STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215132	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Deer's Head Center	351 Deer's Head Hospital Road Salisbury, MD 21801

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 50904 Based on a review of medical records and interview with facility staff and interview with resident's family, it was determined that the facility failed to provide written notice with the reason for transfer to a resident or resident representative. This was evident for one resident (Resident #13) out of one resident reviewed for hospitalization . This findings include: On 07/11/24 at 02:29 PM, during review of Resident #13's record, surveyors discovered a nursing progress note written by registered nurse (RN) #60 on 7/7/2024 at 5:24 PM that stated that Resident #13 was transferred to the hospital for a change in mental status on that date at 4:50 PM. The note stated that the resident's representative was made aware. However, the note did not indicate that a written notice of discharge was provided to the resident or their representative at that time. No other progress note indicated that a written notice of transfer was provided to the resident or their representative. On 07/11/24 at 04:10 PM, during and interview with RN #44, she was asked about the protocols for documenting hospital transfers. She stated that nurses document about a resident's transfer in the electronic record, and that ready-made packets with the patient's demographic information, diagnoses, medications, and laboratory test results are provided to the transport team after getting the doctor's order to transfer the resident. She also stated that families are contacted mostly through phone calls and this notification is documented in a free progress note (a progress note without subheading) and also confirmed that a note is not sent with the resident or family as family members are hardly around at the time of transfer. On 07/11/24 at 04:20 PM, a record review of Resident #13's paper and electronic medical record was done and there was no evidence of written notification being provided to the resident or the resident's family. (continued on next page)

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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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/12/24 at 10:51 AM, Resident #13 was seen in bed with his/her representative at bedside. When the resident was asked if he/she was notified of his/her last hospital transfer, he/she found it difficult to respond. The resident representative was asked if he/she was notified of the recent hospital transfer, and he/she stated that he/she was called when the facility wanted to send the resident out to the hospital and was made aware verbally of the transfer. He/she stated this was also true for past hospitalization s, that they had told him/ her in person or on the phone. The resident representative denied ever being notified in writing.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 50904 Based on review of medical records and interview with facility staff, it was determined that the facility failed to implement a process to ensure that residents and resident representatives were made aware of the facilities bed hold policy upon transfer to the hospital. This was evident for one resident (Resident #13) out of one resident reviewed for hospitalization . This findings include: On 07/11/24 at 02:29 PM, during record review, surveyors discovered a nursing progress note written by registered nurse (RN) #60 on 7/7/2024 at 5:24 PM that stated that Resident #13 was transferred to the hospital for a change in mental status at 4:50 PM of the same day. The note stated that the resident's representative was made aware and the resident was sent out via physician' s order. There was no mention of a bed hold policy noted in the note. On 07/11/24 at 04:05 PM, surveyors conducted an interview with RN #44. When she was asked about the protocol for when a patient is to be sent to the hospital, she stated that nurses document in the electronic record and a packet is given to the transport team. When she was asked about the bed hold policy, she confirmed that the bed hold policy was not given to the resident or family during the time of transfer. She confirmed that there was no copy of the bed hold policy given to Resident #13 for his/her transfer on 7/7/24. On 07/12/24 at 09:14 AM, an interview was conducted with the Assistant Director of Nursing (ADON). When she was asked about the bed hold policy, she stated that there was an admission checklist and a bed hold policy given at the time of admission. She stated that the bed hold policy is followed when residents come back from the hospital. She confirmed that there was