

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215112	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/12/2024
NAME OF PROVIDER OR SUPPLIER Lorien Health Systems - Columbia		STREET ADDRESS, CITY, STATE, ZIP CODE 6334 Cedar Lane Columbia, MD 21044	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>43096</p> <p>Based on record review and interviews with staff, it was determined that the facility failed to ensure that the allegations of injury of unknown, and alleged abuse were reported to the state agency within the required timeframe. This was evident for two (Resident #75 and #89) of seven residents reviewed for injury of unknown origin during the facility's recertification survey.</p> <p>The findings include:</p> <p>1) On 6/25/24 at 8:31 AM, the surveyors investigated Facility Self-Reported incident MD00201951. The incident was about Resident #75, who had left arm swelling noted on 1/25/24 at 9 PM, and an X-ray revealed an acute fracture of the proximal/mid humerus.</p> <p>Further review of Resident #75's medical records on 6/25/24 at 8:59 AM revealed that an assigned nurse of Resident #75 initially observed bluish discoloration on the lower and upper left arm accompanied by pain and swelling on 1/25/24 at 8:50 PM. The physician was notified and ordered an X-ray of the left arm at 9:20 PM on 1/25/24. Resident #75's electronic medical record showed that the X-ray was taken on 1/26/2024 at 3:29 PM, and the result was reported at 6:36 PM on the same day as an acute fracture of the proximal/mid humerus. The resident's change in condition form written on 1/26/24 at 10:43 PM addressed that the X-ray result was reported to the physician at 9:30 PM, family members were notified at 10:00 PM and transferred to the hospital at 10:30 PM on 1/26/24.</p> <p>On 6/25/24 at 10:53 AM, an interview was conducted with the Nursing Home Administrator (NHA). The NHA recalled the incident on 1/25/24 about Resident #75's left arm fracture. She said, We didn't know exactly what happened due to the resident's poor cognition. The resident said he/she fell , and the bruise was noted on the hemiplegic arm. The nursing managers thought it was a positioning issue. The NHA confirmed that the facility staff became aware of this incident on 1/26/24 at 9:50 PM; they left a message, and the NHA woke up at 2 AM to see the message, then submitted an initial incident report on 1/27/24 at 2:30 AM.</p> <p>During the interview, the NHA was asked about the time documented on Resident #75's X-ray as 'reported' in the electronic medical record. She confirmed that it was the time that the staff received the report. The surveyor expressed concerns about the time gap from which the Xray was reported (1/26/24 at 6:36 PM) vs. when the staff became aware of the incident (1/26/24 at 9:50 PM). No answer provided to the surveyor. The NHA validated the surveyor's concern about delayed reporting time about the resident's unknown origin injury.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 215112
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>48168</p> <p>2) On 7/11/24 at 10:10 AM - the Director of Nursing (DON) provided the facility's investigative file for the facility reported incident # MD00207560, which alleged that on 7/06/24 at approximately 5 pm, Resident #31 abused Resident #89.</p> <p>On 7/11/24 at 11:15 AM a review of the facility's report investigation file was conducted. The file contained the self-report to the Office of Health Care Quality (OHCQ) which indicated that the initial report was made on 7/08/24 at 9:05 AM by the Nursing Home Administrator. The facility's investigation concluded that no abuse or injury occurred, and the surveyor's review concurred with that finding. However, the incident was reported more than 2 hours after the required timeframe.</p> <p>On 7/11/24 at 1:40 PM an interview with the Assistant Administrator (Staff #17) was conducted to review the incident and the facility's investigative file documents and pictures. Staff #17 confirmed that the incident of alleged abuse occurred on 7/06/24 at approximately 5:00 PM but was not reported to OHCQ until 7/08/24 at 9:05 AM, which was not compliant with the 2-hour reporting requirement. Staff #17 confirmed this finding.</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>50502</p> <p>Based on a review of the facility investigations, interviews, and record reviews, it was determined that the facility failed to thoroughly investigate an injury of unknown origin and an elopement incident. This was evident for 2 (Resident #75 and Resident #109) of 19 residents reviewed for Facility Reported Incidents during a recertification survey.</p> <p>The findings include:</p> <p>Wanderguard is a wandering management system. The system used a wearable bracelet to monitor residents. A WanderGuard system relies on three components: bracelets that residents wear, sensors that monitor doors and a technology platform that sends safety alerts in real time . When a resident with a bracelet approaches a monitored door, the system alerts.