p> <p>On 09/24/2024 at 11:57 AM, during an interview with GNA Staff #25, he was asked about the incident with Resident #139. He stated that his shift started from 7-3pm on 09/11/23 and as he was doing his rounds at the beginning of the shift with GNA staff #56, he said he noticed that the patient had bruises and he notified the nurse immediately. He added that the nurse told him to wash the resident up and get him/her ready for transfer to the hospital.</p> <p>On 09/25/2024 at 10:58 AM, the surveyor asked for a copy of the facility's assessment of the resident after the bruising and swelling was observed but the facility stated that they did not have documentation of the assessment after the incident.</p> <p>On 09/25/2024 at 12:09 AM, the Administrator notified the surveyor that she was informed that the hospital had called the facility, and that investigation started after she was told about the fractured rib of the resident. She added that the resident was ambulatory.</p> <p>On 09/25/2024 at 2:44 PM, surveyor reviewed the facility's policy on reporting abuse and it showed Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury".</p> <p>In an additional interview with the Administrator and the Director of Nursing at 3:04 PM of the same day, they were asked about the facility's policies and procedures on injury of an unknown origin and the Administrator stated that any injury of an unknown origin should be reported to the state agency within 2 hours because injury of unknown origin could be a form of abuse. They were made aware that the bruising and swelling incident was not reported to the state agency at all until after the resident's daughter had called to report Resident #139's fracture of the ribs which was four days after the incident.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>42782</p> <p>Based on facility administrative and medical records review and interviews, it was determined that the facility staff failed to complete thorough investigations of an alleged resident to resident abuse incident, injuries of unknown origin and failed to maintain and provide investigation documentation of a facility reported incidents reported to the state agency. This deficient practice was evidenced in 4 of 38 facility reported incidents for residents (#67, #131, #72, #89) reviewed during the survey.</p> <p>The findings include:</p> <p>1. On 09/18/24 at 1:31 pm the surveyor requested to review the facility report for MD00208358 associated with Resident #67. The surveyor provided the resident's name and date the alleged incident occurred to Administrator #1.</p> <p>On 09/23/24 at the surveyor requested to view the investigation for the self-report again.</p> <p>On 09/26/24 1:32 pm Administrator #1 verbalized not being able to find the investigation associated with the self-report.</p> <p>On 09/27/24 at 3:28 pm Administrator #1 verbalized they had been filing the self- reports. An investigation would start immediately after the allegation is made and he/she is responsible for maintaining the investigation in their office.</p> <p>42863</p> <p>2. Review of MD00203928 (FRI) and the MD00203241 on 09.17. 24 at 2:15 PM revealed the resident' family member was contacted by facility staff on 02.27.24 and on 03.05. 24 related to Resident #131's change in condition. The change in condition was related to a hematoma of the left breast, however the facility incident report was not initiated until 03.06.24.</p> <p>Further review of the hard copy radiology ultrasound results report by the surveyor on 09.23.24 at 07:03 AM revealed that on 03.05.24 at 21:34 the examination of Resident #131 revealed a ecchymosis, bruising, hematoma of the left breast, measuring 2.8x2.2 x1.6 cm. and routine screening was recommended. The resident was seen by the nurse practitioner, staff # 45 on 03.05.24 for a follow-up and management of the left breast hematoma.</p> <p>On 09.23.24 at 09:30 AM the surveyor interviewed the administrator and inquired whether the facility was aware of the requirement to report injuries of unknown origin to OHCQ within a two-hour time period. The administrator stated that the facility is now providing education to all clinical staff to report these types of incidents to administration as soon as they occur.</p> <p>The facility failed to initiate a thorough investigation in a timely manner and did not submit a facility incident report within the two -hour timeframe related to the injury of unknown origin to the OHCQ. Additionally, the facility failed to provide the surveyor with copies of the facility report related to MD00203928 prior to the surveyor's exit from the facility on 09.26.24.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>50385</p> <p>3. On 9/18/24 at 04:29 PM, a review of facility reported incident MD00203897 was conducted. The incident report revealed that Resident #72 wandered into Resident #46's room and Resident #46 struck Resident #72 leaving a skin tear the size of quarter on the right cheek.</p> <p>On 9/19/24 at 9:30 AM, this surveyor requested for the facilities investigation from Administrator #1 regarding the incident on 3/21/24 relating to MD00203897.</p> <p>On 9/24/24 at 9:03 AM, this surveyor requested the facilities investigation relating to Resident #72 and Resident #46 from 3/21/24 for the second time.</p> <p>On 9/24/24 at 12:05 PM, an interview was conducted with Administrator #1. When asked if the facility had any record of the incident on 3/21/24, Administrator #1 stated that the facility had no investigation in their records.</p> <p>50457</p> <p>4. On 09/17/24 at 12:52 PM, during a review of complaint investigation MD00208860 it was revealed that an alleged incident occurred on 8/10/24, involving Resident #34 and Resident #89. Resident #89 expressed concerned about potential damage to their personal property.</p> <p>During an interview with Resident #89 on 09/20/2024 at 11:08 AM regarding complaint MD00208860, Resident #89 stated that Resident #34 made a false allegation to the police and facility, accusing Resident #89 of throwing yellow bodily fluids onto Resident #34. As a result of the allegations, Resident #89 reported that they were relocated to a new room. Resident #89 confirmed that their personal property was later returned undamaged.</p> <p>On 09/23/24 at 6:45 AM, the surveyor received a copy of the grievance documents related to the incident from the Administrator #1. The Administrator #1 stated that this was the only file concerning the incident and that no investigation had been conducted. When asked why the incident was not investigated, the Administrator #1 responded that they don't know why.</p> <p>Review of the grievance documents on 09/23/24 at 6:45 AM, revealed a handwritten statement from Resident #34, police report number, admission records for Resident #34 and #89, room transfer and/or new roommate notice for both residents, and a psychiatric progress note for Resident #89. Additional documents included an interview with Resident #34 conducted by Resident Success Manager (RSM) #29 on 8/10/24 at 11:00 PM. Further review of grievance documents showed no written statement or interview from Resident #89 nor any statements from nearby residents or staff members.</p> <p>On 09/24/24 at 09:57 AM, during an interview with RSM #29 regarding the incident between Resident #34 and Resident #89, RSM #29 was asked about the process for handling resident grievances. RSM #29 explained that the incident occurred while they were out of the office. Upon their return on 8/11/24, they were asked to meet with Resident #34 to initiate a grievance process and submit the finding Administrator #1 and Director of Nursing #2, who would then address the concerns.</p>		

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<p>F 0640</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49304</p> <p>Based on review of Minimum Data Set (MDS) Assessment documentation and interview with facility staff, it was determined that the facility failed to transmit MDS assessments within 14 days of completion of the assessment. This was evident for 1 (Resident #124) of 61 residents reviewed during the survey.</p> <p>The findings include:</p> <p>The MDS is a federally mandated assessment tool that helps nursing home staff gather information on each resident's strengths and needs. Information collected drives resident care planning decisions. Each assessment must be encoded within seven days and transmitted within fourteen days of the assessment being performed.</p> <p>On 9/26/24 at 11:21 AM review of the medical record revealed Resident #124 was admitted to the facility on [DATE].</p> <p>On 9/26/24 at 1:54 PM review of the Final Validation Report revealed Resident #124's MDS assessment was not transmitted until 5/3/24. Transmission occurred 37 days after completion of the resident's MDS assessment.</p> <p>On 9/26/24 at 2:11 PM in an interview with MDS Coordinator #50 she stated Resident #124's MDS assessment was transmitted on 5/3/24. During the interview MDS Coordinator #50 confirmed Resident #124's MDS was not submitted within the 14 day time requirement.</p>		

