

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215132	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/12/2024
NAME OF PROVIDER OR SUPPLIER Deer's Head Center		STREET ADDRESS, CITY, STATE, ZIP CODE 351 Deer's Head Hospital Road Salisbury, MD 21801	

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)
F 0600 Level of Harm - Actual harm Residents Affected - Few	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37585</p> <p>Based on review of records, observation, and interview, it was determined that the facility failed to keep residents safe from physical and verbal abuse. This was evident for 4 (Residents #27, #2, #11, and #28) of 10 residents reviewed for abuse, one of which was determined to have sustained actual harm (Resident #27).</p> <p>The Findings include:</p> <p>1) On 7/10/24 at 10:14 AM, the surveyor reviewed the facility's investigation of an incident that took place between Geriatric Nursing Assistant (GNA) #36 and Resident #27. The review revealed that, on 5/30/23 at about 10:00 AM, GNA #36 was working with Resident #27 and was transporting him/her to the shower. During transport, the resident defecated onto the floor. The GNA responded by yelling at the resident, grabbing the resident's face and turning his/her head to the floor, saying 'Look at what you did, why would you do this?' This was witnessed by GNA #37, registered nurse (RN) #8, RN #38, and Assistant Director of Nursing (ADON) #4, although not all of them witnessed the GNA yelling directly at the resident or grabbing his/her face. The investigation substantiated verbal and physical abuse by GNA #36 of Resident #27 and provided evidence that GNA #36 was terminated from employment and reported to the Maryland Board of Nursing.</p> <p>Resident #27's medical record was reviewed on 7/10/24 at 10:30 AM. The review revealed that Resident #27 had the diagnosis of vascular dementia. Resident #27's most recent quarterly minimum data set (MDS) assessment prior to the incident on 5/30/23 had an assessment reference date (ARD) of 5/11/23. The quarterly assessment coded that Resident #27 had a brief interview of mental status (BIMS) score of 3/15 (indicating severe cognitive impairment); was totally dependent on staff for bed mobility, transfer, locomotion on and off the unit, eating, toilet use, and personal hygiene; and was always incontinent of bowel and bladder.</p> <p>Ongoing review of Resident #27's record failed to reveal any resident assessment or incident documentation following the incident on 5/30/23. The first note found after 5/30/23 was dated 6/3/23 at 7:35 PM and stated that there were no issues noted with Resident #27. Review of behavior documentation did not show any behaviors after the incident.</p> <p>Observation of the resident on 7/9/24 at 1:00 PM and throughout the survey showed that the resident was comfortable, pleasant, and showed no signs of fear. The resident was unable to communicate meaningfully with the surveyors and appeared confused.</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 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/10/24 at 3:00 PM, the surveyors were provided with timekeeping documentation for GNA #36. The documentation showed that GNA #36 worked a full day on 5/30/23 (8 hours), called out sick on 5/31/23, and then was placed on administrative leave until her eventual termination on 6/28/23.</p> <p>An interview with GNA #37 on 7/10/24 at 2:16 PM confirmed that she witnessed GNA #36 yelling in Resident #27's ear, saying, why did you shit on the floor, and swearing at the resident. When asked if she felt that GNA #36's actions were verbal abuse, she said yes.</p> <p>An interview with the Staff Development Director was conducted on 7/10/24 at 3:15 PM. During the interview, the Director stated that he did not provide any additional abuse training to staff after the incident on 5/30 involving Resident #27 and GNA #36. The Director did recall performing a review of staff training on abuse, but wasn't able to confirm that it was an audit of all employee records. He stated there was no documentation of the review.</p> <p>On 7/11/24 at 9:00 AM, review of GNA task documentation revealed that GNA #36 documented % eaten for Resident #27's lunch on 5/30/23.</p> <p>A phone interview was conducted with RN #8 on 7/11/24 at 9:14 AM. During the interview, the RN stated that she was on the unit on 5/30/23 at the time of the incident involving Resident #27 and GNA #36. RN #8 stated that she witnessed GNA #36 yelling at Resident #27. RN #8 considered the yelling to be abusive and humiliating to the patient. She said that the patient was known to be incontinent and to lack the ability to respond appropriately or to show emotion. He couldn't help [defecating onto the floor], and GNA #36's actions were not right. RN #8 recalled telling RN #38 (not available for interview) to get the unit manager and report what happened as potential abuse.