</p> <p>1) On 6/25/24 at 8:31 AM, the surveyors investigated Facility Self-Reported incident MD00201951, an injury of unknown origin. The review revealed that on 1/25/24 at 8:50PM, Resident #75 was initially observed with bluish discoloration on the lower and upper left arm accompanied by pain and swelling. The physician was notified and ordered an Xray to the left arm at 9:20 PM on 1/25/24. The result was received on 1/26/24 at 6:36PM and indicated an acute fracture of the proximal to mid humerus. Physician was notified and ordered to transfer the resident to the hospital for further treatment. Further review of the facility's investigation packet revealed that 9 staff members were interviewed and no issues were reported. The facility conducted education for safe transfers, positioning of patients during care on 1/29/24, which was attended by 16 staff members and an inservice providing education for restraining of residents which was also attended by 17 staff members. However, the facility did not provide any other documentation of interviews with other residents.</p> <p>On 6/25/24 at 10:53 AM, during an interview with the Administrator, she stated, we didn't know exactly what happened to Resident #75 due to the resident's poor cognition. Resident said he/she fell , and a bruise was noted on the hemiplegic arm. The nursing managers thought it was a positioning issue, the resident is usually resistive during positioning, he/she usually pulls outwards during care, he/she wears onesies. The Administrator was not able to figure out what happened. The surveyor asked the administrator how the facility investigates an injury of unknown origin. The administrator said, typically staff reports the incident to the doctor, then to the supervisor and then to the administrator. Normally the administrator and the DON completes the self-report. We usually interview the resident and the staff. The surveyor further asked the administrator if other residents were interviewed after the incident. The Administrator stated, historically they didn't interview other residents, but recently started interviewing other residents after their sister facility recommended doing so. She added, I think it's a good practice to interview the roommate then other residents.</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>2) On 6/26/24 at 12:50 PM, surveyors investigated Facility Self-Reported incident MD00203918. Resident #109 had an elopement incident on 3/22/24 around 9:30 AM. The self-report form indicated Resident #109 cut off his/her wander guard and eloped from the facility building through the main entrance door by following another visitor. At 10:30 AM, the resident was brought back to the facility. Further review of the facility's investigation packet revealed that it contained the facility's interventions such as elopement drills, staff education, family education when signing out, 1:1 sitter, providing the resident with plastic silverware, and room change. However, the facility failed to put interventions to address the frequent cutting of the wanderguard, and how the resident came back to the facility.</p> <p>On 6/26/24 at 2:16 PM, an interview was conducted with the Director of Nursing (DON) and the Administrator. The administrator stated, Everything went wrong, it was a perfect storm for this resident. Resident #109 was recently moved to another unit, he/she looks like a visitor. The resident had a wandering issue and we applied a wanderguard. However, he/she frequently cuts the wanderguard using a makeshift cutter. The resident went out from the facility using a walker and was wearing his/her jacket and brought a grocery bag. An hour later he was brought back by a good Samaritan. Head to toe assessment was documented. No injuries noted.</p> <p>On 6/26/24 at 2:16 PM, during an interview with Administrator, the surveyor asked for any documentation on how Resident #109 was found/returned to the facility. Administrator said, a good Samaritan brought him/her back to the facility. The surveyor verified that there was no documentation about the resident's returning.</p> <p>On 6/26/24 at 2:30 PM, during an an interview with Administrator, the surveyor shared the concern regarding lack of investigation about how Resident #109 cut the wanderguard, and how he/she returned to the facility. The Administrator validated the concern.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>42886</p> <p>Based on medical record review and interview, the facility failed to provide adequate pressure ulcer management for a resident (resident #553). This was evident in 1 of 14 residents reviewed when investigating facility reported incidents and complaints during the facility's recertification survey.</p> <p>The findings include:</p> <p>Review of resident #553's medical record on 7/9/24 at 11:45am revealed the resident was admitted to the facility with a stage two sacral pressure wound. Continued review of the resident's medical record revealed that the resident's sacral pressure wound continued to worsen until the resident was assessed with a stage 4 sacral pressure wound approximately eight weeks later. Further review of the resident's medical record revealed that the facility failed to provide adequate pressure wound management treatments to attempt to prevent the worsening of the resident's sacral wound for approximately 8 weeks. The resident's attending provider ordered specialized wound care treatment after the resident was assessed with a stage 4 sacral pressure wound.