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<p>F 0646</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>21859</p> <p>Notify the appropriate authorities when residents with MD or ID services has a significant change in condition.</p> <p>Based on a medical record review, interview with facility staff, and the resident RP (Responsible Party) it was revealed the facility staff failed to notify the physician in a timely manner of a resident (#135) change in condition. This occurred in 1 of 1 resident reviewed during the survey.</p> <p>The findings include:</p> <p>Review of the investigation of Facility Reported Incident MD00198432, on 9/16/24 at 10:00 AM revealed the following: On 10/7/23 at approximately 3AM Resident #135 complained of heartburn. The resident was assessed by the nurse #59 at least twice during the night shift (11pm-7am) to include review of pain. An antacid medication and pain medication was administered to Resident #135.</p> <p>Review of the medical record on 9/17/24 at 9am revealed at Approximately 5:30am nurse #59 received a call from Resident #135's daughter stating the resident called her complaining of abdominal pain, and if the facility intervention was not effective the resident should be transferred to the hospital. According to the medical record the physician was not contacted regarding the resident complaint of pain until 7am on 10/7/23 at that time the physician gave an order to transfer the resident to the hospital via 911.</p> <p>During an interview on 9/17/24 at 11am, the Administrator staff #1, verified the findings and stated the Nurse staff# 59 was terminated for not following the facility protocols.</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</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** 49304</p> <p>Based on review of medical records and interview with facility staff, it was determined that the facility failed to develop a baseline care plan within 48 hours of residents' admission to the facility and provide the resident and their representative with the baseline care plan. This was evident for 7 (#27, #104, #12, #48, #49, #54, #281)) of 12 residents reviewed for baseline care plans during the annual survey.</p> <p>The findings include:</p> <p>A baseline care plan must be completed within 48 hours of a resident's admission to the facility and must include the minimum healthcare information necessary to properly care for each resident. Completion and implementation of the baseline care plan within 48 hours of a resident's admission is intended to promote continuity of care and communication among nursing home staff, increase resident safety, and safeguard against adverse events (undesirable outcomes) that are most likely to occur right after admission.</p> <p>1. On 9/17/24 at 9:34 AM review of the medical record revealed Resident #27 was admitted on [DATE]. Further review of the medical record revealed the baseline care plan dated 9/1/22, 15 days after the resident was admitted to the facility.</p> <p>On 9/20/24 at 2:31 PM in an interview with the Director of Nursing (DON), she stated the baseline care plan must be completed within 48 hours of admission. During the interview, the DON confirmed Resident #27's baseline care plan was not completed within 48 hours of admission to the facility.</p> <p>2. Resident #104's medical record was reviewed on 9/19/24 at 2:07 PM and revealed the resident was admitted to the facility on [DATE].</p> <p>On 9/20/24 at 2:15 PM review of the baseline care plan provided by the DON was dated 8/27/22, 16 days after Resident #104's admitted . On 9/20/24 at 2:35 PM in an interview with the DON, when asked if the baseline care plan for this resident was completed in the required timeframe she stated, no.</p> <p>50385</p> <p>3. On 9/20/24 at 12:40 PM, an interview was conducted with Director of Nursing (DON). When asked if a baseline care plan given to Resident #12 or their Representative (RP), the DON stated, I cannot provide any documentation confirm that Baseline Care plan was given to RP or resident. The DON provided a care plan meeting sign in from August of 2020.</p> <p>09/20/24 12:49 PM, a review of Resident # 12's chart was conducted. Resident #12 was admitted on [DATE]. No documentation of baseline care plan being given to Resident Representative or Resident was in charts.</p> <p>(continued on next page)</p>

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>4. On 9/20/24 at 11:20 AM, a review of Resident #48's record was conducted. There were no notes or record indicating the baseline care plan was discussed or given to Resident #48 or their Representative.</p> <p>On 9/20/24 at 11:32 AM, an interview with the Director of Nursing (DON). When asked if the baseline care plan was given to resident/resident representative, the DON stated that she would get back to the surveyor with an answer.</p> <p>On 9/20/24 at 12:40 PM, an interview was conducted with the DON. When asked if a baseline care plan was given to Resident #48 or their Representative (RP), the DON stated, I cannot provide any documentation confirm that Baseline Care plan was given to RP or resident.</p> <p>5. On 9/23/24 at 5:12 AM, Resident #49's baseline care plan was reviewed. The Baseline Care plan Assessment was completed, but no signatures from Resident #49 or the resident's representative under the section that states, I have received the above information and understand the content of this information. I understand any updated information will be communicated with me prior to, or at the care plan conference, after the comprehensive care plan is developed.</p> <p>On 9/23/24 at 7:15 AM, an interview was conducted with the Administrator. When asked if the facility could provide evidence that the baseline care plan was given to Resident #49 or their representative, the Administrator stated, We do not have any documentation to confirm resident or the resident's representative was given a copy of the baseline care plan.</p> <p>6. On 9/23/24 at 9:41 AM, Resident #54's baseline care plan was reviewed. The Baseline Care plan Assessment was completed, but no signatures from Resident #54 or the resident's representative under the section that states, I have received the above information and understand the content of this information. I understand any updated information will be communicated with me prior to, or at the care plan conference, after the comprehensive care plan is developed.</p> <p>50457</p> <p>7. On 9/16/24 at 9:36 AM, during the surveyors initial screening of Resident #281, both the resident and a family member reported concerns about removal of the resident' indwelling catheter.</p> <p>On 9/16/24 at 3:28 PM, review of Resident #281's medical records reveal that the resident was admitted to the facility on [DATE] from a local hospital with an indwelling catheter. Further review of the medical records showed that the resident only had a treatment order to maintain a secure device to the urinary catheter every shift. There was no treatment order to assess or monitor the indwelling catheter daily. The records failed to reveal a urinary catheter care plan.</p> <p>On 09/19/24 at 2:57 PM, during an interview with the DON #2 regarding Resident #281's care plan for their indwelling catheter, the DON #2 admitted that she failed to create a baseline care plan because the resident was admitted to the facility without a qualifying urinary diagnosis.</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42782</p> <p>Based on record review and interview it was determined that the facility failed to complete a care plan for a resident who was receiving hospice care and a resident who was receiving oxygen therapy. This deficient practice was evident in 2 (#67 & #129) out of 7 medical records reviewed for care plan during the survey.</p> <p>The findings include:</p> <p>1. On [DATE] at 9:26 am a review of Resident #67's electronic medical record (EMR) revealed the resident was receiving hospice care. Further review of the EMR revealed the resident did not have a care plan for hospice.</p> <p>Review of Resident #67's care plans revealed a care plan was initiated on [DATE] that indicated the resident was a Full Code. Review of Resident #67's MOLST form revealed the resident's code status was No CPR Option B Palliative & Supportive Care.</p> <p>On [DATE] at 11:48 am during an interview with Director of Nursing #2 the surveyor asked if Resident #67 should have a care plan for hospice care. DON #2 verbalized the resident should have a care plan for hospice care.</p> <p>2. On [DATE] at 1:45 pm a review of Resident #126's EMR revealed the resident was prescribed oxygen therapy and did not have a care plan for oxygen that should have been administered. DON #2 was made aware.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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>42782</p> <p>Based on medical record review and interview it was determined the facility staff failed to have quarterly care plan meetings for a resident. This deficient practice was evident in 1(#42) of 3 records reviewed for care plan meetings during the survey.</p> <p>The finding include:</p> <p>On 09/18/24 2:10 pm a review of Resident #42 electronic medical record revealed there were no care plan meeting notes.</p> <p>On 09/19/24 at 9:08 am during an interview with Social Work Assistant #8, the surveyor asked when were care plan meetings held. SW Assistant #8 verbalized they receive a list the end of the month. They call the family and resident to let them know they have an upcoming meeting. The residents are made aware in person a week before the meeting or the morning of the meeting. Care plan meetings are held quarterly; new admissions within 48 hours, then quarterly however SW Assistant #8 revealed they had not been working at the facility for the past three quarters to schedule the quarterly meetings.