

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215149	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/01/2024
NAME OF PROVIDER OR SUPPLIER  Denton Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  420 Colonial Drive Denton, MD 21629	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25232</b></p> <p>Based on observations, interviews, record review, and facility policy review, the facility failed to ensure that two of five residents (Resident (R) 14 and R65) were treated with dignity and respect, out of a total sample of 31 residents. This failure has the potential to negatively affect all residents residing in the facility by affecting a resident's psychosocial well-being.</p> <p>Findings include:</p> <p>Review of the facility's policy titled, Promoting/Maintaining Resident Dignity, dated 02/02/24 indicated, It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and is in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident's rights .When interacting with a resident, pay attention to the resident as an individual .Maintain resident privacy.</p> <p>1. Review of R14's Admission Record, located under the Profile tab in the electronic medical record (EMR) indicated that R14 was readmitted to the facility on [DATE] with a diagnoses of anxiety and depression.</p> <p>Review of R14's Minimum Data Set (MDS), located under the MDS tab in the EMR, with Assessment Reference Date (ARD) of 07/18/24 indicates R14 has a Brief Interview for Mental Status (BIMS) of 15 out of 15, indicating R14 was cognitively intact.</p> <p>During an interview on 10/29/24 at 12:30 PM, R14 indicated that the staff do not knock and/or introduce themselves prior to entering her room. During the resident interview, observed Certified Medicine Aide (CMA)1, opening R14's bedroom door without knocking or asking for permission, walked into the bedroom and placed R14's lunch tray on her overbed table, without introducing herself.</p> <p>During an observation on the 400-hall on 10/31/24 at 8:10 AM, R14 was telling CMA1, who was standing at the medication cart, You did not ask if I wanted that then R14 left the area going towards the nursing station, while CMA1 was observed rolling her eyes.</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: 215149	If continuation sheet Page 1 of 53

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/31/24 at 9:18 AM, CMA1 was asked about R14, and she stated that R14 was saying something about her medication but could not explain exactly what the concern was, stating she does not know. CMA1 appeared to be nonchalant and continued to pass residents' medication. Another interview on 11/01/24 at 12:30 PM, CMA1 indicated that she did not roll her eyes at R14 and indicated that it was the expectation that staff treat all residents with respect. CMA1 said that all staff are to knock and wait for permission before entering a resident's room.</p> <p>During an interview on 11/01/24 at 9:15 AM, R14 indicated that the concern in the hallway yesterday was over CMA1 picking up her lunch tray on Tuesday prior to her being done. R14 said that CMA1 rolls her eyes all the time and was glad that someone saw this, indicating that this pisses her off when staff do this, and that she hates fake people.</p> <p>During an interview on 11/01/24 at 11:22 AM, the Interim Director of Nursing (DON) confirmed that staff are to knock and wait for an answer before entering a resident's room and confirmed at no time would she expect staff to roll their eyes at a resident.</p> <p>2. Review of R65's Admission Record, under the Profile tab in the EMR indicated, R65 was readmitted to the facility on [DATE] with a diagnoses of obstructive and reflux uropathy.</p> <p>During a bath and catheter care observation in R65's room on 10/31/24 at 8:49 AM, Geriatric Nursing Assistant (GNA) 4 removed R65's gown, leaving R65 uncovered and exposed. GNA4 washed, rinsed, and patted dry R65's back, and assisted R65 to lay back on the bed, uncovered and exposed. At this point, R65 said that she was cold, and GNA4 told R65 that she was going to hurry up. GNA4 then proceeded to wash, rinse, and dry R65's chest area. GNA4 removed R65's incontinent brief, and washed, rinsed, and dried R65's perineal area, while R65 was observed lying on her bed, uncovered, exposed. Again, R65 said that she was cold. GNA4 did not respond to R65. GNA4 observed to wash, rinse, and pat dry R65's catheter tubing. Observed R65 placing both hands on the top of her head, stating Can you hurry up, as R65 was lying on her bed uncovered and exposed. Observed GNA4 did not respond to R65's comment and continued. GNA4 did not offer R65 a blanket and/or sheet to cover herself. GNA4 proceeded to wash, rinse and dry both legs. At this point, GNA4 assisted in turning R65 to her right side and washing, rinsing, and drying R65's back and bottom area. R65 was lying on her right side with her knees bent towards her chest, uncovered, and exposed.