</p> <p>Interview with the Director of Nursing on 7/9/24 at 1:00pm revealed that the facility admitted to failing to provide preventative wound care treatment to prevent the worsening of resident #553's sacral pressure wound from a stage two pressure wound at admission to a stage 4 pressure wound approximately 8 weeks later. The surveyor expressed concern for the facility's failure to provide adequate pressure wound management. The DON understood and provided no additional information on the deficient practice.</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>50502</p> <p>Based on a review of the facility investigation, resident medical records, other pertinent documentation, interviews, and observations, it was determined that the facility failed to provide ongoing supervision/intervention to address a resident who was known to have exit-seeking/elopement behaviors. This was evident for 1 (Resident #109) of 2 residents reviewed for elopement during the survey.</p> <p>The Maryland Office of Health Care Quality (OHCQ) determined that this concern met the Federal definition of Immediate Jeopardy. After the incident, the facility implemented effective and thorough corrective measures. The facility's plan and action were verified during this survey; therefore, this deficiency will be cited as past noncompliance. The date of correction was 3/22/24.</p> <p>The findings include:</p> <p>Wanderguard is a wandering management system that monitors residents using a wearable bracelet. The system relies on three components: bracelets that residents wear, sensors that monitor doors, and a technology platform that sends real-time safety alerts. When a resident with a bracelet approaches a monitored door, the system alerts.</p> <p>On 6/27/24 at 10 AM, a review of Resident #109's medical record revealed that the resident had wandering and exit-seeking behavior since his/her admission in December 2023. The progress notes were documented as follows:</p> <p>1/05/24 at 9:30 AM: The resident was found on the 1st floor.</p> <p>1/07/24 at 2:48 PM: The resident wandered around the unit (2nd floor).</p> <p>3/06/24 at 10:00 PM: The resident entered another resident's room.</p> <p>3/12/24 at 9:42 AM: The resident entered another resident's room.</p> <p>3/14/24 at 3:00 PM: the resident entered another resident's room.</p> <p>3/17/24 at 2:48 PM: the resident went to the 3rd floor via elevator.</p> <p>Further review of Resident #109's medical records revealed that the facility had applied a wander guard on the resident since 1/15/24. However, the resident's progress note revealed that Resident #109 removed/cut the wanderguard several times, as below:</p> <p>wanderguard not on: 1/22/24, 2/29/24, 3/1/24, 3/17/24</p> <p>wanderguard removed: 3/19/24, 3/22/24, 3/25/24</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 6/26/24 at 12:50 PM, surveyors investigated Facility Self-Reported incident MD00203918. Resident #109 had an elopement incident on 3/22/24 around 9:30 AM. The self-report form indicated that Resident #109 cut off his/her wanderguard and eloped from the facility building through the main entrance door by following another visitor. At 10:30 AM on 3/22/24, the resident was brought back to the facility by a good samaritan.</p> <p>On 6/26/24 at 2:16 PM, an interview was conducted with the Director of Nursing (DON) and the Administrator about Resident #109's elopement incident on 3/22/24. The Administrator stated, Everything went wrong. It was a perfect storm for this resident. Resident #109 recently moved to another unit, and [he/she] looks like a visitor. The resident had a wandering issue, so we applied for a wanderguard. However, [he/she] frequently cuts the wanderguard using a makeshift cutter. The resident went out of the facility using a walker, was wearing [his/her] jacket, and brought a grocery bag. An hour later, [he/she] was brought back by a good Samaritan. Head-to-toe assessment was documented. No injuries noted. The DON and Administrator also stated that after the incident, Resident #109's room was changed on 3/22/24 to one of the rooms at the end of the hall and the resident has to pass the nursing station to get out of the building. Also, the Administrator stated that the facility hired a 24-hour 1:1 sitter for the resident for a month, and continued a 1:1 sitter for 12-hour shifts (7 AM to 7 PM) until 5/30/24.</p> <p>On 6/26/24 at 2:50 PM, surveyors observed Resident #109 lying in bed with a wander guard on his/her left ankle. The resident greeted the surveyors but was not able to express his/her concerns. The resident appeared well-groomed, was wearing appropriate clothing, and was able to mobilize him/herself with a walker under staff supervision.</p> <p>On 6/27/24 at 7:11 AM, in an interview with the DON, he confirmed that no additional elopement episodes occurred since March 2024 in this facility including Resident #109.</p> <p>On 6/28/24 at 10:08 AM, Resident #109 was observed sitting in the dining room without the wanderguard on.</p> <p>On 06/28/24 at 10:09 AM, an interview with the assigned Licensed Practical Nurse (LPN #55) confirmed that Resident #109 was not wearing the wanderguard. LPN #55 stated, The resident took it off; 11-7 shift nurse reported that the resident took the wanderguard off early this morning.</p> <p>On 6/28/24 at 10:16 AM, an interview with the Unit Manager (Staff #9) revealed that the night shift nurse reported that Resident #109 took the wanderguard off this morning. Staff #9 further stated, Since he/she only goes to the station and has been calm recently, we are trying to evaluate the resident. He/she wanders from his/her room to the nurse station but not further. We plan to get an order from the doctor to discontinue the wanderguard order.