</p> <p>On 09/19/24 at 2:03 pm during an interview with Social Work Director #9 who verbalized all department heads are supposed to attend the care plan meetings along with the resident, and family. If the family are unable to attend the are invited to participate on the phone. The surveyor and SW Director #9 reviewed the care plan notes; the meetings were not held quarterly. Also, the surveyor asked to review the sign-in sheets for the care plan meeting notes because other disciplines were not mentioned in the notes. SW Director #9 verbalized the other disciplines put their notes in, and the social work notes are added. The resident receives an invite, and the family member gets a phone call. When asked why Resident #42 had not received quarterly care plan meetings, Social Work Director #9 verbalized they identified in August 2024 that the resident was not receiving quarterly care plan meetings.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>42782</p> <p>Based on observations, medical record review and interviews it was determined that the facility staff failed to adhere to professional nursing standards as evidenced by not signing the narcotic form to verify the was completed during change of shift, failed to give resident report to the oncoming nurse, failed to report narcotics were taped in the blister packs, and administering oxygen therapy without a complete order. This was evident for 1 of 1 (Resident #67) reviewed for oxygen and 4 of 6 change-of-shift narcotic counts that were reviewed during the survey.</p> <p>The findings are:</p> <p>1. On 09/23/24 at 9:45 am review of Resident #67's electronic medical record (EMR) revealed on 09/20/24 at 10:08 pm Nurse Practitioner ordered oxygen (O2) nasal cannula (NC) as needed for shortness of breath (SOB). The order did not indicate how many liters of oxygen that should be administered.</p> <p>On 09/23/24 at 9:55 am the surveyor observed Resident #67 in bed with 2 liters (L) of O2 being administered by NC.</p> <p>On 09/23/24 at 10:09 am the surveyor asked LPN #26 to show the surveyor Resident #67's order for oxygen. The surveyor and LPN #26 reviewed the order together. The surveyor asked, how do you know how many liters of oxygen to administer to the resident. LPN #26 verbalized generally the residents are started on 2 liters of oxygen. The surveyor made LPN#26 aware, the order did not indicate how much oxygen the resident should receive.</p> <p>2. On 09/26/24 at 8:21 am the surveyor asked Agency RN #63 if the narcotic count was completed. Agency RN #63 verbalized they did not complete the narcotic count on the [NAME] Cove unit at the beginning of their shift and LPN #26 did not give a report, they just threw the keys to them. LPN #26 did not report to Agency RN #63 the narcotic count was completed. The surveyor reviewed the Controlled Substance Shift Inventory Form and observed the form was incomplete and did not have a signature of the incoming nurse.</p> <p>On 09/26/24 at 9:40 am during an interview with Director of Nursing (DON) #2 the survey asked what the expectation of the nursing staff when counting the narcotics during change of shift. DON #2 verbalized the nurses should count how many narcotics there are and the outgoing and oncoming nurse are expected to sign the form. DON #2 was made aware the narcotic sheet on [NAME] Cove was not signed by the oncoming nurse and there were two medications taped to the blister pack. the DON advised the medication should have been wasted with two nurses but they should not pull it until they are with the resident.</p> <p>On 09/26/24 at 11:23 am the surveyor called LPN #37 who signed the Controlled Substance Shift Inventory Form dated 09/27/24 at 7am. The surveyor asked if the narcotic count was done and why the form was not signed. LPN #37 verbalized the narcotic count was completed during change of shift with LPN #26. The surveyor asked why the form was not signed by the oncoming nurse after the count was completed; LPN #37 did not have an answer. The surveyor asked LPN #37 if they noticed two narcotics were taped in the blister pack. They verbalized, yes. The surveyor asked LPN #37 who was made aware of the issue. LPN #37 verbalized they did not report the problem.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 09/26/24 at 11:32 am during an interview with LPN #26, the surveyor asked if the narcotic count was completed. LPN #26 verbalized completing the narcotic count with LPN #37. The surveyor asked LPN #26 if they completed the narcotic count, why they did not sign the Controlled Substance Shift Inventory Form. LPN #26 verbalized the incoming nurse was supposed to sign the form. The surveyor asked LPN #26 if they noticed two narcotics were taped in the blister pack and if so, was it reported. LPN #26 verbalized the count was correct and they did notice one medication was taped and they did not report the issue to Director of Nursing #2.</p> <p>50904</p> <p>3. On 09/26/2024 at 8:00 AM review of Facility Reported Incident MD00210153 investigation, revealed that on 09/14/24 during the 7:00am-3:00pm shift agency LPN #50 left the medication cart and narcotics box unlocked on the Promenade unit.</p> <p>During change of shift on 9/14/24 at 3:15pm, LPN #50 and LPN# 53 identified there were 4 narcotic pain medications blister packs missing from the narcotic box. The medications belonged to Residents #17, #53, and #115.</p> <p>During a narcotic observation review on 9/26/24 at 08:15 AM on the Promenade unit, surveyor observed Agency Nurse (Staff # 61) during a medication administration pass. The surveyor reviewed narcotic count sheets with Staff #61. There were 4 narcotic count sheets in the narcotic book that were flagged. The medications for the four flagged sheets could not be accounted for. When asked about the unaccounted medications, the Nurse (#61) stated that today was her first day at the facility and she was told by the outgoing LPN #62 that the medications were missing.</p> <p>Further review of the Controlled Substance Shift Inventory Sheet with staff # 61 revealed that on 9/15/24 at 7:00AM, there was no nurse signature for the outgoing nurse, but there was a nurse signature for the incoming nurse. Staff #61 was unable to provide any further explanation.</p> <p>At 8:35 AM, the DON #2 was notified and confirmed that the 4 flagged narcotic sheets were for the missing narcotics for the incident that occurred on 9/14/24 as reported in MD00210153. She stated that the investigation was on-going. The DON (#2) stated that the narcotic sheets should have been removed and proceeded to remove the sheets from the book. She confirmed that there should be a nurse signature in the narcotic book for both the outgoing and the incoming nurse.</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** 42863</p> <p>Based on observations, record reviews and interviews it was determine the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for the residents' highest practicable being. This was evident for 4 of 82 residents (Resident #27, #104, #61) reviewed during the survey.</p> <p>The findings include:</p> <p>1. On 9/17/24 at 3:00 PM, in an interview with Resident #27's Power of Attorney (POA) he/she stated that they had requested Resident #27 have an evaluation to see if they could go from a pureed diet to a mechanical soft diet.</p> <p>Review of Resident #27's medical record on 9/17/24 at 3:10 PM revealed the resident had a Brief Interview for Mental Status (BIMS) of 5 out of 15, which indicated the resident had severe cognitive impairment. Further review of the medical record revealed the resident was diagnosed with dementia.</p> <p>On 9/19/24 at 1:40 PM in an interview with the Director of Rehabilitation #11 she stated that Resident #27 was referred to therapy for a swallow evaluation, but when the Speech Language Pathologist (SLP #33) attempted to do the evaluation, he/she refused. During the interview the Director of Rehabilitation #11 provided a copy of the Screen/Referral Form for Resident #27's swallow evaluation dated 8/28/24, signed by SLP #33, and that documented pt (patient) refused assessment despite education.</p> <p>On 9/19/24 at 1:44 PM review of the medical record did not reveal documentation of Resident #27's refusal nor documentation that Resident #27's POA was notified of the refusal.</p> <p>On 9/19/24 at 1:48 PM in an interview with Director of Rehabilitation #11 she confirmed there was no note from SLP #33 documenting Resident #27's refusal of the swallow evaluation. Furthermore, she confirmed his/her POA was not contacted and also confirmed there was no documentation that the POA was notified. During the interview when asked the expectation if a resident diagnosed with dementia and a BIMS of 5 refused care, she stated the proper parties are contacted so we can have what we need in place to properly treat the resident. Additionally, she stated this resident did not have the capacity to refuse treatment and we should have reached out and contacted his/her POA.</p> <p>On 9/23/24 at 12:00 PM in an interview with the Administrator she was asked if Resident #27's swallow evaluation was completed, and she stated she would let the surveyor know.</p> <p>On 9/23/24 at 1:45 PM in an interview with the Administrator she stated Resident #27's POA was not contacted after his/her refusal on 8/28/24, the swallow evaluation was not completed, and that a new swallow evaluation was scheduled where the POA would come to assist.