</p> <p>Review of R65's quarterly MDS assessment with ARD of 08/06/24, located under the MDS tab in the EMR, indicated R65 a Brief Interview for Mental Status (BIMS) score of zero out of 15 which indicated R65's cognition was severely impaired. The MDS indicated that R65 was not interviewable due to short-term and long-term memory issues.</p> <p>During an interview on 10/31/24 at 9:30 AM, GNA4 indicated that R65 states she is cold all the time, and said that if R65 complains of being cold, she will turn on the heat in her bedroom.</p> <p>During an interview on 10/31/24 at 6:00 PM, the Interim Director of Nursing (DON) stated that she expected staff to cover residents during care by using a blanket and/or sheet so that the resident would not be exposed.</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 25232</p> <p>Based on observations, interviews, and record review, the facility failed to allow one of one resident (Resident (R) 15) reviewed from a sample of 31 residents for self-determination to make their own choice on the size of incontinent briefs to wear. This failure has the potential to affect R15 and other residents residing at the facility by not allowing the residents to make choices about aspects that affect their daily lives.</p> <p>Findings include:</p> <p>Review of R15's Admission Record, under the Profile tab in the electronic medical record (EMR) indicated, R15 was readmitted to the facility on [DATE] with a diagnosis of morbid obesity.</p> <p>During an interview with R15 on 10/29/24 at 1:00 PM, she said that she needs bigger incontinent briefs because the size she has now is rubbing her skin and they are painful to wear. During the interview, R15 was observed wearing a white incontinent brief which appeared to be too little and tight around her waist and thigh area. She said that she can not sit up with this size of an incontinence brief. R15 indicated that the nurse aides even say that she needs a bigger size. R15 stated that she has expressed this to the facility for the past two months and has been given no resolution.</p> <p>Review of R15's quarterly Minimum Data Set (MDS) assessment, located under the MDS tab in the EMR, with Assessment Reference Date (ARD) of 08/30/24 indicated, Brief Interview for Mental Status (BIMS) 15 out of 15, which indicates R15 is cognitively intact.</p> <p>During an interview on 10/31/24 at 7:15 AM, the Medical Records/Central Supply staff indicated that all residents were measured by the brief company about two to three months ago and indicated that R15's current size is 3x but said that R15 was measured at a large size. She indicates that the tape on the briefs should stop on the resident's hips and not be able to go over resident's stomach. About one month ago, R15 requested a larger size, so she let the staff try a 4x-5x which went all the way around R15. Medical Records/Central supply staff confirmed that she made the decision that R15 did not need the larger size of incontinent briefs and indicated that R15 did not complain afterwards. She indicated that she stocks each resident rooms with their appropriate size each Friday so that residents will have the necessary sizes over the weekend.</p> <p>During observation on 10/31/24 at 10:00 AM, R15 was lying in her bed with the right side of her incontinence brief undone, and the left side of the incontinent brief fastened on her hip area. An opened package of white incontinence briefs size 3x-4x size were in R15's closet.</p> <p>During an interview on 11/01/24 at 10:40 AM, GNA3 said that R15 currently wears an incontinent brief size 3x-4x; however, this size is not long enough. Indicated that R15 is a heavy wetter, so she needs an incontinent brief that can absorb the urine. GNA3 indicated that R15 has been trying to obtain a larger size of incontinence brief for some time. GNA3 indicated that if a larger size incontinent brief was needed for a resident, that staff should be able to obtain the larger size.</p> <p>(continued on next page)</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/31/24 at 6:18 PM, the Interim Director of Nursing (DON) indicated that the incontinent briefs appear little; however, from her understanding, is that residents have been measured and given sizes according to the manufacture's recommendation. The DON stated that she understands to get optimum usage out of the incontinent brief, it needs to be the correct size. The DON did not provide a response as to why R15 was not provided a larger size incontinence brief.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 31145</p> <p>Based on review of complaints, observation of resident rooms and equipment, and resident and staff interview, it was determined the facility staff failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This was evident on 3 of 4 nursing units observed.</p> <p>The findings include:</p> <p>On 10/30/24 at 8:30 AM a review of complaint MD00201981 alleged that there was black mold in the rooms on the 400 wing.