</p> <p>On 6/28/24 at 10:28 AM, an interview with the Maintenance director (Staff #10) revealed the wanderguard sensors are located in all the elevators on each floor and the front door. Surveyors toured with Staff #10 within the facility and tested all the wanderguard sensors, including elevators and each door, and did not find any issues.</p> <p>On 7/01/24 at 8:04 AM, during an interview with the Registered Nurse (RN #5), he/she stated, We think Resident #109 cuts the wandering guard using a plastic knife; the resident gets the knife from the food tray. RN #5 confirmed the mobility status of Resident #109 as supervision with a walker.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 7/01/24 at 8:09 AM, an interview with Unit Manager (Staff #9) revealed that the resident got plastic knives from a tray. Staff #9 further stated that the staff ensured that they checked for the plastic knife when they retrieved the tray. Staff #9 also said, Nobody has seen Resident #109 actually using the knife to cut the bracelet. The wanderguard that was removed was found in his/her drawer with plastic knives, so we assumed he/she cut it with a knife. He/she was a veteran and so smart. After the 3/22/24 elopement incident, we changed the silverware to plastic ones.</p> <p>On 7/03/24 at 2:00 PM, the surveyor reviewed and verified the completion of the facility's plan of action, which was formulated in response to the 3/22/24 incident, which included a Quality Assurance (QA) meeting held on 3/22/24 with Administrator, Medical Director, DON, QA nurse, unit managers, Security staff and Maintenance, and the following interventions completed by 3/22/24:</p> <ol style="list-style-type: none"> 1. Assessment of the resident for injury on return and documented. 2. Notified the Responsible Party and provider. 3. The resident was placed on 24-hour 1:1 sitter on 3/22/24 for a month and continued a 1:1 sitter for 12-hour shifts (7 AM to 7 PM) until 5/30/24. 4. Completed wandering/elopement risk assessment, pain, fall, Patient Health Questionnaire 9(PHq9), and Brief Interview of Mental Status(BIMS) assessment. (PHq9- is a self-report tool used to screen, diagnose, monitor, and measure the severity of depression in adults. BIMS- is a standardized assessment that helps identify a patient's cognitive patterns and impairment.) 5. Social work evaluation completed. 6. The resident was started on plastic silverware. 7. The room was changed to be on the other side of the nurse's station. 8. Check the wanderguard system to ensure door alarms when the wanderguard is present. 9. All wanderguards in the facility were checked for placement and tested . 10. Elopement assessments for all residents will be reviewed to ensure accuracy and completion. 11. 138 Staff members received education on elopement policy and expectations. Staff will receive education on hire, annually, and as needed. 12. Drills will serve as education and competency assessments. 13. Education to families regarding signing out. 14. Front desk drills for alertness. 15. Photos of residents at risk of elopement are posted on the left upper wall inside the front desk station and photos of residents at risk of elopement posted at the nurses ' station. <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>16. Elopement binder located at the front desk</p> <p>During an interview with the Administrator and the DON on 7/05/24 at 9:04 AM, the surveyor informed that Resident #109's elopement incident was considered as Past Non-Compliance Immediate Jeopardy.</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</p> <p>50502</p> <p>Based on a review of the facility investigation, record review, observation, and interview, it was determined that the facility failed to identify and provide appropriate treatment and services to assist residents in attaining their highest practicable mental health. This was evident for 1 (Resident #109) of 5 residents reviewed for behavior-emotional well-being during the annual survey.</p> <p>The findings include:</p> <p>Wanderguard is a wandering management system that monitors residents using a wearable bracelet. The system relies on three components: bracelets that residents wear, sensors that monitor doors, and a technology platform that sends real-time safety alerts. When a resident with a bracelet approaches a monitored door, the system alerts.</p> <p>On 6/26/24 at 12:50 PM, surveyors investigated Facility Self-Reported incident MD00203918. Resident #109 had an elopement incident on 3/22/24 around 9:30 AM. The self-report form indicated that Resident #109 cut off his/her wander guard and eloped from the facility building through the main entrance door, following another visitor. At 10:30 AM, the resident was brought back to the facility.</p> <p>On 6/26/24 at 2:16 PM, an interview was conducted with the Director of Nursing (DON) and the Administrator about Resident #109's elopement incident on 3/22/24. The Administrator stated, The resident had a wandering issue, so we applied for a wanderguard. However, [he/she] frequently cuts the wanderguard using a makeshift cutter. Also, the Administrator stated that the facility hired a 24-hour 1:1 sitter for the resident for a month and continued a 1:1 sitter for 12-hour shifts (7 AM to 7 PM) until 5/30/24.