</p> <p>49304</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>2. Resident #104's resident representative was interviewed on 9/17/24 at 11:48 AM. He/she stated the resident's top and bottom dentures had been missing for about one year. Resident #104's resident representative stated in a meeting with the Ombudsman, the facility said he/she had canceled Resident #104's dental insurance. Resident #104's resident representative stated they never canceled the dental insurance and was then given a packet from the facility of forms to fill out. When the resident representative contacted the dental insurance company from the facility packet, they were told the dental insurance company was not contracted with the facility. After that, the resident representative reported speaking to Unit Manager (UM#24) and he stated this information was shared with the Nursing Home Administrator (NHA) who said she would look into it, but the resident representative had not heard anything since. During the interview, they also stated that Resident #104 had been missing his/her hearing aids for about 8 months and this concern was shared with Resident Success Manager #29.</p> <p>Review of the medical record for Resident #104 on 9/17/24 at 2:10 PM revealed Resident #104 with a documented BIMS of 1 out of 15, which indicated the resident had severe cognitive impairment. Further review revealed the resident was diagnosed with dementia.</p> <p>On 9/18/24 at 1:25 PM in an interview with Geriatric Nursing Assistant (GNA #60) she stated she was Resident #104's GNA and confirmed Resident #104 used to have dentures on the top. She also confirmed that Resident #104 had hearing aids and stated they each had a small loop and were on a wire to keep them from getting lost. GNA #60 advised one morning she went to provide Resident #104's care and one was missing and after she returned from vacation the other one was missing. When GNA #60 asked other staff about the hearing aids, everyone said something different, but they were gone.</p> <p>Continued review of the medical record revealed a care conference note dated 4/19/24 that stated, quarterly care plan meeting was held with resident and Power of Attorney (POA) at bedside. POA expressed her concern about denture she had reported two months ago, and she needed a response from facility administration. Facility administrator agreed to follow up and update her. Further review revealed an Attending Physician Request for Services/Consultation for Resident #104 for denture fitting from Medical Doctor #71 with UM #24 as the nurse who took the order, dated 6/7/24, and a Grievance/Concern Form dated 7/9/24, documented by Resident Success Manager #29 where the POA stated he/she has been asking for over a year about trying to get dentures for Resident #104. Furthermore, Hearing Aid/Assistive Listening Device Delivery Receipt & Purchase Agreement documented that a left and right hearing aid were delivered to the facility on [DATE].</p> <p>On 9/23/24 at 9:37 AM Unit Manager (UM#24) and the Director of Nursing (DON) were interviewed. During the interview, UM#24 stated the resident did have dentures when he started working at the facility about 1 year ago and that the GNAs would clean Resident #104's dentures. He also confirmed Resident #104 had hearing aids and it had been since about October 2023 that she did not have them. The DON stated when she started working at the facility, facility staff confirmed that Resident #104 had dentures, but she had never seen the resident with dentures. The DON then stated the resident's representative canceled his/her dental insurance, so when the facility was trying to get them replaced, he/she did not have insurance and the resident's representative had to reapply for dental insurance. Finally, the DON stated we do need to follow up with the dental provider from the packet not being contracted with the facility, but everything else was followed up on. At the time of survey exit, Resident #104 still did not have dentures or hearing aids.</p> <p>50457</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>3. On 09/17/24 at 12:24 PM, during the review MD00195230 revealed that an alleged incident involving Resident #61, and a broken oxygen tank that occurred on 8/6/23.</p> <p>On 09/19/24 at 9:08 AM, the surveyor observed Resident #61 sitting on the side of their bed with an oxygen concentrator infusing humidified oxygen at 2 liters via nasal cannula. Resident #61 reported a medical history of chronic obstructive pulmonary disease, asthma, being a former smoker, and asbestos exposure. When asked about an alleged incident in August of 2023 related to oxygen, the resident stated they did not recall much about the incident. They reported sitting on the side of the bed working with a geriatric nursing aide, then waking up in the hospital. Resident #61 mentioned they returned from the hospital with oxygen.</p> <p>On 09/19/24 at 10:07 AM, review of medical record progress note dated on 8/6/23 at 11:14 AM, revealed that resident was noted to have had a slight temperature around 6:28 AM. All vital signs were checked. Resident #61 was given as needed pain medication after he verbalized pain of 4 of their shoulder. Further assessment shows the temperature dropped and resident was found sleeping. Then the resident was found shaking in their room at around 8:33 AM and oxygen saturation level was around 89%. Fifth teen minutes later, the oxygen level was observed to have dropped to around 78%. The primary physician was called and reached around 9:33 AM. Emergency responders were called a few minutes later. The resident was taken out to the emergency department at around 9:50 AM. Resident #61's family member was called and informed at 9:51AM.</p> <p>On 09/19/24 at 10:34 AM, review of Resident #61 medication administration record and treatment administration record for July 2023 revealed an order for as needed supplemental oxygen 2-liter via nasal canula for chronic pulmonary disease. The medical record failed to show that Resident #61 was given as needed oxygen as ordered by the doctor. After review of Resident #61's oxygen vital signs in August 2023, the records failed to include documentation of the resident's oxygen levels on 8/6/23.</p> <p>On 09/19/24 at 12:18 PM, during an interview with the DON #2 regarding the progress note from 8/6/23, the DON #2 stated that, based on the information documented in the medical record, the incident appeared to reflect no oxygen had been provided prior to the hospital transfer. The DON #2 stated that they were unable to identify any interventions that were implemented during the time Resident #61 was documented to have low oxygen levels.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50385</p> <p>Based on record review and staff interview, the facility failed to provide supervision to prevent a resident-to-resident altercations and to ensure residents were free of accident hazard devices. This was evident for 3 (Resident #72, #140, #34) of 6 resident's reviewed for supervision.</p> <p>The findings include:</p> <p>1. On 9/16/24 at 02:51 PM, facility reported incident MD00203897 was reviewed. The facility reported a resident-to-resident interaction that happened on 3/21/2024. The report incident stated that Resident #72 wandered into Resident #46's room. Based on the incident detail, Resident #46 struck Resident #72 on the right cheek leaving a quarter size skin tear.</p> <p>On 9/18/24 at 4:27 PM, a review of Resident #72's progress notes was conducted. Review of Change of Condition Assessment note on 3/21/24 stated, [Resident #72] in wheelchair wandered to [Resident #46]'s room [ROOM NUMBER]A. [Resident #46] started yelling get out of my room and punched [Resident #72] on right side of cheek and obtained a superficial skin tear about a size of a quarter. Resident denies pain upon assessment. In the interventions section of the note it states, The two residents were separated immediately and are now being monitored. NP was notified and Bacitracin and Dry dressing was applied until healed. Called police to report the incident. [Police case #]: RP was notified as well.</p> <p>On 9/18/24 at 4:40 PM, Resident #72's care plans were reviewed. There was a care plan with a focus stating, [Resident #72] is an elopement risk/wanderer r/t patient's intrusive behavior and history of wandering into other patient's rooms. This care plan was created and initiated on 10/09/2023. Interventions of this care plan include, Monitor location. Document wandering behavior and attempted diversional interventions in behavior log. Redirect resident if resident is seen attempting to enter another resident's room. Resident to be redirected away to an alternate task</p> <p>On 9/24/24 at 12:05 PM, An interview was conducted with Administrator #1. When asked if the facility had any record of the incident on 3/21/24, Administrator #1 stated that the facility had no investigation in their records.</p> <p>2. On 9/24/24 at 12:32 PM, a review of facility reported incident MD00206040 was conducted. The facility reported that Resident #140 went into Resident #71's room and was struck on the head by Resident #71 causing a laceration on the top of Resident #140's head on 5/24/24.</p> <p>On 9/24/24 at 2:16 PM, a review of Resident #140's care plan and interventions for wandering were reviewed. The focus of the care plan was, [Resident #140] has a behavior problem r/t Wandering the Hall Ways and intermittent screaming. 05/24/2024 - Resident wandered into another resident's room and was hit by the resident.</p> <p>On 9/24/24 at 2:30 PM, a review of the facility's follow-up report was conducted. The report stated that staff were educated on redirecting residents who were wandering into other residents' rooms.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>50457</p> <p>Based on observations, interviews, and record reviews, it was determined that facility staff fail to arrange medical transportation for a resident's follow up appointment. This deficient practice was evident for 1 (#281) of 1 resident reviewed for incontinence during the survey.</p> <p>The findings include:</p> <p>On 9/16/24 at 9:36 AM, during the surveyors initial screening of Resident #281, both the resident and a family member reported that the resident had a scheduled follow up appointment on 09/16/24 at 8:30 AM to have their urinary catheter removed. According to Resident #281, transportation was not arranged, and the resident missed the appointment.</p> <p>On 9/16/24 at 3:28 PM, review of Resident #281 treatment administration records failed to reveal urinary catheter treatments or care plan.</p> <p>On 09/19/24 at 2:57 PM, during an interview with the DON #2 regarding Resident #281's care plan for their indwelling catheter, the DON #2 admitted that she failed to create a baseline care plan because the resident was admitted to the facility without a qualifying urinary diagnosis. When asked about the resident's missed urology appointment scheduled for 9/16/24, at 8:30 AM, the DON #2 explained that Resident #61's follow up appointment was in the resident's paper chart, however, the unit manager failed to arrange medical transportation. The DON #2 was not able to provide further information about the missed appointment.</p>		