no written (paper) bed hold policy given to the resident or families around the time of a resident's transfer to the hospital by nursing staff. On 07/12/24 at 09:54 AM, during an interview with a licensed social worker (Staff #21), he was asked what he does during a resident's transfer to the hospital. He stated that he did only his Minimum Data Set section. He also stated that upon admission, he went over the bed hold policy with each resident. He confirmed that paper bed hold policy is not given to residents and families at the time of transfer to the hospital. Staff #21 came back at 10:13 AM to inform surveyors that a copy of the bed hold policy is not given to residents or their representatives when residents are hospitalized and that going forward, it was something they are looking into starting.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 42782 Based on medical record review and interviews it was determined that the facility staff administered a psychotropic medication that was contraindicated for Dementia, failed to monitor a resident for extrapyramidal side effects, and failed to complete a gradual dose reduction in the past year. This deficient practice was evidenced in 1 (#21) of 1 resident record reviewed for unnecessary psychotropic medications during the survey. The findings include: According to the Mayo Clinic)a not-for-profit academic medical center), Quetiapine is used alone or together with other medicines to treat bipolar disorder (depressive and manic episodes) and schizophrenia. Quetiapine extended-release tablet is also used together with other antidepressants to treat major depressive disorder. This medicine should not be used to treat behavioral problems in older adult patients who have dementia or Alzheimer disease. Quetiapine is an antipsychotic medicine that works in the brain. On 07/08/24 at 12:55 pm during observation rounds the surveyor entered Resident #21's room and observed the resident in a chair sleeping. The surveyor called Resident #21's name several times until they awakened and was able to speak with the surveyor. On 07/10/24 at 9:52 am the surveyor observed Resident #21 in bed and the surveyor was unable to arouse the resident. Unit Manager #28 entered the resident's room and was able to arouse the resident with difficulty. Resident #21 opened their eyes briefly and went back to sleep. On 07/10/24 at 11:28 am the surveyor asked Medical Director #30 when a resident is on a psychotropic medication, when is a gradual dose reduction (GDR) attempted. Medical Director #30 verbalized a GDR is attempted every 6 months; during the Mood-Behavior rounds the intent of a GDR is discussed. The multidisciplinary team such as nursing, therapy, and the Activities staff is involved during the rounds. They try to get residents off psychotropic medications. Medical Director #30 indicated residents who have Schizophrenia, Huntington's Disease, and Tourette's Syndrome, a GDR is not indicated and Resident #21 had a history of Schizophrenia. On 07/10/24 at 1:15 pm the surveyor reviewed Resident #21 EMR (electronic medical record) which revealed the resident did not have a history of Schizophrenia, but the resident did have a history of Dementia. Further review of the EMR revealed the resident was prescribed Quetiapine Fumarate 25 mg PO (by mouth) BID (two times a day). The medication was ordered on 04/18/22. Also, Resident #21 was ordered Quetiapine Fumarate 25 mg PO QD (every day) at 9:00 pm and Quetiapine Fumarate 50 mg PO QD at 9:00 pm. The start date for both medications is 04/26/23. The surveyor reviewed the progress notes and there was not documentation to verify a GDR was attempted. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/12/24 at 10:14 am the surveyor received a copy of Resident #21's behavioral report. The last documented behavior occurred on 01/08/24 at 11:13 pm. According to the note written by the nurse, the resident was resistive to care and medication administration. The staff had difficulty getting the resident to go to bed but was persuaded to do so. Review of Resident #21's EMR revealed the resident was not being monitored for extrapyramidal side effect related to psychotropic medication administration. On 07/12/24 at 2:45 pm during a telephone interview with Certified Registered Nurse Practitioner (CRNP) #47 they verbalized Resident #21 was admitted from a state hospital on a higher dose of Quetiapine; shortly after the resident was admitted the medication was discontinued. Resident #21 has Dementia with a lot of behaviors and physical aggression. Within the last month the resident displayed behaviors such as cursing, hollering and being belligerent. Sometimes they grab people or push them away. When asked about behavioral monitoring CRNP #47 verbalized