</p> <p>On 6/27/24 at 10 AM, a review of Resident #109's medical record revealed that the resident resided in this facility since December 2023. Since the resident had exit-seeking/elopement behaviors, the facility started applying a wanderguard for the resident on 1/15/24. However, the resident's progress note revealed that Resident #109 removed/cut the wanderguard several times as below:</p> <ul style="list-style-type: none"> -wanderguard not on: 1/22/24, 2/29/24, 3/1/24,3/17/24 -wanderguard removed: 3/19/24, 3/22/24, 3/25/24 -tried to remove the wanderguard: 5/1/24 -tried to cut the wanderguard: 6/6/24 -cut the wanderguard: 6/10/24, 6/12/24, 6/28/24 <p>On 6/28/24 at 10:08 AM, Resident #109 was observed sitting in the dining room without a wanderguard</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 06/28/24 at 10:09 AM, an interview with the assigned Licensed Practical Nurse (LPN #55) confirmed that Resident #109 was not wearing the wanderguard. LPN #55 stated, The resident took it off; the 11-7 shift nurse reported that the resident took the wanderguard off early this morning. LPN #55 confirmed a wanderguard order in the system and stated, The wanderguard is not on right now, but we will get the bracelet from the front desk; we usually have some in the unit, but we ran out.</p> <p>On 7/01/24 at 8:04 AM, during an interview with the Registered Nurse (RN #5), he/she stated, We think Resident #109 cuts the wandering guard using a plastic knife; the resident gets the knife from the food tray. RN #5 confirmed the mobility status of Resident #109 as supervision with a walker.</p> <p>On 7/01/24 at 8:09 AM, an interview with the Unit Manager (Staff #9) revealed that the resident got plastic knives from a tray. Staff #9 further stated that the staff ensured that they checked for the plastic knife when they retrieved the tray. Staff #9 also said, Nobody has seen Resident #109 actually using the knife to cut the bracelet. The wanderguard that was removed was found in his/her drawer with plastic knives, so we assumed he/she cut it with a knife. He/she was a veteran and so smart. After the 3/22/24 elopement incident, we changed the silverware to plastic ones.</p> <p>On 7/01/24 at 8:20 AM, a review of Resident #109's Care Plans revealed: Non- compliance with wanderguard placement as evidenced by removing wanderguard from lower extremity. which was created on 1/23/24 and revised on 2/29/24, did not mention an intervention to address cutting of the wanderguard. Another care plan indicated, I am at risk for Elopement as evidenced by wandering to the first-floor lobby. created on 1/23/24, was updated on 3/22/24 stating, Walked out of the building Resident has been cutting his wander guard. which again did not have an intervention to address the frequent cutting of the wanderguard.</p> <p>On 7/01/24 at 8:31 AM, a review of the physician's progress notes for the 6/28/24 visit created on 6/29/24 at 11:18 PM did not address the recent cutting of the wanderguard bracelet.</p> <p>On 7/01/24 at 9:00 AM, the surveyor reviewed Resident #109's medical record for wandering monitoring under Treatment Administration Record (TAR). The wanderguard order wander guard at all times for safety. Test for functioning every shift. that was entered on 2/26/24 remained the same and no behavior monitoring was initiated in the TAR after the first elopement on 3/22/24.</p> <p>On 7/01/24 at 9:25 AM, the surveyors informed the DON and the Administrator that the wanderguard was still being cut without alternative interventions or additional monitoring. The DON validated the concern.</p>		

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NAME OF PROVIDER OR SUPPLIER Lorien Health Systems - Columbia		STREET ADDRESS, CITY, STATE, ZIP CODE 6334 Cedar Lane Columbia, MD 21044	
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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>47200</p> <p>Based on observation, interview and record review it was determined the facility failed to ensure residents remained free from unnecessary medications. This was evident for 2 (#138, #163) out of 9 residents reviewed for unnecessary medications during the facility's recertification survey, and 1 (resident #545) out of 14 reviewed during facility reported incident and complaint investigations during the recertification survey.</p> <p>The findings include:</p> <p>1.) On 7/2/24 at 11:47AM the surveyor observed Resident #138 with the upper half of their body laying down horizontally across the shorter width of their bed and they verbally acknowledged the nurse's presence, however, their body position remained the same.</p> <p>Review of the medical record on 7/2/24 at 12:38PM by the surveyor revealed multiple mental health diagnoses documented for Resident #138.</p> <p>On 7/2/24 at 12:54PM the surveyor observed the following active medical orders for the resident: Seroquel Tablet 25 MG (Quetiapine Fumarate): Give 1 tablet by mouth two times a day for delusional disorder and Sertraline HCl Oral Tablet 50 MG (Sertraline HCl): Give 3 tablets by mouth in the morning for Depression.</p> <p>On 7/2/24 at 1:19PM the surveyor conducted an interview with Director of Nursing (DON) regarding the location of medication regimen reviews and responses. The DON provided the following information in response to the surveyor's inquiry: All medication regimen reviews are on paper (documentation), if you need more information regarding a flagged item, you can request it.