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<p>F 0711</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit.</p> <p>42782</p> <p>Based on medical record review and interview with facility staff it was determined that the nurse practitioner failed to ensure physicians documented resident conditions and treatments accurately, write complete orders, address, sign & date pharmacy recommendations, and failed to ensure that physician progress notes were entered into the medical record. This deficient practice was evidenced in 4 (#56, #67, & #129, #139) of 8 resident records reviewed for physician care during the survey.</p> <p>The findings include:</p> <p>1. On 09/24/24 at 8:45 am the surveyor reviewed Resident #56's pharmacy recommendations. The pharmacy reviews for May 2024 were not signed, June 2024 had an unreadable signature without a date, and July 2024 had a date that was scratched out. The recommendation dated 05/06/24 Fluoxetine HCL 20 mg capsule give one tab by mouth one time day for mood was to change the order so the indication was for depression. Review of the medication administration record (MAR) for May 2024, revealed there was no change on the MAR in May or June 2024. The pharmacy recommendation was not addressed by NP #17 prior to the survey.</p> <p>On 09/24/24 at 9:46 am during an interview with Director of Nursing(DON) #2 who verbalized the pharmacy report comes monthly, and they are supposed to go to the psychiatric group and Nurse Practitioner (NP) #17. After they review the recommendation, they will agree or disagree. DON #2 advised they were not doing this before and she was not sure of the process before he/she was hired.</p> <p>2. On 09/20/24 at 10:08 pm Nurse Practitioner #17 wrote an order for Resident #67 to receive Oxygen nasal cannula (NC) as needed for SOB (shortness of breath) every shift for monitoring.</p> <p>3. Review of Resident #129's EMR revealed NP #17 wrote an order on 04/05/24 at 1:18 pm 02 (oxygen) NC x needed for SOB or keep sats above 94%.</p> <p>On 09/25/26 at 3:15 pm during an interview with NP# 17 the surveyor asked NP#17 to review the resident's oxygen orders. NP#17 verbalized the oxygen orders were incomplete because the orders did not indicate the amount of oxygen that should be received. The surveyor reviewed the pharmacy recommendations with NP#17 who confirmed Resident #56's May 2024 pharmacy recommendations were not signed and dated, the signatures on the pharmacy reviews for June & July were illegible signatures, the pharmacy review in June 2024 was not dated, and the pharmacy review for July 2024 had a date that was altered.</p> <p>On 09/25/24 at 11:27 am review of Resident#129's EMR revealed the resident had a diagnosis of Heart Failure on 03/22/24. The Resident had a chest x-ray on 06/20/24 which revealed a moderate right pleural effusion. On 06/27/24 the resident complained of difficulty breathing and a diuretic was ordered. Another chest x-ray was completed which revealed bilateral pleural effusions with bilateral basilar atelectasis (collapsed lungs). The resident's last documented weight was done on 05/03/24 at 5:59 am. NP#17 ordered a diuretic and increased the dosage but did not monitor the effectiveness of the treatment.</p> <p>(continued on next page)</p>		

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<p>F 0711</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>50904</p> <p>4. On 09/24/2024 at 9:20 AM, a review was conducted of facility reported incident investigation MD00197034, and it revealed that on 09/11/2023 Nursing progress note showed that Resident #139 had a change in mental status. Oxygen saturation level was at 85% and he/she was on a non-rebreather mask. Nurse Practitioner, NP Staff #17 was notified. She assessed the resident ordered to be transferred out to hospital via 911. Resident was transferred to the hospital for a change in mental status and hypoxia.</p> <p>On the same day at 10:02 AM, the surveyor reviewed the electronic health record and closed record of the resident and there was no documentation of the NP Staff #17's assessment of the resident's condition at the time of the 9/11/23 hospital transfer in either of the facility records.</p> <p>On 09/25/2024 at 2:51 PM, in an interview with the NP Staff #17, she was asked what she knew about the fractured rib incident with Resident #139 on 09/11/2023. She stated she observed the resident to be in respiratory distress and started the paperwork for the resident to be sent out to the hospital. She also admitted that she saw bruises and the swelling on the resident's eyes but she neither documented the resident's lethargic and hypoxic condition nor documented the bruises and swelling of the eyes and observed on the resident. She stated that she should have documented the assessment and observation on her visit to the resident irrespective of whether the resident was in the facility or was going to the hospital.</p>		

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<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Post nurse staffing information every day.</p> <p>30440</p> <p>Based on observations and interviews with facility staff it was determined the facility failed to ensure that the posted staffing schedule was updated and accurate. This was found to be evident when tours of the facility were conducted during the facility's survey.</p> <p>Findings include:</p> <p>The survey team conducted a tour of the facility on 9/23/24 at 2:15 AM, and observations were made of the Memory Unit located on the second floor. The assignment board which listed the staff assignments was dated 9/22/24 7:00 AM, and had staff #48 as the assigned nurse for the unit and staff #46 and #47 as the assigned GNA's. The nurse who was present and working on the unit was staff #31, and not staff #48. The GNA's who were present and working on the unit were staff #42 and staff # 46. GNA # 47 was not working.</p> <p>An interview was conducted with the nurse #31 on the same date at 2:18 AM and she was asked who was responsible for ensuring that the assignment board was accurate, and her immediate response was, I don't usually work here, I am an agency nurse. The nurse further acknowledged that she received a report from the previous shift nurse (staff # 48) whom she relieved, but did not update the assignment board. The two GNA's (Staff #42 and #46) were at the nurse station during the interview with nurse #31 and they were not wearing name badges. They both told the surveyor their names, when asked, and said that they work for the agency and were not provided with a name badge.</p> <p>An interview was conducted with the NHA on 9/23/24 at 5:30 AM and she made aware that the assignment boards were not accurate and the agency staff were not wearing name badges. At this time the survey team asked her who was responsible for ensuring that the assignment boards are accurate, and that staff, including agency are wearing name badges. She stated that the nurse was responsible for updating the assignment board for accuracy, and that all agency staff have badges from their agency and if they don't have a badge on person, they are to stop at the front desk and get a printed-out sticker and/or create a temporary badge. She stated that staff will be re-educated.</p> <p>All concerns were discussed with the administration team at the time of exit on 9/30/24 at 4:30 PM.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>42782</p> <p>Based on medical record review and interviews it was determined that the pharmacist failed to communicate timely the need to discontinue two unnecessary intranasal medications after the pharmacy review was completed in August and September 2024. This deficient practice was evidenced in 1 (#9) of 2 resident records reviewed for unnecessary medications during the survey.</p> <p>The findings include:</p> <p>On 09/19/24 at 11:28 am a review of Resident #9's medication administration record revealed on 06/16/24 at 12:54 AM an order was written for Flonase 1 spray each Nare one time a day for allergy and on 08/11/24 at 10:38 am an order for Flonase Allergy Relief Nasal Suspension 50 mcg/act 2 sprays in both nostrils one time a day for allergy was ordered which was a duplicate medication order. Further review of the electronic medical record (EMR) revealed both medications were being signed off as given by the nurses.</p> <p>On 09/19/24 at 2:56 pm the surveyor reviewed Resident #9's Electronic Medical Record (EMR) with Pharmacist #23, the surveyor asked why the resident had two different orders for Flonase. Pharmacist #23 verbalized they would take a closer look at the resident's record and get back to the surveyor.</p> <p>On 09/19/24 at 3:12 pm the surveyor asked Agency LPN #3 to pull up Resident #9's EMR for review. Agency LPN #3 verbalized the two Flonase orders appeared to be repeat entries and both were signed off as given. Agency LPN #3 denied giving the medication twice even though it was signed off twice.</p> <p>On 09/19/24 at 3:35 pm in an interview with Pharmacist #23 they advised they spoke with the physician and made a recommendation and it was pending to send the information out. They also advised they had the recommendations sitting since last week and sometimes they are done staggered. They try to make sure everything is updated by the end of the month.</p> <p>Review of Resident #9's Monthly Medication Review dated 09/05/24 at 3:01 pm revealed there were no pharmacy recommendations. Review of the Monthly Medication Review dated 08/02/24 at 1:40 pm revealed there were no pharmacy recommendations.</p>		

