

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2025
NAME OF PROVIDER OR SUPPLIER Carroll Lutheran Village		STREET ADDRESS, CITY, STATE, ZIP CODE 200 St. Luke's Circle Westminster, MD 21157	

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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>Based on medical record review, and staff interviews, it was determined that the facility failed to review and revise care plans by Interdisciplinary team (IDT) members, when quarterly, annual, and significant change assessments were completed. This was evident for one resident (#44) of the 29 Residents reviewed for the care plan participation during the recertification survey.</p> <p>The findings include:</p> <p>The interdisciplinary team meets and develops care plans once the facility staff completes a comprehensive resident assessment. Care plans provide direction for individualized care of the resident. A care plan flows from each resident's unique list of diagnoses and should be organized by the resident's specific needs. The care plan is a means of communicating and organizing the actions and ensuring the resident's needs are attended to. The care plan is to be reviewed and revised at each assessment of the resident to ensure the interventions on the care plan are accurate and appropriate for the resident.</p> <p>Review of the medical record on 06/05/25 at 09:57 AM revealed that Resident # 44 had been a resident at the facility for more than a year, receiving long-term care.</p> <p>Comprehensive assessments for Resident #44 were completed on 2/22/24, 08/20/24, 11/19/24, and 2/13/25. IDT care plan attendance did not reflect the signatures of the GNA and the physician.</p> <p>On 06/06/25 at 11:49 AM, the surveyor reviewed care plan attendance and participation of required members with Director of Nursing (DON) and Nursing Home Administrator (NHA) who acknowledged that the Geriatric Nursing Assistant and the Physician did not participate in care plan meetings on the four above-mentioned dates and stated that they will develop a system to include them. Both agreed that they will develop a system that will involve all required members to attend.</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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>Based on observation, medical record review, and interview, it was determined the facility staff failed to follow physician orders and label oxygen tubing and humidifier bottle when changed. This was evident for 1 (Resident #20) of 29 residents reviewed during a recertification/complaint survey.</p> <p>The findings include:</p> <p>Oxygen (O2) therapy is a treatment that provides you with extra oxygen to breathe in. It is also called supplemental oxygen. It is only available through a prescription from your health care provider.</p> <p>On 5/29/2025 at 9:35 AM during initial pool screening, surveyor observed Resident #20 in bed. The resident was wearing a nasal cannula (a device that delivers extra oxygen through a tube and into your nose) that was connected to a humidifier (water) bottle connected to an oxygen concentrator set at 4LPM (liters per minute). The LPM oxygen flow rate of 4 indicates that 4 liters of oxygen should flow into the resident's nose in 1 minute. There was no date/time and/or staff initials noted on both the oxygen tubing and humidifier bottle. When asked the resident stated the oxygen tubing was changed last week but s/he could not remember the exact date/day the oxygen tubing and/or humidifier bottle were changed.</p> <p>On 5/29/2025 at 9:45 AM, Registered Nurse (RN #2) verified and confirmed that Resident #20's oxygen tubing and humidifier bottle were not labelled with the date/time they were hung. She stated that both the oxygen tubing and humidifier bottle should be changed at least once a week and should be dated. RN #2 further stated she was going to change both the oxygen tubing and humidifier bottle right away so as to label them.</p> <p>On 5/29/2025 at 10:25 AM, in an interview with the Director of Nursing (DON), surveyor reviewed the above observations regarding Resident #20's oxygen tubing and humidifier bottle not labeled as per physician orders. DON stated she was aware of surveyor's observation and they were in the process of doing an audit of all the residents on oxygen to make sure the tubing and humidifier bottles were dated.</p> <p>During a review of Resident #20's medical record conducted on 6/2/2025 at 8:54 AM, surveyor noted an active physician order dated 4/29/2025 for: Oxygen at 4L/min via nasal cannula continuous to maintain SPO2 > greater than 90% every shift. There were additional orders dated 5/5/2025 for Change Oxygen tubing and humidifier bottle weekly. Date and initial, every night shift every Mon.</p> <p>On 6/2/2025 at 9:03 AM, review of Medication Administration Record (MAR) and Treatment Administration Record (TAR) for May 2025 revealed staff documentation that the oxygen tubing and humidifier bottle were changed on Monday 5/26/2025. However, when surveyor observed the Oxygen tubing and humidifier bottle on 5/29/2025, there was no date/time and/or initial to indicate that the oxygen tubing and humidifier bottle had been changed as per physician orders.