</p> <p>An interview was conducted with ADON (then-Unit Manager) #4 on 7/11/24 at 9:28 AM. The ADON remembered being called by the administrator to go investigate a commotion on the Whispering [NAME] unit. The ADON did not hear shouting herself. She arrived to find GNA #37 cleaning feces off the floor. GNA #37 said to her that Resident #27 defecated on the floor while being transported to the shower room. GNA #37 said that GNA #36 was working with the resident when the resident defecated and began shouting at the resident. The ADON instructed GNA #36 not to work with Resident #27 for the rest of the day but did not stop GNA #36 from working on the unit. The ADON requested statements from GNA #36 and #37 which were supplied to her in a short time. The ADON stated that GNA #37's statement only mentioned that GNA #36 had been yelling.</p> <p>Continuing the interview, the ADON stated that she was approached by the Administrator later on the same day, around 2:30 PM. The Administrator informed her that GNA #37 had reported additional details about the incident that morning. GNA #37 had claimed that, in addition to yelling at the resident, GNA #36 had also pulled on Resident #27's lip, forcing him/her to face the pile of feces on the floor. The ADON stated that she then asked GNA #37 to confirm these details and amend her statement. The ADON said that these additional details elevated the occurrence from only verbal abuse to being verbal and physical abuse.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/11/24 at 9:58 AM, the surveyor interviewed the Administrator. During the interview, the Administrator confirmed overhearing a commotion on the Whispering [NAME] unit outside of her office on the morning of 5/30/23. She recalled asking ADON #4 to investigate the situation but stated that she didn't witness any of the incident herself. She also confirmed that GNA #37 came to her office later in the day on 5/30/23 to provide the additional details about seeing GNA #36 pulling on Resident #27's lip and showing him/her the pile of feces.</p> <p>Ongoing review of the facility's investigation file revealed GNA #37's witness statement. The statement had an initial text that was signed and dated 5/30/23. An addendum could be seen below the signature in the same handwriting. The initial text stated that GNA #36 was very upset about Resident #27 defecating on the floor and that GNA #36 was pretty loud in the hallway. The initial text did not mention that GNA #36 touched the resident. However, the addendum did, stating that GNA 36 held [Resident #27's] face and showed him/her what he/she had done on the floor but it wasn't with any force or harm.</p> <p>Review of the facility's abuse policy on 7/11/23 revealed that the following definition was categorized as verbal abuse: Derogations - A patient shall not be spoken to in a threatening manner or by threatening words which cause the patient to have a non-therapeutic feeling of having been ridiculed, scorned or teased, or in general spoken to with rude or harsh words.</p> <p>Although Resident #27 did not have any documented emotional distress, behaviors, or other negative outcomes from the incident on 5/30/23, the resident was known to be unable to respond normally to situations, to communicate effectively with staff, or to express their feelings clearly. In situations where a resident is unable to express their feelings such as this, the Reasonable Person Concept can be used to approximate how a reasonable person in the resident's situation would have reacted for the purpose of determining the outcome of a deficient practice. Using this concept, it was determined that a reasonable person would have experienced humiliation, anger, shame, and intimidation in response to the actions of GNA #36. Therefore, it was determined that psychosocial harm occurred to Resident #27.</p> <p>42863</p> <p>2) The surveyor reviewed the facility reported incident (FRI) MD00160152 packet 07.10.24 at 2:15 PM. On 04.24.20, as staff #1 was coming up the back staircase from dialysis reportedly yelling was heard by the staff and once the door was opened, observed Resident #2 and staff # 51 screaming at each other. Staff # 51 was observed turning off the call light for room [ROOM NUMBER]A, resident #2's room, while leaving the room staff #51 yelled to hell with you to resident # 2.</p> <p>Staff #51 was placed on administrative leave on 4.24.20 and a facility investigation was started.