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<p>F 0761</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50457</p> <p>Based on record reviews, staff interviews, and review of other pertinent information, it was determined that the facility failed to keep and maintain a safe and effective system for securing and counting narcotic medications. This was evident for 2 out of 7 medication carts reviewed for medication storage.</p> <p>These actions resulted in the finding of an Immediate Jeopardy which was identified on 9/26/24 at 5:45 PM. An IJ summary tool was provided to the facility on [DATE]. The facility submitted a draft of their plan to remove the immediacy on 9/26/24 at 8:36 PM, and it was not accepted. The facility submitted a second draft of their plan to remove the immediacy on 9/26/24 at 9:30 PM, and it was not accepted. The facility submitted a third plan on 9/27/24 at 12:15 AM and it was accepted by the state agency at 9/27/24 at 12:30 AM. After removal of the immediacy, the deficient practice remained with a scope and severity of E.</p> <p>The Immediate Jeopardy was removed on 9/30/24 after on-site confirmation of the completion of the facility's plan of removal.</p> <p>The findings include:</p> <p>1. On 09/26/2024 at 10:16 AM review of Facility Reported Incident MD00210153 investigation, revealed that on 09/14/24 during the 7:00am-3:00pm shift, agency Licensed Practical Nurse (LPN) #50 left the medication cart and narcotics box unlocked on the Promenade unit.</p> <p>During the change of shift on 9/14/24 at 3:15pm, LPN #50 and LPN# 53 identified there were 4 narcotic pain medications blister packs missing from the narcotic box. The medications belonged to Residents #17, #53, and #115.</p> <p>According to the investigation, Unit Manager #24 was notified of the incident on 09/14/24 at 3:23 pm. Unit Manager #24 notified Director of Nursing (DON) #2 on 9/14/24 at 3:38 pm and a facility investigation was initiated.</p> <p>During an interview with DON #2 on 9/26/24 at 12:15 pm it was reported that the Environmental Service (EVS) Director #36 had been informed by EVS employee #51 about an incident involving Resident #78. EVS #51 called after their shift to report she observed Resident #78 remove medication from an opened medication cart on the Promenade unit on 9/14/24 during the 7:00 am-3:00 pm shift. EVS #51 reported to EVS Director #36 that they followed Resident #78 and asked them to return the medication. Resident #78 responded back and stated, It's not my fault they left the cart open. EVS #51 reported that Resident #78 refused to return the medication. EVS employee #51 failed to report the incident until after the end of their shift.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview with the DON and the Administrator on 9/26/24 at 1:00 PM, both confirmed that the resident admitted to taking the medications to the police officer who was at the facility on 9/14/24, which was captured on the officer's body cam. The DON went on to say the resident stated, it's not their fault the nurse left the medication cart open.</p> <p>The DON advised as a result of their investigation the facility placed LPN #50 on a Do Not Return list, and a facility audit was completed on all medication carts to ensure they were locked. All licensed nurses were educated on the importance of securing medication carts properly. Additionally, random observational rounds were being conducted to ensure compliance with medication pass protocols. The involved resident had also been educated about not touching the medication cart.</p> <p>Review of the facility's medication administration policy revealed that areas without automated dispensing systems utilized a substantially-constructed storage unit with two locks and a paper system for 24-hr recording of controlled substance use. Patient-specific controlled substances are stored under double lock until administered to the patient. If any unauthorized person is seen lingering around a location where controlled substances are stored, staff are to call the police and notify their supervisor for such incident.</p> <p>50904</p> <p>2. A narcotic observation during medication administration with Agency Nurse #61 was completed on the Promenade unit on 9/26/24 at 8:15 AM. While reviewing the controlled substance shift inventory sheets, four narcotic count sheets in the narcotic log were flagged, and the medications for those sheets could not be accounted for by Nurse #61. When asked about the missing medications, Agency Nurse #61 stated that it was their first day at the facility, and the outgoing LPN #62 had informed them that the medications were missing.</p> <p>Further review of the controlled substance shift inventory sheet with the Agency Nurse #61 revealed that on inventory sheets on 9/15/24 at 7:00AM, there was no signature from the outgoing nurse, although there was a signature from the incoming nurse. The Agency Nurse #61 was unable to provide any further explanation for the discrepancy.</p> <p>On 09/26/24 at 8:35 AM, the DON #2 was notified and confirmed that the four flagged narcotic sheets were related to the missing narcotics from the incident that occurred on 09/14/24 when Resident #78 took the medications from the medication cart. She stated that the investigation was still ongoing. The DON #2 also noted that the narcotic sheets should have been removed and proceeded to take them out of the book. She further confirmed that there should be signatures from both the outgoing and incoming nurses on the narcotic count sheets.</p> <p>42782</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>3. On 09/26/24 at 8:33 AM, while on the [NAME] Cove Unit, the surveyor and Agency Nurse #63 checked the narcotics for accuracy. The controlled substance shift inventory form dated 09/26/24 at 7:00 AM, was signed by LPN #64, but had not been signed by the oncoming nurse. Agency Nurse #63 and the surveyor observed Resident #22 was prescribed Tramadol 50mg, take half a tablet by mouth every eight hours. Agency Nurse #63 and the surveyor observed one of the tablets had been removed from the blister pack, a pill was replaced and the blister pack was taped shut. Further review of the narcotic count revealed Resident #2 was prescribed Pregabalin 25 mg, take one capsule by mouth every 12 hours for pain. The surveyor and Agency Nurse #63 observed that a capsule had been removed from the blister pack, replaced and taped shut.</p> <p>On 09/26/24 at 11:23 AM the surveyor called LPN #64 to ask if they had completed the narcotic count that morning on [NAME] Cove as the outgoing nurse. The nurse explained that they had completed the narcotic count with another nurse and the count was accurate. When asked if they had noticed two narcotic blister packets taped shut, LPN #64 stated they did not remember. LPN #64 further explained that the narcotic count must be completed with a second nurse, and both nurses are required to sign the sheet. If a narcotic is wasted it must be witnessed by another nurse and signed by both nurses.</p> <p>On 09/26/24 at 11:32 AM, during an interview with LPN #26 on the [NAME] Cove unit, she was asked why she had not signed the controlled substance shift inventory form. LPN #26 explained that the incoming nurse was responsible for signing the form, as they were not working on that side of the [NAME] Cove unit. LPN #26 verbalized the narcotic count was correct. When asked if they had noticed any tape on medication blister packs, LPN #26 reported seeing one blister pack where the medication had been taped in place. The surveyor then inquired if they had noticed that Resident #38 who had been discharged still had narcotics being counted. LPN #26 explained that, typically, medications for discharged residents are removed from the facility every Thursday.