</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>Based on medical record review and interview, it was determined the facility staff failed to ensure that a resident was given pain medication consistent with professional standards of practice. This was evident for 1 (Resident #20) of 29 residents reviewed during a recertification/complaint survey.</p> <p>The findings include:</p> <p>Review of Resident #20's clinical records on 6/2/2025 at 8:40 AM revealed the resident was admitted to the facility in April 2025 with medical diagnoses that include but not limited to unspecified fracture of right femur, subsequent encounter for closed fracture with routine healing, unspecified atrial fibrillation, chronic obstructive pulmonary disease with (acute) exacerbation, acute and chronic respiratory failure with hypoxia.</p> <p>On 6/2/2025 at 8:54 AM, a review of physician orders for Resident #20 revealed the following orders:</p> <ul style="list-style-type: none"> - Tylenol Oral Tablet 325 MG (Acetaminophen), Give 2 tablets by mouth every 4 hours as needed for pain/fever Do not exceed 3000mg/day, start date 4/29/2025. [Of note: this PRN (as needed) order has no parameters for administration] <p>There were also discontinued orders for:</p> <ul style="list-style-type: none"> - Oxycodone HCl Oral Tablet 5 MG (Oxycodone HCl), Give 1 tablet by mouth every 6 hours as needed for pain management 6-10, start date 4/29/2025 and discontinued on 5/14/2025, and - Oxycodone HCl Oral Tablet 5 MG (Oxycodone HCl), Give 1 tablet by mouth every 6 hours as needed for Pain 6-10 for 1 Week, start date 5/14/2025 and completed on 5/21/2025. <p>On 6/2/2025 at 9:03 AM, record review revealed that Resident # 20's pain was not managed consistently: A review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) for May 2025 was completed. Staff documentation revealed that the resident was given:</p> <ul style="list-style-type: none"> - Oxycodone 5 mg (1 tab) for pain outside ordered parameters (pain 6-10) on the following dates: <p>On 5/1/2025 at 1938 (7:38 PM) for pain score of 5, 5/4/2025 at 2058 (8:58 PM) for pain score of 5, 5/10/2025 at 0936 (9:36 AM) for pain score of 4, 5/10/2025 at 1536 (3:36 PM) for pain score of 5, 5/11/2025 at 1007(10:07 AM) for pain score of 5, 5/16/2025 at 0940 (9:40 AM) for pain score of 5, 5/18/2025 at 2238 (10:38 PM) for pain score of 5, and 5/19/2025 at 0402 (4:02 AM) for pain score of 5.</p> <ul style="list-style-type: none"> - PRN Tylenol 325 mg (2 tabs) ordered without parameters for pain management was given multiple times (17 times) for pain scores ranging from 3 to 8: pain score 5 on 5/8/25 at 2024 (8:24 PM), pain score of 4 on 5/19/2025 at 2349 (11:49 PM), pain score of 6 on 5/20/2025 at 1358 (1:58 PM), pain score of 7 on 5/21/2025 at 2131 (9:31 PM), pain score of 8 on 5/22/2025 at 1409 (2:09 PM), pain score of 5 on 5/23/2025 at 0757 (7:57 AM), pain score of 3 on 5/24/2025 at 0801 (8:01 AM) etc. <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/2/2025 at 10:45 AM, an interview was conducted with Registered Nurse (RN #3), who has worked in the facility for about 2 years. Regarding administration of PRN pain medications, RN #3 stated that prior to giving any pain medication, he will assess the resident's pain and choice of pain med to be given will be based on physician orders/ordered parameters. He stated that Oxycodone was usually given for a pain score of 6 or greater. RN #3 added that for a pain score of below 6, he would give Tylenol and monitor resident for pain relief. If pain was not relieved by Tylenol, he (RN #3) will call the doctor and get an order to administer something else. RN #3 further stated that ordered parameters for PRN pain meds should always be followed.</p> <p>On 6/3/2025 at 9:35 AM, in an interview with the Director of Nursing (DON), surveyor reviewed Resident #20's MAR and TAR for May 2025 regarding pain management and staff not following ordered parameters for PRN pain med administration. DON reviewed and verified that the ordered PRN Tylenol did not have parameters for administration. She further verified that PRN Oxycodone was given outside ordered parameters on the dates noted above. DON stated that the PRN Oxycodone appeared to have been given by the same nurses and she (DON) was going to find out if they documented in the progress notes why the Oxycodone was given outside ordered parameters.</p> <p>On 6/3/2025 at 10:16 AM, in a follow up interview with the DON, she stated that she (DON) reviewed the nurses' progress notes and could not find any documentation why the nurses gave the PRN Oxycodone outside ordered parameters. She added that she will educate the nurses.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>Based on observation, interview and record review, it was determined that the facility failed to ensure that medications were secure and inaccessible to unauthorized staff and residents. This was evident for 1 (Resident #12) of 29 residents observed during the recertification/complaint survey.</p> <p>The findings include:</p> <p>On 5/30/25 at 8.49 AM during the initial tour of the facility, a round pink medication was found in a medication cup at Resident #12's bedside table with a half-empty cup of water. The resident was not in the room at the time.