</p> <p>On 7/3/24 at 12:25PM the surveyor requested complete documentation of the previous three months medication regimen reviews for the resident from the DON.</p> <p>On 7/3/24 at 1:13PM the surveyor received and reviewed the pharmacy medication regimen reviews for Resident #138 which revealed one recommendation made on 4/25/24 for a dosage decrease for trazodone, a psychotropic medication the resident had previously been prescribed. At this time, the surveyor reviewed the discontinued medical orders and observed the April 2024 Medication Administration Record which revealed the psychotropic medication, trazodone, was prescribed by two separate orders documented as needed, in both orders, and was ongoing for the resident from 10/30/2023 until 5/1/24, and from 10/30/23 until 5/7/24.</p> <p>On 7/5/24 at 8:57AM the surveyor conducted an interview and shared their concern for the as needed use of trazodone via medical order not limited to 14 days with the facility Administrator, who confirmed there was no other documentation to provide regarding the concern and acknowledged understanding of the concern.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/05/24 at 9:33AM the surveyor conducted an interview with the DON, who reported the following to the surveyor: Trazodone is not an antipsychotic so it is not limited to 14 days, it is an anti depressant so yes, it can be an ongoing order.</p> <p>On 7/5/24 at 10:40AM the surveyor reviewed the July 2024 medication administration record and treatment administration record for Resident #138 which revealed no comprehensive monitoring for side effects of psychotropic medication use or comprehensive monitoring for behavior.</p> <p>On 7/5/24 at 11:03AM the surveyor conducted an interview and shared their concerns with the Assistant Unit Manager, Licensed Practical Nurse (LPN) #46. LPN #46 reviewed the medical record with the surveyor present and reported the following information: They (staff) did not put it back in, at one point s/he was on monitoring, it just didn't get re-ordered when s/he got readmitted . LPN #46 further communicated to the surveyor that the side effect and behavior monitoring was last in effect for the resident during 2023. LPN #46 shared with the surveyor the following monitoring that should be in place for behavior and side effects of psychotropic medications: Any kind of adverse behaviors, biting, hitting, kicking, any changes with aggression, depression worse or better, any changes not his/her normal, side effect monitoring for movement and non-movement monitoring, we usually put both orders in, and behavior monitoring we have a standard order. After surveyor intervention, LPN #46 reported they were now instituting side effect monitoring and behavior monitoring orders for the resident. At this time, the surveyor requested a copy of the orders being instituted.</p> <p>On 7/05/24 at 11:32AM the surveyor reviewed documentation of the monitoring instituted on 7/5/24 by LPN #46.</p> <p>On 7/9/24 at 10:37AM the surveyor shared their concerns with the facility Administrator, who acknowledged and confirmed understanding of the concerns.</p> <p>On 7/12/24 at 10:29AM the surveyor conducted an interview with the DON as to the facility's process for ensuring the monitoring surrounding psychotropic medication use. The DON stated the following regarding the facility's current process: The expectation is that the admitting nurse enters the monitoring order and the unit manager should be reviewing records, daily orders, to catch any that didn't get ordered and then bring that issue to the daily meeting. At this time, the surveyor requested the last six pharmacy medication regimen review recommendations made for the resident from the DON.</p> <p>On 7/12/24 at 10:55AM, during an additional documentation request form the surveyor to the DON, the surveyor was handed one pharmacy recommendation made for the resident, however, the surveyor observed additional pharmacy recommendation documents on their desk with Resident #138's name on them. When the surveyor inquired as to the additional recommendations present, the DON gave the surveyor a second pharmacy recommendation for Resident #138. The surveyor then inquired again, as to the additional remaining pharmacy recommendation on their desk. At this time, the third pharmacy recommendation was handed to the surveyor. The DON stated the following to the surveyor: Oh you need this? Upon surveyor review of the third pharmacy recommendation received, the surveyor noted that the recommendation dated 4/25/24 included the following information regarding the trazodone orders: Psychotropic drugs PRN (as needed), orders for psychotropic drugs are limited to 14 days and included an area for the physician's response to the recommendation. At this time, the surveyor noted the recommendation had no physician response documented on it, and the two orders for trazodone were documented as continuing until one was discontinued on 5/1/24 (6 days after the recommendation was made) and one was discontinued on 5/7/24 (12 days after the recommendation was made).</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2.) On 7/5/24 at 1:11PM the surveyor conducted a review of the medical record for Resident #163 which revealed active medical orders for several psychotropic medications including Lorazepam and Seroquel, however, no medical orders for monitoring of medication side effects, or behavioral monitoring of the resident could be found.