</p> <p>On 10/30/24 at 9:00 AM an environmental tour was conducted, and the following was observed:</p> <p>Room: 401/403 bathroom: Observed in the shared bathroom on the wall was a 1 ft. by 4-inch hole in the wall where the plaster was busted through to the wood studs.</p> <p>Room: 407 - (A) bed: the over the bed light on the wall was rusted from top to bottom. (B) bed area on back wall by the head of the bed was a 3 ft. by 2 ft. area of spackle that was not painted. The Resident stated it has been that way for a least 8 months. The trim on the wall under the television area was pulled away from the wall. The front of the counter of the sink was chipped approximately 1 1/2 inches by 1 inch. There was a gap around the radiator that had no molding.</p> <p>Room: 408 - The wall in the bath had spackle approximately 8 ft. by 20 inches that was not painted over. In the bedroom under the sink was a 2 ft. area of black appearing mold.</p> <p>Room: 410 - black mold appearing spots on the wall under the sink that covered a 2 ft. area.</p> <p>Room: 412 - the toilet was constantly running and the housekeeper stated it had been like that for 1 week.</p> <p>Room: 400 - there was black appearing mold ingrained on the inside of the wood bathroom door.</p> <p>Room: 307 - there was black appearing mold under the sink counter on the wall that covered approximately 3 ft.</p> <p>Room: 200 - there was missing base molding in the bathroom to the left of the toilet approximately 3 ft. in length.</p> <p>Room: 203 - the wall by the hand sanitizer was missing paint approximately 6 inches by 3 inches.</p> <p>Room: 204 - in the bathroom the cover to the smoke detector was missing and the cover to the ceiling ventilation fan was missing.</p> <p>Room: 205 - there was black appearing mold on the wall under the sink.</p> <p>(continued on next page)</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 10/30/24 at 9:22 AM an interview was conducted with Staff #14 who stated, the maintenance guy didn't do anything last week. Last Friday was his last day. Staff #14 stated, there was massive mold in room [ROOM NUMBER] on the toilet. Maintenance was aware of all the mold and didn't take care of it.</p> <p>On 10/30/24 at 9:45 AM an interview was conducted with Resident #8 who stated she had been telling the Maintenance Director about the mold, but he wouldn't do anything about it. Resident #8 had a yellow sticky note on the bathroom door where the mold was located.</p> <p>On 10/30/24 at 11:00 AM a tour was conducted with the Regional Director of Maintenance (RDM) who was shown all areas of concern. The RDM confirmed the surveyor's findings and stated there was a lot of work to be done.</p>

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35690</p> <p>Based on interviews, record review, and facility policy review, the facility failed to ensure one of 31 sample residents (Resident (R) 4) reviewed for Resident Council grievances was promptly resolved. Specifically, the facility failed to ensure a grievance voiced by R4 during a resident council meeting on 09/24/24 was investigated, resolved, and followed up by staff. This failure had the potential to cause further grievances to be unresolved for residents throughout the facility.</p> <p>Findings include:</p> <p>Review of the facility's policy titled, Resident Council Meetings, dated 02/06/24 and provided by the facility revealed, The facility will make prompt efforts to resolve grievances.</p> <p>1. Review of R4's Admission Record, located under the Profile tab of the Electronic Medical Record (EMR), revealed R4 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's Disease, dementia, and major depression.</p> <p>Review of R4's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/08/24 and located under the MDS tab of the EMR, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R69 was cognitively intact.</p> <p>2. Review of R34's Admission Record, located under the Profile tab of the EMR, revealed R34 was admitted to the facility on [DATE] with diagnoses that included traumatic brain injury, major depression, and dementia</p> <p>Review of R34's quarterly MDS, with an ARD of 08/08/24 and located under the MDS tab of the EMR, revealed a BIMS score of 15 out of 15 which indicated R34 was cognitively intact.</p> <p>Review of the Resident Council Minutes provided by the facility, dated 09/26/24 revealed the Council Concern/Recommendation Form revealed [R4] expressed that [R34] is being rude to him because of the toilet not being cleaned properly after he goes to the bathroom. The Staff Response portion of the form revealed, Staff will assist [R4] with completing his toileting hygiene. The form was undated and unsigned.</p> <p>During the group meeting held on 10/31/24 at 1:57 PM, R4 stated when he goes to the bathroom, R34 who lives next door to him will start banging on the wall and tell him to get out of the bathroom. R4 said that he needs staff's help to get out of the bathroom. R4 said that one day in the dining room, R34 came to him and yelled at him for not cleaning up the toilet after he used it.