</p> <p>An immediate jeopardy was declared on 9/26/24. The provision of the plan to remove the immediacy had a completion date 9/26/24 and included the following:</p> <p>Agency LPN #50: Agency was contacted and notified of the incident, staff member was DNR DO NOT RETURN Date of compliance: 9/14/24</p> <p>Pain assessment will be completed on res #53, and #115, Resident #17 has discharged the facility. Date of compliance: 9/26/24</p> <p>EVS Employee #51 was educated on reporting suspicious activities immediately. Date of compliance: 9/26/24</p> <p>Agency staff #61 was educated on Controlled Substance Administration and Accountability Policy. Specifically, that two nurses signatures are required to reconsolidate the narcotic sheet. Specifically, that two nurses signatures are required to reconsolidate the narcotic sheet. Date of compliance: 9/26/24</p> <p>Agency staff #61: Agency was contacted and notified of the incident, staff member was DNR DO NOT RETURN Date of compliance: 9/26/24</p> <p>Nurse #63 was educated on Controlled Substance Administration and Accountability Policy, specifically not sealing medications with tape once removed from blister pack Date of compliance: 9/26/24</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>DON #2 will be educated on the Controlled Substance Administration and Accountability Policy by the Administrator Date of compliance: 9/26/24</p> <p>LPN #26 has been educated on the Controlled Substance Administration and Accountability Policy specifically on transfer of care process highlighting two nurses must sign off on narcotic sheet. Date of compliance: 9/26/24</p> <p>LPN #26 was educated on not taping meds back into the blister pack. Date of compliance: 9/26/24</p> <p>Identification: The Director of Nursing, Unit Manager, MDS Coordinators inspected all med carts to ensure they were locked, secured, and all discharged and medications were pulled Compliance Date: 9/26/2024</p> <p>System change: The DON, unit managers, supervisors, charge nurses, and/or administrator has educated licensed nursing staff including agency staff on the Controlled Substance Administration and Accountability Policy and locking the narcotic box and their med cart when not in use prior to their next shift. Education will be completed prior to licensed nursing staff's shift. Education is on going. Compliance Date: 9/26/2024</p> <p>Monitoring: Director of Nursing, or designee, will check the medication carts used by licensed nursing staff including agency for five days, weekly for four weeks, and monthly for three months. Compliance Date: 9/26/2024</p>		

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain dental services for each resident.</p> <p>50457</p> <p>Based on interviews, and medical record reviews it was determined that facility staff failed to follow physician orders and fail to schedule dental appointments. This deficient practice was evident for 1 (#120) of 1 residents reviewed for pain during the survey.</p> <p>The finds include:</p> <p>On 09/17/2024 at 09:53 AM, during an interview with Resident #120, the surveyor asked if they have any pain concerns. Resident #120 reported tooth pain in their left upper and lower molars due to cracked teeth. The surveyor asked Resident #120 if they had gone to the dentist to address the cracked teeth, Resident #120 replied No. When ask why, Resident #120 stated they did not know the reason.</p> <p>During an interview with the Director of Nursing (DON) #2 on 09/17/24 at 10:01 AM, the surveyor inquired about Resident#120's cracked teeth and any scheduled dental appointments. The DON #2 responded that they would need to review the resident's chart to provide information.</p> <p>Following the surveyor's inquiry about Resident #120's cracked teeth and dental appointment, a new dental appointment order was placed on 9/17/24 at 10:11am.</p> <p>On 9/17/24 at 10:57 AM, a review of Resident #120's medical record revealed an order dated 7/29/24 at 10:50 AM, for a dental consult regarding left upper tooth pain. Further review of the medical record revealed another order dated 8/20/24 at 12:05 PM, requesting a dental consult for left upper tooth pain.</p> <p>During an interview with the Administrator #1 on 9/19/24 at 1:52 PM, when asked about the dental consults for Resident #120 on 7/29/24 and 8/20/24, the Administrator #1 reported that the facility uses an in-house dental provider who did not accept Resident #120's dental insurance. When the surveyor asked for more information concerning the denial, and any attempts to address the resident's dental issues, the Administrator #1 stated they would look into the matter.</p> <p>On 9/19/24 at 2:11 PM, the Administrator #1 stated that there was no documentation to indicate any attempts were made to find another dental provider after the in-house provider declined Resident #120 dental insurance.</p>		

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<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** 49304</p> <p>Based on observations of the facility's kitchen and food services, it was determined that the facility failed to store food items to maintain the integrity of the specific item and accurately maintain dishwasher temperature logs. This was evident during the initial tour of the kitchen.</p> <p>The findings include:</p> <p>1. On [DATE] at 7:57 AM initial observations were made in the facility's kitchen. Dietary [NAME] (DC #75) stated she was the staff in charge as the cook until the Dietary Manager (DM) comes in. After surveyor observations in the kitchen, freezer and refrigerator, observations with DC #75 revealed the following:</p> <p>At 8:12 AM, the walk-in refrigerator had ham covered very loosely with saran wrap open to air and undated. When asked about the expectations for food storage, she stated it was supposed to be in a Ziplock bag and dated. There were 2 logs of ground beef without an expiration date. When the surveyor asked DC #75 what the expiration date of the ground beef was, she stated, there is not one. The surveyor asked how staff would know if it were safe to serve to residents and she stated, I do not know.</p> <p>Continued observations with DC #75 revealed most of the food products had a blue label with two date stacked horizontally one on top of the other. When asked to clarify the dates on the labels she stated the first/top date is the date the food was opened, and the second/bottom date is the expiration date. There was a box halfway filled with waffles with the first/top date [DATE] and the second/bottom date, expiration date [DATE] and an entire case of oat milk and half a case of prune juice with an expiration date of [DATE]. DC #75 stated that the stock person was labeling wrong, and the products were actually not expired. However, on closer inspection, there was large plastic container of pickles and the expiration date on the container was [DATE]. DC #75 confirmed they were expired. There was celery in an unsealed, open to air plastic bag that was all brown on the first 2 inches of the celery stalks and with an expiration date of [DATE], which DC #75 also confirmed as expired.</p> <p>At 9:04 AM, the walk-in freezer observation revealed 8 bags of hamburger and hotdog buns that were undated. Dietary Manager (DM) #72 confirmed, No I did not see an expiration date on any of the hot dog or hamburger buns in the freezer. As the surveyor and DM #72 were exiting the walk-in freezer, an open jar of jelly was observed in a Tupperware container of spices. The surveyor picked up the container which read, Refrigerate after opening. DM #72 confirmed the jelly should have been refrigerated. In addition, one of the loaves of bread on the vertical cart had an expiration date of [DATE] and there was mold on it. DM #72 confirmed the mold and disposed of the bread.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Patapsco Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 9109 Liberty Road Randallstown, MD 21133	

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. At 9:28 AM, in an interview with DM #72 when asked who was responsible for signing the dishwasher temperature logs, she stated she signed them. The surveyor pointed to the Dishwasher Temperature/Chemical Record for the month of [DATE] and noted [DATE]-15, 2024 had temperatures documented for breakfast, lunch and dinner's wash and rinse cycle. During the interview, DM #72 stated that all the recorded temperatures on the log were recorded by her. The surveyor reiterated the question and again asked if all the recorded temperatures were written by her and she stated, yes. However, when asked if she worked on Saturday, [DATE], she stated, no. When asked how she was able to observe the wash and rinse cycles for breakfast, lunch and dinner to document temperatures, she stated she asked the Sunday cook if the dishwasher was working ok and was told yes. When asked how she was able to determine the very specific temperatures recorded on the sheet, she stated, well, that's what it has usually been running.</p>