</p> <p>On 07/09/24 09:20 AM Resident # 2 denied any current examples of abuse in recent months. Both verbal altercations involved male GNA s. The first verbal altercation that occurred was on 04.24.2020 with staff # 51 and the resident does not recall the specifics. The second incident (verbal altercations with GNA #59) the resident recalled occurred on 11.02.2020, and Resident #2 remembers the incident. Resident #2 stated that he/she was able to speak his/her mind and he/she was satisfied with the results of the investigation that the administrative team shared with him/her.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 07.10.2024 at 11:12AM Resident #2 stated that staff currently treat him with respect and that he/she enjoys being the President of the Resident Council. The Resident was out of bed in a motorized wheelchair in the hallway in front of the nurses' station</p> <p>On 07.12.24 at 10:30 AM the surveyor requested that the HR file for staff #51, the alleged perpetrator.</p> <p>At 1:16 PM on 07.12.2024 the surveyor reviewed the hard copies of staff #51's human resource (HR) record. Staff #51 had a hire date of 09.14.2013 and resigned on 05.04.2020. The packet of staff #51's HR included a copy of the employee's 12.23.19 performance evaluation. This employee was reported to the Maryland Board of Nursing (MBON) on 04.24.2020 by the facility administrator. The resident #2 wrote a statement/grievance regarding the incident on 04.24.20 and stated that he/she started ringing the call bell at 2:25 PM x's 3 requesting to be assisted with changing his diaper. Staff #51 responded at 2:40 PM and 2:55 PM and proceeded to argue and curse at the resident without providing the requested assistance with ADL's.</p> <p>On 07.12.24 at 1:54 PM the surveyor spoke with the nursing home administrator (NHA) who was one the witnesses for the incident related to Resident #2. She stated that she did not remember if the employee was sent home immediately. The NHA stated that the time of the incident was close to the change of shift on 04.24.2020. Also, the NHA stated that she would check with the HR director to verify the date and time staff #51 was placed on administrative leave and left the workplace.</p> <p>On 07.12.24 at 2:00 PM the surveyor spoke with another witness, staff # 58 who stated that she/he was not aware of when the perpetrator, staff # 51 left the unit on 04.24.20 and that she/he was in another resident's room at the time of the incident.</p> <p>3) On 07.10.24 at 1:20 PM the surveyor reviewed the OHCQ intake related to Resident # 2. Per the facility related incident report (FRI) MD00160152 on 11.02.2020 at 09:00 AM, a facility employee, GNA #59 verbally abused resident #2 on the Whispering [NAME] clinical unit. The verbal abuse was substantiated by the facility in its final report dated 11.09.2020. Enclosed within the FRI was a complaint form and a handwritten statement that was completed by LPN #69 and dated 11.02.2020 in which the employee stated that resident #2 stated to her that GNA # 59 told him/her to shut the f .up. Also, enclosed within the FRI packet was a memorandum written by staff #70, dated 11.10.2020 counseling staff # 69 for not assisting and intervening not immediately responding to LPN #69 request for assistance to deescalate the verbal interactions between staff #59 and resident #2. Additionally, a statement written by GNA# 59 admitting that he /she loudly whispered shut the F .up to resident #2 was enclosed in the FRI provided to the surveyor by the administrator.</p> <p>The surveyor interviewed the DON and the Corporate Operations Officer (COO) on 07.11.24 at 1240 PM and reviewed the contents of resident #2's 11.02.2020 packet related to MD#00160152.</p> <p>On 07.12.24 at 1:20 PM the surveyor requested the administrator to provide written documentation that GNA #59 was immediately removed from the clinical setting after the incident. Documentation provided by the administrator showed that GNA #59 was placed on administrative leave around 10:00 AM after being interviewed by the unit manager, staff # 56 and remained on administrative leave for four days.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 07.12.24 at approximately 1:30 PM the surveyor reviewed the human resources records of GNA #59 who was no longer employed by the facility.</p> <p>4) On 07.10.24 at 9:40 AM the surveyor reviewed the intake, MD00204619 related to resident #11. The facility reported the resident was verbally abused by a volunteer, staff # 63 on 04.10.24 at 12:15 PM. Surveyor reviewed the facility reported incident (FRI) packet which documented that Resident #11 went to the facility canteen and started yelling obscenities when it was time to pay for his food. The resident was upset that he/she was charged tax. Per the facility documentation the resident was also upset that he /she did not get a free soda.