</p> <p>Staff #22 a Registered Nurse (RN), was called to the resident's room on 5/30/25 at 8: 55 AM and was shown the medication. She identified it as TUMs (Calcium Carbonate) prescribed for acid reflux and stated that it must have been left there by the night shift nurse. She stated that she has not given the resident her morning medications yet because the resident was in the dining room having breakfast. Staff #22 took the medication, discarded it with the half empty cup of water.</p> <p>A review of Resident #12's May 2025 Medication Administration Records (MAR) on 5/30/25 at 9:15 AM revealed that s/he was prescribed tums-calcium carbonate 600mg twice a day (BID), it was signed off as given on 5/29/25 by the night nurse.</p> <p>On 5/30/25 at 10:00 AM-the surveyor went back to interview the resident. S/he was asked about the medication left at the bedside. The resident stated that s/he was unable to swallow the medication because it was too big and would normally request to have it crushed.</p> <p>On 5/30/25 at 10:15AM, the Director of Nursing (DON) was made aware of the findings, she stated that she will follow up.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observations of the facility's kitchen, review of kitchen records, and interview of dietary staff, it was determined that the facility failed to store food items to maintain the integrity of the specific item, and prevent ice from building up on the floor in the walk-in freezer. These deficient practices have the potential to affect all residents served food out of the facility's kitchen identified during the recertification survey.</p> <p>The findings include:</p> <p>Surveyor's initial observation of the kitchen, accompanied by dietary shift supervisor #23 on 05/29/25 at 08:36 AM, revealed that:</p> <ul style="list-style-type: none"> - Caramel topping, artificially flavored, was dated as 04/24 without labeling the year. - Black mission figs from Jeppe Nut Company were labeled as 04/21, without mentioning the year. - The bread rolls' expiration date was noted as 05/26/25, and the hot dog bread expired on 05/20/25. - Noted open container of Orange natural flavor extract, without an open date. Noted the label received on 4/24. <p>On 05/29/25 at 08:36 AM, the surveyor interviewed Dietary staff # 24 who stated that the labels should have a complete date, including the year, or it should have a label of best use by; their labeling gun cannot add the year for the label. They will come up with a different process, including the complete date. Staff # 24 also added that their culinary team, whoever is at work, checks the expiration of bread every day except Sundays.</p> <p>On 05/29/25 at 09:20 AM, surveyor observation of the cold storage revealed that small pieces of ice were noted on the floor, making the floor wet and slippery.</p> <p>On 06/02/25 at 11:30 AM, in cold storage, two of the storage shelves had boxes stacked up to the ceiling, leaving less than an inch of clearance from the ceiling.</p> <p>On 06/02/25 at 11:45 AM, findings were reviewed with Dietary staff #24 and reviewed with the Nursing home administrator.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of the medical record and staff interview, it was determined that the facility failed to ensure accurate documentation of staff communication with the Resident. This was evident for 1 (Resident # 64) out of 29 Residents reviewed for accurate medical records during the recertification survey.</p> <p>The findings include:</p> <p>The medical record must contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress, including his/her response to treatments and/or services, and changes in his/her condition, plan of care goals, objectives and/or interventions.</p> <p>On 06/04/25 at 10:22 AM, Medical record review revealed that Resident #64 was admitted on [DATE], for short-term rehab, and his/her roommate was admitted during the weekend. Further review of documentation revealed that the Resident# 64 left the facility against medical advice on 03/23/25.</p> <p>On 06/04/25 at 10:59 AM, an Interview with the unit manager staff #14 revealed that the admission coordinator communicates with staff and residents regarding the new roommate. No documentation was provided on staff communication with the Resident, regarding upcoming, new roommate admission.</p> <p>On 06/04/25 at 11:31 AM, an interview with staff #11 revealed that, when he/she went to inform resident #64 regarding the new roommate, the Resident #64 told staff #11 that he/she does not like to have a roommate. Staff #11 told the Resident that the facility will review alternative arrangements. Staff #11 was unable to provide documentation to reflect the communication between the staff member #11 and Resident #64.</p> <p>On 06/04/25 at 11:39 AM, an Interview with the Director of Nursing (D.O.N) revealed that weekend Supervisor staff (#25) reported that the resident was offered alternatives, including a private room, but the Resident insisted on leaving along with a family member, against medical advice (AMA). DON was unable to provide any documentation that the supervisor spoke to the resident, offering alternatives.</p> <p>On 06/04/25 at 02:51 PM the surveyor reviewed with the D.O.N. and the Nursing Home Administrator (N.H. A) regarding the Resident's discharge against medical advice and staff not documenting the communication with the Resident, about the new roommate. Both of them acknowledged the concern.</p>		