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<p>F 0838</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42782</p> <p>Based on record review and interview it was determined that the facility staff did not update the facility assessment to reflect how the facility with address all the needs of the residents. This deficient practice was discovered during the survey.</p> <p>The findings include:</p> <p>On 09/30/24 at 1:15 pm the surveyor reviewed the facility assessment and noticed the facility manager was not updated to reflect the current facility manager. The diagnoses that the facility staff can manage did not reflect the residents who were currently residing within the facility. The facility currently housed residents who receive wound care, and had compromised musculoskeletal system. There was no mention of the residents' acuity levels the facility was able to manage. The assessment did not mention how the ethnic, cultural, or religious factors of the current residents or potential residents are addressed or will be addressed. The staffing plan did not indicate how many nurses and geriatric nursing assistants are needed to care for the residents. The staff training, education, and competencies did not completely reflect the competency form provided to the surveyor by Director of Nursing #2. The competency and skills checklist did not completely reflect current residents and/or potential residents. There were no policies and procedures for provision of care included in the assessment. There was no mention of how the facility plans to recruit and retain nurse practitioners who are adequately trained and knowledgeable in the care of the residents. NP#17 is currently working in the facility.</p> <p>On 09/30/24 at 3:30 Administrator #1 provided an updated copy of the facility assessment dated [DATE]. The surveyor reviewed the facility assessment with Administrator #1 and verbalized the assessment had missing information.</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>21859</p> <p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>Based on a review of the facility investigation, medical record, interviews with facility staff and other pertinent documentation it was determined that the facility nursing staff failed to document the administration of medication and failed to have updated and accurate records of the residents' belongings in the medical record. This was true for 3 of 4 residents (Resident #135, #42, #111) reviewed during the survey.</p> <p>The findings include:</p> <p>1. Review of the investigation of Facility Reported Incident MD00198432, on 9/16/24 at 10:00 AM revealed the following that on 10/7/23 at approximately 3am Resident #135 complained of heartburn. The resident was assessed by the nurse (staff #59) at least twice during the night shift (11pm-7am) to include review of pain. An antacid medication and pain medication was administered to Resident #135. Review of the medical record on 9/17/24 at 9am revealed at Approximately 5:30am staff #59 received a call from Resident #135's daughter stating the resident called her complaining of abdominal pain, and if the facility intervention was not effective the resident should be transferred to the hospital. The physician was contacted and gave an order to transfer the resident to the hospital via 911.</p> <p>Continued review of the medical record, Medication Administration Record and progress notes failed to reveal an order for an antacid medication or pain medication, therefore the medications were not signed off as being administered.</p> <p>During an interview with the Director of Nursing on 9/17/24 at 11am, she stated she was not employed at the facility during that time.</p> <p>During an interview with the Administrator on 9/17/24 at 11:30am, she provided an Employee Counseling Form for staff #59 dated 8/16/23 which stated, Final Warning-orders received for Tums 500mg for heartburn and Tylenol 500mg for pain but not documented. When asked why the Counseling form was dated 8/16/23 (2 months prior to the incident) she stated the date was an error.</p> <p>42782</p> <p>2. On 09/20/24 at 10:59 am during an interview with LPN Unit Manager #24 the surveyor asked what the process was for managing resident's personal items when they are in the facility. LPN Unit Manager #24 verbalized when a resident is admitted to the facility the staff must complete the Inventory of Personal Effects form; the form is in the residents' paper chart. If the residents receive items while in the facility, the form is updated.</p> <p>On 09/20/24 at 11:10 am the surveyor checked the Resident #111's paper chart located on the unit, and the Inventory of Personal Effects form was not in the resident's paper chart.</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>On 09/20/24 at 11:20 am the surveyor checked Resident #42's paper chart, and the Inventory of Personal Effects was in the chart. The surveyor compared the list to the items visualized in the resident's armoire. The resident also had a plastic bag with clothing on top of the armoire. The form did not coincide with the resident's belongings. The resident had more belongings that were documented on the form.</p> <p>On 09/20/24 at 1:23 pm the surveyor made Unit Manager #24 aware Resident #111 did not have a Inventory of Personal Effects form in their chart and Resident #42 did not have an updated Inventory of Personal Effects form in the chart to reflect the resident's actual belongings.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30440</p> <p>Based on observations and interviews with facility staff it was determined the facility failed to adhere to infection control practices and guidelines linen management and for resident's residing in the facility. This was found to be evident for 1 (Resident # 15, #2) of 77 residents observed during observations made during the survey.</p> <p>The findings include:</p> <p>1. During a random observation of the facility on 9/23/24 at 2:15AM the following observations were made while on the second floor. Room # 213 had two cover pads on the floor with a medium size dark brown substance protruding through the top of the cover pads. Flies were observed in the room [ROOM NUMBER] and landing onto the Resident (#15). Staff at the nursing station were made aware of the observations. The NHA was made aware of the findings on the same date at 5:30AM.</p> <p>All concerns were discussed with the Administration team at the time of exit on 9/30/24 at 4:30PM.</p> <p>42782</p> <p>2. On 09/16/24 at 10:35 am the surveyor entered the elevator on the first floor and observed two female employees on the elevator with bags of linen in the hands. The elevator went to [NAME] Cove located on the ground level. The two female employees got off the elevator and entered the laundry room. The surveyor walked down the long hall on [NAME] Cove, then went to the laundry room. At 10:39 am the surveyor entered the laundry room and observed uncovered linen on three linen carts and four bags of blankets wrapped in plastic on the floor in front of the room where the washing machines were located.</p> <p>On 09/24/24 at 7:42 am during an interview with Employee Success Manager #10 the surveyor asked why the laundry was placed on the floor. Employee Success Manger #10 verbalized they handed it over to the laundry person; they needed to supply linen and didn't know where it was stored. They don't know how it got on the floor.</p> <p>3. On 09/20/24 at 10:46 am the surveyor went to Resident #2's room and observed urine and stool inside a plastic bag inside the pail of the bedside commode. Geriatric Nursing Assistant (GNA) #34 was in the resident's room providing Activities of Daily Living (ADL) care. Later the same day when entering the room with Director of Nursing #2, the surveyor asked GNA #34 where they put the bag with the resident's urine and excrement. GNA #34 verbalized discarding the bag with the resident's waste in the trash can.</p> <p>On 09/20/24 at 2:40 pm Director of Nursing #2 and the surveyor entered Resident #2's room and observed Environmental Services Director #36 standing on the resident's bedside commode.</p> <p>On 09/23/24 at 6:03 am the surveyor asked EVS Director #36 why they were standing on Resident #2 bedside commode. They verbalized that incident was totally out of their character.</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep all essential equipment working safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42782</p> <p>Based on observations and interviews it was determined that the facility staff failed to keep the facility in good operating condition. This deficient practice discovered on the [NAME] Cove unit during the survey.</p> <p>The findings include:</p> <p>On 09/16/24 at 8:19 during observation rounds the surveyor checked the shared bathroom in room [ROOM NUMBER] and observed urine and excrement in the commode. The surveyor attempted to flush the commode, and the commode contents almost overflowed onto the floor. At 10:56 am the surveyor observed the trim below the window on the floor in the Dayroom located on [NAME] Cove unit.</p> <p>At 11:25 am the surveyor observed Resident #2 in bed exposed. Agency LPN #3 attempted to pull the privacy curtain over to cover the resident, but the curtain was unable to be fully extended. Afterwards the surveyor made Agency LPN #3 aware the commode in room [ROOM NUMBER] was clogged and unable to be flushed.</p> <p>On 09/16/24 at 12:12 pm the surveyor observed Regional Director of Operations #5 pushing the trim under the window in the Dayroom on [NAME] Cove with their shoe.</p> <p>On 09/19/24 at 9:01 am during an interview with Maintenance Director #70 they verbalized the floor techs were supposed to take care of the curtains, and they are in the process of developing a preventative maintenance schedule. They use TELS system to address maintenance concerns; currently they are all over the building right now.</p> <p>On 09/23/24 at 9:24 am during an interview with Director of Nursing #2 they verbalized Maintenance and Environmental Services should make sure the curtains fit before they are installed, and the nursing staff are the second line of defense.</p> <p>On 09/23/24 at 2:15 am during observation rounds the surveyor noticed the call bell was on outside of room [ROOM NUMBER] on [NAME] Cove unit. LPN #37 verbalized they removed the light. When they started their shift, the light was on and they think it was removed because it was hypersensitive.</p>