</p> <p>According to the facility report, staff # 64 overheard resident # 11 yelling and cursing. Also, staff # 64 observed staff #63 walk from the canteen to the hallway and ask for security. Staff # 64 also reported that resident #11 stated: You got security? and staff #63 responded, He will put you in handcuffs. Security Guard Staff #65 reported that staff #63 was agitated when he/she arrived and overheard him/her say, I hope he gets arrested and handcuffed. Staff # 65 entered the canteen and removed resident #11 and returned the resident via wheelchair to his/her room.</p> <p>Resident #11 requested the administrator file a complaint on his behalf shortly after the incident described above. The volunteer was suspended administratively for four days while the investigation was completed. The staff #63 was verbally counseled by his/her supervisor and received Relias training related to abuse, resident rights, customer service, and de-escalation techniques upon return from administrative leave. Staff #63, the volunteer completed the required training based on the documentation within the FRI packet.</p> <p>On 07.10.24 at 12:16 PM the surveyor observed resident #11 in his wheelchair in his room looking at his lunch tray. The surveyor asked the resident whether he/she remembered the incident that occurred in April 2024 in the canteen. Resident #11 stated that he/she did recall being angry with the volunteer. The resident stated that he planned to go to the canteen today to purchase food because he/she was not satisfied with the lunch that was delivered to his room. Resident # 11 denied experiencing any other verbal abuse from facility staff.</p> <p>On 07.10.24 at 12:20 PM the surveyor spoke with the RN passing medications in front of resident #11's room. RN #68 stated that the resident has a history of being short tempered, yelling, and being verbally abusive but when allowed to cool down will respond positively to verbal interactions displayed by staff.</p> <p>On 07.11.24 at 12:45 PM the surveyor interviewed the DON and CNO regarding the contents of the facility incident report related to resident # 11 and reviewed the contents of the facility incident report and the events documented.</p> <p>The potential citation was discussed with the administrative team on 07.12.24 prior and during the exit conference.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>5) The surveyor reviewed the hard copy documents of the facility incident report (FRI) MD00193399 provided by the administrative team on 07.10.24 at 1:00 PM. The facility report described an unusual occurrence related to an incident of resident-to-resident physical abuse. The perpetrator, resident # 38 with a history of dementia walked into resident #28's room on 06.06.23 around 07:30 PM. Resident #28 called for help and the facility staff came to the resident's room. The facility documented that resident #28 reported that resident # 38 hit resident #28's left hand and left side of his/her face with the call bell cord which resulted in a minor injury. The surveyor found no documentation that any staff members had observed the physical abuse based on the documentation in the initial self-report. The only reported witness was resident #28, the victim per the facility documentation provided to the surveyor. Review of the resident # 38's electronic medical record showed one documented episode of physical aggression towards staff members but none towards any residents during the previous three months.</p> <p>The FRI packet provided by the facility administrative team, included a copy of the initial report submitted to OHCQ dated and timed: 06.07.23, at 11:00 AM. Per the initial report the incident of physical abuse perpetrated by Resident # 38 occurred on 06.06.2023 at 7:30 PM. Resident # 38 was placed on every 15 minute check, a psychiatric consult was ordered, and a medication review for his/her dementia diagnosis was recommended per the facility report completed on 06.13.23. The resident had a dementia and aggressive behavior care plan. Additionally, the facility failed to include any progressive notes or change of condition documentation related to minor injuries sustained by Resident #28 in the facility report- incident packet. The facility did not include any statements from the staff working the evening shift on 06.06.23 or any statements from other residents who were located on the same unit on 06.06.23 within the initial or the final facility report to OHCQ.