behavioral monitoring is a nursing question. When asked about a GDR being done, CRNP #47 verbalized providing documentation the previous day that a GDR was done. The surveyor made CRNP #47 aware the documentation did not have a name of a medication, the dose, or any information to verify a GDR was attempted. CRNP #47 did not know when Resident #21 had a GDR; they believe it was last September. A GDR is done annually; twice in the first year, three months part and annually. On 07/12/24 at 3:06 pm during an interview with Medical Director #30 the surveyor reported after reviewing Resident #21's diagnoses, the resident did not have a history of Schizophrenia. Medical Director #30 verbalized reviewing the resident's medical diagnoses and agreed the resident did not have a history of Schizophrenia. Medical Director #30 verbalized the resident's medication regimen was changed once in 2022 and twice in 2023 and that they try to make sure the lowest possible dose of medication is given. Once they get them down to a certain point and behaviors occur, they must stop a GDR. Medical Director #30 was made aware the GDR documentation the surveyor received did not include a name of a medication, a dose, or any changes indicating a dose reduction of a medication occurred. There was not sufficient documentation to verify a GDR was done

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 49304 Based on observation, record review, and interview with facility staff, it was determined that the facility failed to ensure the medication error rate was less than 5 percent. This was evident for 2 (#28, #42) of 4 residents observed with 32 medication administration opportunities which resulted in an error rate of 31.25% by 2 (#55, #58) of 4 staff observed. The findings include: On 7/11/24 at 8:45 AM the surveyor walked up, introduced self, and advised that they wanted to observe med (medication) pass. Registered Nurse (RN) #55 stated she just came from administering morning medications to Resident #28 who complained of 7/10 throat pain and wanted to see if he/she has a PRN (as needed) pain medication ordered. Upon scrolling through the electronic health record (EHR) she then stated, he/she does have an order for PRN acetaminophen 500mg (milligrams), 2 tablets. RN #55 dispensed the medication and at 8:47 AM entered Resident #28's room and administered the medication. On 7/11/24 at 9:20 AM, review of Resident #28's medical record revealed an order for Good Sense Pain Relief Extra Strength 500 MG Tablet, Medication Order, 500 MG, Oral, Tablet, Analgesic/Anti-Inflammatory/Migraine/Gout Agents/Anesthetics, ANALGESICS - NonNarcotic. 2 Tablet by mouth As Needed Every Eight Hours for pain 1-6/10. 55 mins Effectiveness. On 7/11/24 at 9:35 AM in an interview with RN #55 when asked about the asked the indication for the acetaminophen, she pulled up the order in the EHR and stated the indication is for pain 1-6/10. The surveyor asked what pain score the resident reported to her and the nurse stated 7. During the interview, when asked if as the order is written she should have administered the acetaminophen, RN #55 stated no. RN #55 failed to follow physician's orders. The Assistant Director of Nursing (ADON) was notified of the concerns on 7/11/24 at 9:54 AM. During a second medication administration observation that took place on 7/11/24 at 9:27 AM, Licensed Practical Nurse (LPN) #58 administered amlodipine 5mg, carvedilol 25mg, clobazam 10mg, modafinil 200mg, lacosamide 20mL (milliliters), keppra 15mL, prednisone 10mg, and lansoprazole 10mL to Resident #42. Review of Resident #42's medical record on 7/11/24 at 9:28 AM revealed that all the above medications were ordered and scheduled to be administered Every day at 8:00 AM. On 7/11/24 at 9:32 AM, in an interview with LPN #58 when asked the standard of practice for administering a medication on time, she stated it is that you administer medications up to 1 hour before or 1 hour after the scheduled time. During the interview, LPN #58 confirmed the medications were late and stated we can write a note in the MAR (medication administration record) why it [medication] was late. LPN #58 administered the medications at 9:27 AM which was 1 hour and 27 minutes after the prescribed time. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/11/24 at 9:54 AM, review of the facility's Medication Management Policy; Chronic Hospital and CCF Units revealed, Medications are administered to patients/residents by qualified personnel in compliance with federal and state laws and standards of professional practice. Furthermore, in the Medication Error Management Definitions section of the policy it stated, Medication Error- a discrepancy between what the physician ordered and what was reported to occur; types of errors include omissions, extra doses, wrong doses, unauthorized drugs, wrong drug form, wrong rate, wrong time, wrong administration technique, transcription. The administrative team was made aware of the findings at the time of survey exit on 7/12/24 at 4:45 PM.