</p> <p>On 7/9/24 at 10:24AM the surveyor conducted an interview with the Resident's assigned nurse, Licensed Practical Nurse (LPN) #51. When the surveyor inquired as to the monitoring for side effects and behavior monitoring for psychotropic medication use for Resident #163, they reviewed the medical record with the surveyor present, and they responded: It should be ordered.</p> <p>On 7/9/24 at 10:37AM the surveyor conducted an interview with the facility Administrator. During the interview, the Administrator reviewed the resident's medical record and confirmed that side effect and behavior monitoring should be in place via a medical order and was not currently ordered for the resident. At this time, the surveyor shared their concerns and the Administrator acknowledged and confirmed understanding of the concerns.</p> <p>On 7/12/24 at 10:29AM the surveyor conducted an interview with the DON as to the facility's process for ensuring the monitoring surrounding psychotropic medication use. The DON stated the following regarding the facility's current process: The expectation is that the admitting nurse enters the monitoring order and the unit manager should be reviewing records, daily orders, to catch any that didn't get ordered and then bring that issue to the daily meeting.</p> <p>42886</p> <p>3) During the investigation for MD 00181057, a review of resident #545's medical record on 7/8/24 at 9:29am revealed that the pharmacist consultant recommended a gradual dose reduction (GDR) for Seroquel (Quetiapine Fumarate). Continued review of resident #545's medical record revealed the facility contracted an agency psychiatric nurse practitioner (agency psychiatric NP) to assess the resident to ensure that the gradual dose reduction was safe for the resident. On 7/21/22, the agency psychiatric NP failed to assess the resident for a GDR due to his/her failure to locate Seroquel in the resident's medical orders. Further review of resident #545's medical record revealed the GDR was ordered by the attending provider on 8/11/22. The attending provider reduced the Seroquel order from 1 tablet twice a day to 0.5 tablet twice a day.</p> <p>During an interview with the Director of Nursing (DON) on 7/9/24 at 1:30pm, the DON admitted that resident #545 received an additional dose of 0.5 tablet twice a day from 7/21/22 to 8/11/22 because the agency psychiatric NP failed to assess the resident for the recommended GDR. The surveyor expressed concern about the facility's delay in starting the recommended GDR. The DON understood and provided no new information.</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42507</p> <p>Based on interview and medical record review, it was determined that the facility failed to ensure that residents who require dental services on a routine or emergent basis receive necessary or recommended dental services in a timely manner, and 2) to assist a resident in scheduling a dental visit/appointment to obtain dental care outside the facility. This was evident for 2 (#49, #453) of 7 residents reviewed for dental services during a recertification/complaint survey.</p> <p>The findings include:</p> <p>1) On 6/21/2024 during the initial pool screening, Resident #49 told a surveyor that s/he was seen by a dentist and indicated that s/he needed a new tooth but was told they were not sure if the resident's insurance will take care of it.</p> <p>On 6/27/2024 at 1:27 PM, a review of physician orders did not reveal any active orders for dental consult. However, further review revealed an order for dental consult dated 4/11/2023 that was discontinued on 2/3/2024:</p> <p>Dental Consult for loose tooth.</p> <p>No directions specified for order.</p> <p>Other Discontinued 2/3/2024 4/11/2023</p> <p>On 6/27/2024 at 2:28 PM, a review of nurses' progress notes from April 2023 through June 2024 did not reveal that Resident #49 was having any dental issues, seen by a dentist, and/or went out for a dental appointment/consult.</p> <p>On 6/27/2024 at 3:02 PM, surveyor reviewed progress notes by external staff for the above time frame. There were no treatment notes by a dentist/dental group in the resident's electronic record.</p> <p>On 7/1/2024 at 11:45 AM, an interview was conducted with Resident #49. The resident stated that s/he was missing some teeth on both sides of the upper jaw and opened their mouth to show the missing teeth. The surveyor observed Resident #49's upper front middle tooth (central incisor) and back teeth (canines and molars) were missing. Resident #49 further stated that they say they are too expensive to put them back in and the dentist does not take my insurance. Resident #49 added that s/he would love to have his/her teeth back: I have been telling them, but they say they will give me a temporary one for the front tooth, but I can't chew because the back ones are not there. When asked when s/he last saw a dentist, Resident #49 could not recall.</p> <p>On 7/1/2024 at 11:51 AM, in an interview with Resident #49's nurse, Licensed Practical Nurse (LPN #3), she stated that she (LPN #3) was not aware that the resident had dental concerns, wanted to have missing teeth replaced and/or requested to see a dentist. Regarding dental consults, LPN #3 stated that dental appointments were scheduled by the unit secretary per doctor's orders and/or residents'/family request.