</p> <p>During an on 07.10.24 12:06 PM resident #28 stated that he/she remembers the incident, but no serious injury occurred on 06.06.23 when he/she was struck by resident #38. Currently the resident # 28 denies any type of verbal or physical abuse occurring during the past year and does feel safe in the clinical unit.</p> <p>On 07.11.24 at 12:40 PM the surveyor interviewed the DON and CNO regarding the contents of the facility incident report related to resident # 28. The surveyor expressed concern regarding the lack of documentation related to the incident within its final report to OHCQ dated for 06.13.23 at 3 PM. The DON and CNO stated that they would attempt to find additional information related to the 06.06.23 FRI. The surveyor discussed the lack of documentation within the facility report regarding the perpetrator with dementia and the facility efforts to prevent the resident-to-resident physical abuse incident.</p> <p>As of 5:30 PM on 07.12.24 during the exit conference the facility failed to provide any additional documentation related to substantiated physical abuse towards resident #28 by resident # 38.</p> <p>The deficient practice to prevent a resident-resident physical abuse incident was discussed during the exit conference on 07.12.24 with facility administrative staff.</p>		

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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>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>37585</p> <p>Based on review of records and interview with facility staff, it was determined that the facility failed to report instances of abuse to the state agency (SA) within 2 hours of it being identified or reported and the final report within 5 working days. This was evident for 3 of 11 facility reported incidents reviewed during the survey.</p> <p>The Findings include:</p> <p>1) On 7/10/24 at 10:14 AM, the surveyor reviewed the facility's investigation of an incident that took place between Geriatric Nursing Assistant (GNA) #36 and Resident #27. The investigation determined that, on 5/30/23 at about 10:00 AM, GNA #36 verbally and physically abused Resident #27 after the resident defecated on the floor during transport. This was witnessed by GNA #37, registered nurse (RN) #8, and RN #38. The investigation provided evidence that GNA #36 was terminated from employment and reported to the board of nursing.</p> <p>Further review of the investigation file revealed an initial facility self-report form dated 5/31/23 at 7:00 AM, 21 hours after the incident occurred and was witnessed by multiple staff. Additionally, an email was found that was written by the Chief Nursing Officer (CNO, Staff #29) dated 5/31/23 at 6:51 AM that stated, I will be filing a self-report of this incident.</p> <p>An interview with GNA #37 on 7/10/24 at 2:16 PM confirmed that she witnessed GNA #36 yelling in Resident #27's ear, saying, why did you shit on the floor, and swearing at the resident. She confirmed that she considered what she witnessed to be abuse and that ADON #4, her unit manager at the time of the incident, had been informed of the incident only minutes after the incident occurred.</p> <p>A phone interview was conducted with RN #8 on 7/11/24 at 9:14 AM. During the interview, the RN confirmed that she witnessed GNA #36 yelling at Resident #27 on 5/30/23, considered it abuse, and told RN #38 (not available for interview) to get the unit manager and report what happened.</p> <p>An interview was conducted with ADON #4 on 7/11/24 at 9:28 AM. The ADON confirmed that she arrived to the scene of the incident around 10:15 AM on 5/30/23 and quickly determined that verbal abuse had possibly occurred. The ADON indicated that she did not complete a self-report to the state agency about the incident, saying that the CNO is usually responsible for that.</p> <p>No evidence could be found that the CNO had been notified of the incident prior to the morning of 5/31/23.</p> <p>Review of the facility's Abuse Prevention policy on 7/11/24 revealed the statement, If unable to [immediately] rule out without a doubt that alleged abuse is unsubstantiated, a self-report will be sent to the OHCQ within 24 hours of discovery. No part of the policy required staff to file a self report within 2 hours in instances of abuse or serious injury.