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49304 Based on record review and interview with facility staff, it was determined that the facility failed to don appropriate personal protective equipment (PPE) when transferring a resident. This was evident for 1 (#4) of 21 residents reviewed during the survey. The findings include: On 7/9/24 at 9:20AM in an interview with Unit Manager (UM) #28, when asked about the Enhanced Barrier Precaution (EBP) signage (with 9B [Room # for Resident #4] written on it in black marker) she stated it is not for a current infection, but for staff to be aware of a history of infection. Furthermore, she stated, I believe [s/he] has a history of MRSA (methicillin-resistant staphylococcus aureus). During the interview, she stated yes, there is different signage for a resident on transmission based precautions (TBP) versus EBP. The surveyor made UM #28 aware that the facility matrix provided to the survey team by Staff #3 yesterday (7/8/24 at 1:06 PM) had an X for Resident #4 under TBP. UM #28 asked, Can I look that up? and pulled up the electronic health record (EHR). She then stated, the order is in as EBP and she could ask the Director of Nursing (DON) about that because they may have made an error. During the interview she stated, she could call the Infection Control Nurse (ICN) #41 which she did. After talking to ICN #41, UM #28 stated, [Resident #4] has no active infection. During the interview, the Assistant Director of Nursing (ADON) approached UM #28's office at 9:26 AM. UM #28 explained the situation and the ADON stated, it [facility matrix] was brought down to you all [survey team] quickly and there are errors. She further stated, I looked at it yesterday and saw some mistakes. In addition, the ADON stated she usually likes to look it over but was busy and that it [facility matrix] said we have an IV [Intravenous] and that is not true anymore. The ADON stated, I am going to get you an updated copy. Review of Resident #4's medical record on 7/9/24 at 10:04 AM revealed the resident was ordered, Enhanced Barrier Precautions (EBP) Treatment Order Precautions and Directions: Every eight hours Every day at Day Shift 7:00am-2:59pm, Evening Shift 3:00pm-10:59pm, Night Shift 11:00pm-06:59am. EBPs are indicated during high-contact resident care activities including; dressing, bathing, showering; transferring; providing hygiene; changing linens, changing briefs or assisting with toileting; device care e.g. indwelling catheters of any type; wound care requiring a dressing. EBP signage instructs staff on what must be done (hand hygiene, gowns, gloves) and when. On 7/9/24 at 10:12 AM UM #28 was observed performing hand hygiene and entering Resident #4's room to assist Geriatric Nursing Assistant (GNA) #35, transfer the resident to his/her wheelchair. Neither staff member were observed donning a gown. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/9/24 at 10:20 AM in an interview with UM #28 when asked what they were doing in Resident #4's room she stated, transferring the resident with a [NAME] lift because you must have 2 people. When asked if she had shared that the resident is ordered EBP she stated yes, and you caught that. I did not have a gown on. During the interview when asked what personal protective equipment (PPE) do EBP orders and signage state providers and staff must don when transferring, UM #28 stated, I had my gloves on and should have had a yellow gown on too. On 7/9/24 at 10:27 AM in an interview with GNA #35 when asked what she was doing in Resident #4's room she stated she washed him/her up, provided ADL (activities of daily living) care to get him/her ready for the day, and transferred the resident from the bed to his/her wheelchair and that requires 2 people. When asked what PPE staff must wear when transferring residents who are ordered EBP, GNA #35 stated, I do not know what that means. The surveyor and GNA #35 walked around the corner to the resident's room. The surveyor pointed out the EBP signage with his/her room/bed, 9B, written on the sign and GNA #35 stated she thought he was cleared by now. UM #28 (whose office is located directly next to Resident #4's room) interjected and stated no, remember he/she has a history, so we must wear a gown and gloves to protect ourselves and other residents. UM #28 stated that she did not wear one [gown] either and to make sure to tell everyone [staff] up front too. When GNA #35 was asked if she was wearing a yellow gown when transferring Resident #4, she stated no.