</p> <p>(continued on next page)</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>On 7/1/2024 at 12:34 PM, in an interview with the 2 [NAME] Unit Manager (UM #4), she stated that dental appointments were made based on the type of insurance that the residents have: If a resident has PPHP (Medicare Advantage plan) insurance, they can see Mobile Dentist that comes to facility, otherwise, they will have to go out. However, UM #4 stated that she was not aware Resident #49 had any dental concerns. The surveyor requested from UM #4, documentation regarding the last time Resident #49 saw a dentist, if ordered dental consult for lose tooth dated 4/11/2023 was kept/notes of that appointment, and if there was a follow up dental visit, and why that order was d/c on 2/3/2024.</p> <p>On 7/2/2024 at 2:53 PM, in a follow up interview with UM #4, she stated that Resident #49 was not seen by a dentist as ordered on 4/11/2023. She stated that the reason why order was d/c on 2/3/2024 was because Resident #49 got readmitted from the hospital on 2/3/2024 (same day order was d/c) and the admitting nurse deleted it. The admitting nurse deleted the old orders to put in the new orders, and so the order for dental consult fell off. UM #4 confirmed that Resident #49 has not been seen by a dentist since the order was placed on 4/11/2023. However, UM #4 added that she was going to follow up with the resident and schedule an appointment for a dental consult.</p> <p>On 7/3/2024 at 12:44 PM, a follow up review of the nurses' progress notes revealed the following Nursing Narrative Note dated 7/2/2024 at 15:43 (3:43 PM): Patient's son - [name] has refused to pay for stretcher transportation for patient to go out to see the dentist, stated he is willing to pay for Mobile Dentist services for [parent] at the facility, awaiting next date the Mobile Dentist will be back for dental services, patient has no c/o tooth pain at this time, will continue to monitor.</p> <p>On 7/3/2024 at 1:02 PM, an interview was conducted with the Nursing Home Administrator (NHA). Regarding Resident #49's dental appointment not being made, NHA stated that UM #4 had informed her (NHA) about the missed order on 4/11/2023 for dental consult. NHA stated that she did not know how the order got missed at the time it was put in but that it fell off the resident's orders when Resident #49 went to the hospital and was readmitted to the facility on [DATE]. However, NHA stated that they spoke with Resident #49's son yesterday (7/2/2024) and were in the process of having the Mobile Dentist see the resident as soon as possible.</p> <p>On 7/3/2024 at 2:32 PM, in a follow up interview with NHA, she stated that Resident #49 has been scheduled to go for an outside dental appointment on 7/8/2024. NHA added that Son doesn't want to pay for it. I don't have a date for the Mobile Dentist to see the resident. Worst case scenario I will have to pay for it because no one wants to pay for transportation, and it has been over a year.</p> <p>On 7/12/2024 at 9:27 AM, in an interview with the Director of nursing (DON) and VP of clinical services (Staff #44), surveyor shared concerns regarding Resident #49's missed dental consult ordered on 4/11/2023. DON stated he did not think the resident had a loose tooth now and added that if Resident #49 was complaining, staff would have picked it up and scheduled an appointment for the resident. However, DON added that he will leave it to the Administrator to address since she (Administrator) was already on it.</p> <p>44441</p> <p>2) On 7/11/24 at 8:40AM, a review of a complaint incident #MD00207517 alleged that Resident #453 needed dental services secondary to a cracked tooth and obvious decay and that staff has been delinquent in arranging it despite frequent reminder by the resident's family member since March 2024.</p> <p>(continued on next page)</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>A review of the resident's medical records on 7/11/24 at 9:56 AM revealed a Social Work's (SW) note dated 3/27/24 which documented a request by the resident's family member for a dental appointment for the resident for which the SW indicated she will follow up. Further review of the medical records did not reveal any further documentation about setting up a dental appointment for Resident #453.</p> <p>On 7/11/24 at 11:20 AM an interview was conducted with Staff #54 a social worker in charge of the Long-Term Care Unit (LTC). She was asked if resident was on her tracking list of residents waiting to be seen by a dentist. She said that resident was not on her list because nursing staff did not put in a request for resident to be seen per protocol. She was asked if she was notified by the previous SW that the family requested for resident to be seen. She indicated that she was not made aware of such a request by the family.</p> <p>The surveyor met with the complainant at the resident's bedside on 7/11/24 at 2:03 PM. S/he reiterated that they have spoken to multiple social workers including the administrator on different occasions. That he was told that the dental visit has to be arranged by a social worker, yet nothing has been done.</p> <p>On 7/11/24 at 2:22 PM, the unit manager on 2W, staff #4, came into the room and was made aware of the concern. She promised to follow up.</p>		