</p> <p>Cross Reference F 600</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 - Few</p>	<p>49304</p> <p>2) On 7/9/24 at 10:32 AM, the administrative team provided the survey team with a copy of the facility reported incident that occurred on July 17, 2020. Review of the documentation of the incident reported by the facility, it stated that, On July 17 [2020] at 11:41, Resident #37 reported to Nursing Home Administrator (NHA) #1, that on July 15th, in the evening, staff came to provide care and he/she was treated like 'a sack of potatoes'. In addition, it stated, Resident #37 further stated he/she felt this incident was 'assault and battery' though he/she declined to have law enforcement notified. The Self- Report Form completed by the facility stated the Type of Report was Abuse (as denoted by an X in the Abuse type). Furthermore, the Self- Report Form completed by the facility stated the incident was initially reported to OHCQ on 7/17/2020 at 1528 (3:28 PM).</p> <p>On 7/12/24 at 9:11 AM in an interview with NHA #1, when asked about the day of the incident with Resident #37 in July 2020, she stated she remembered Resident #37 and that he/she was here for quite some time. During the interview, she stated he/she was alert and oriented. Furthermore, the NHA #1 stated that the process for investigating abuse allegations is an alleged incident is reported within 2 hours if there is an allegation of abuse. She also stated that abuse was any verbal, physical, sexual, mental abuse, neglect, or misappropriation of funds. The surveyor showed NHA #1 the Self- Report Form that stated she was the staff member notified of the allegation by Resident #37 on 7/17/2020 at 11:41 AM and that the Self- Report Form documented OHCQ was notified 7/17/2020 at 3:28PM who confirmed it was outside of the 2 hour window.</p> <p>On 7/10/24 at 1:23 PM, review of the facility's policy, Abuse Prevention General Policy section revealed, The Administrator and Director of Nursing will send a self-report to the OHCQ within 2 hours of discovery of neglect or abuse. Furthermore, the Definitions section revealed, An Allegation is a spoken or written statement, offered without proof that an event occurred. Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish (42 CFR 488.301). This also includes the deprivation by an individual, including a caretaker, of good or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. This presumes that the instances of abuse of all residents, even those in a coma, cause physical harm or pain or mental anguish.</p> <p>42863</p> <p>3) The surveyor reviewed the intake MD00193399 related to Resident #28 on 07.09.2024 at 11:40 AM. The facility had reported that on 06.06.23 at approximately 7:30 PM, Resident #28 called staff for help from his room, while sitting on his/her bed. The nurse found the perpetrator Resident # 38 standing in front of Resident #28. The surveyor reviewed the hard copy documents of the facility incident report (FRI) provided by the administrative team on 07.10. 24 at 1:00 PM. Within the report related to resident-to-resident physical abuse: the perpetrator, Resident # 38 with a history of dementia walked into Resident #28's room. The facility documented that Resident #28 reported that Resident # 38 hit resident #28's left hand and left side of his/her face with the call bell cord which resulted in a minor injury. The surveyor found no documentation that the any staff members observed the physical abuse based on the documentation in the initial self-report and the only witness was Resident #28, the victim.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215132	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/12/2024
NAME OF PROVIDER OR SUPPLIER Deer's Head Center		STREET ADDRESS, CITY, STATE, ZIP CODE 351 Deer's Head Hospital Road Salisbury, MD 21801	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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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>The FRI packet provided by the facility administrative team, included a copy of the initial report submitted to OHCQ dated and timed: 06.07.23, at 11:00 AM. Per the initial report the incident of physical abuse perpetrated by Resident # 38 occurred on 06.06.2023 at 7:30 PM.</p> <p>Additionally, the facility failed to include any progressive notes or change of condition documentation related to minor injuries sustained by Resident #28. The facility did not include any statements from the staff working the evening shift on 06.06.23 or any statements from other residents who were located on the same unit on 06.06.23.</p> <p>On 07.11.24 at 12:40 PM the surveyor interviewed the DON and CNO regarding the contents of the facility incident report related to resident # 28. The surveyor expressed concern regarding the lack of documentation related to incident that was substantiated by the facility within its final report to OHCQ on 06.13.23 at 3 PM which exceeded the 5-day final submission timeframe.</p> <p>The DON and Chief Nursing Officer (CNO) stated that they would attempt to find additional information related to the 06.06.23 FRI. As of 5:30 PM on 07.12.24 during the exit conference the facility failed to provide any additional documentation related to substantiated physical abuse towards resident #28 by resident # 38.</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>37585</p> <p>Based on review of resident records and interview with facility staff, it was determined that the facility failed to keep residents protected from an alleged perpetrator during an abuse investigation. This was evident 1 of 11 facility reported incidents during the survey.</p> <p>The Findings include:</p> <p>On 7/10/24 at 10:14 AM, the surveyor reviewed the facility's investigation of an incident that took place between Geriatric Nursing Assistant (GNA) #36 and Resident #27. The review revealed that, on 5/30/23 at about 10:00 AM, GNA #36 was working with Resident #27 and was transporting him/her to the shower. During transport, the resident defecated onto the floor. The GNA responded by yelling at the resident, grabbing the resident's face and turning his/her head to the floor, saying 'Look at what you did, why would you do this?' This was witnessed by GNA #37, registered nurse (RN) #8, RN #38, ADON #4, although not all of them witnessed the GNA yelling directly at the resident or grabbing his/her face. The investigation substantiated verbal and physical abuse by GNA #36 of Resident #27 and provided evidence that GNA #36 was terminated from employment and reported to the board of nursing.</p> <p>On 7/10/24 at 3:00 PM, the surveyors were provided with timekeeping documentation for GNA #36. The documentation showed that GNA #36 worked a full day on 5/30/23 (8 hours), called out sick on 5/31/23, and then was placed on administrative leave until her eventual termination on 6/28/23.</p> <p>An interview with GNA #37 on 7/10/24 at 2:16 PM confirmed that she witnessed GNA #36 abuse Resident #27 verbally, yelling in his/her ear and swearing. GNA #37 also stated that she believed GNA #36 continued working with the resident for the rest of the day.</p> <p>On 7/11/24 at 9:00 AM, review of GNA task documentation revealed that GNA #36 documented % eaten for lunch on 5/30/23, suggesting that the GNA continued to work with the resident after the incident.</p> <p>An interview was conducted with ADON (then-Unit Manager) #4 on 7/11/24 at 9:28 AM. During the interview, the ADON stated that she arrived on the scene of the incident at 10:15 on the morning of 5/30/23. She stated that GNA #37 explained what happened and then said that GNA #36 was in the shower with the resident. The ADON asked RN #39 and an unknown GNA to come relieve GNA #36 of working with Resident #27 in the shower. The ADON instructed GNA #36 not to work with Resident #27 for the rest of the day but did not stop GNA #36 from working on the unit. The ADON requested statements from GNA #36 and #37 which were supplied to her in a short time (possibly about an hour). GNA #36 completed her shift.</p> <p>When asked about whether the incident as she understood it on the morning of 5/30/23 constituted abuse, she said that she felt it was verbal abuse, and that later information she gained at 2:30 PM made her believe it was also physical abuse. She stated that, instead of having the GNA continue to work on the nursing unit, she would have kept the GNA in my office and off the nursing unit if she knew that the GNA had perpetrated physical abuse as well. She explained that as a manager, I cannot relieve an employee from duty. Human Resources can only do that.</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>Ongoing review of the facility's investigation revealed an email from the Chief Nursing Officer (CNO, Staff #29) dated 5/31/23 at 6:51 AM. In the email, the CNO writes In the past, when a situation like this occurred, the GNA was put on administrative leave until an investigation is completed . [GNA #36] should not be caring for any of our residents at this point. She called out sick today.</p> <p>Additionally, a letter was found dated 5/31/23 addressed to GNA #36 and written by a human resources representative that informed GNA #36 that she was being placed on administrative leave pending investigation.</p> <p>No evidence could be found showing that GNA #36's assignment or work hours changed on the day of the incident, 5/30/23.</p> <p>Review of the facility's Abuse Prevention policy on 7/11/24 revealed a statement that said, In a staff-to-patient abuse allegation, the employee involved will be removed from the care of the patient immediately pending investigation and the patient will be kept safe.</p>		