</p> <p>During an interview on 11/01/24 at 10:58 AM, the Activities Director (AD) stated that when a resident expressed a concern in resident council, she would write the concern on the Council Concern/Recommendation Form and then give the form to the Social Services Assistant (SSA). The AD said once she gets the form back, she will review it in the next Resident Council. She thought R4's concern had been forgotten because the Director of Nursing (DON), who received the concern, was no longer employed at the facility.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/01/24 at 11:08 AM, the SSA said she was the grievance officer and would ensure that the grievance had been followed up on and a resolution was in place. She said then she would also follow up with the residents to ensure there were no further concerns. She said regarding the incident with R4 and R34, she had given the form to the former DON and had not seen it since.</p> <p>During an interview on 11/01/24 at 11:17 AM, the Administrator said that she oversaw all grievances and when a grievance was resolved she would review the documentation and provide the final signature. She said she had not seen the concern from R4 but confirmed there should be more follow-up. She said she expected any time a resident expressed a concern there should be follow-up within the week.</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 37590</p> <p>Based on interviews, record reviews, and review of the facility's policy, the facility failed to protect the resident's right to be free from physical abuse for one of six residents (Resident (R) 39) reviewed for abuse out of a total sample of 31.</p> <p>Findings include:</p> <p>Review of the facility's policy titled, Compliant with Reporting Allegations of Abuse/Neglect/Exploitation, with an implementation date of 02/20/24, revealed, the purpose of . assuring the facility is doing all that is within its control to prevent occurrences [of abuse] . The policy recorded that abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include . certain resident to resident altercations.</p> <p>Review of R39's Electronic Medical Record (EMR) revealed the resident was admitted to the facility on [DATE] with diagnoses that included chronic hepatitis, alcoholic cirrhosis of the liver, anxiety disorder, panic disorder, and dementia.</p> <p>Review of R39's annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/22/24 and located under the MDS tab of the EMR, revealed R39 had long and short-term memory problems.</p> <p>Review of R63's EMR revealed the resident was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease, vascular dementia, and altered mental status.</p> <p>R63's care plan was reviewed and revealed a focus, initiated on 07/25/24, that recorded R63 had the potential to be physically aggressive related to dementia. Interventions included medications as ordered, to analyze triggers, and try to assess and anticipate his needs.</p> <p>Review of R39's EMR revealed a Practitioner Note, dated 08/07/24 at 1:00 AM. The note stated that R39 was in an altercation with another resident. Per the note, R39 was punched in the face by R63, then the residents were separated and redirected. The note also indicated that R39 had no pain or bruising.</p> <p>An interview was conducted with the Administrator and the Nurse Practitioner (NP) on 10/29/24 at 2:47 PM, and they indicated that they were not aware of an incident between R39 and R63. The Administrator confirmed that she was not aware of report being made regarding the resident-to-resident incident.</p> <p>The Director of Nursing (DON) was interviewed on 10/30/24 at 2:19 PM, and she stated that she was not familiar with the incident as she has only been the DON for about a month. She stated she would gather more information. At 2:42 PM the DON confirmed that there was no internal investigation into the incident and the State Agency had not been notified.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Registered Nurse (RN) 3, a nurse supervisor, was interviewed on 10/30/24 at 2:49 PM, and she stated that she did not witness the incident but had been told R39 wandered into R63's room. RN3 stated R63, who had a BIMS of 15, could be aggressive and hard to redirect at times. RN3 stated R63 was very particular about his space. RN3 stated a stop sign had been placed in front of R63's door to help prevent other residents from entering the room. She stated she could not be sure that R39 understood the purpose of the sign.</p> <p>Continuing with the interview on 10/30/24 at 2:49 PM, RN3 stated that R39 appeared to be agitated, wandered the unit, and at times wandered into other residents' rooms. She stated that she had been advised that R39 was found in R63's room and was removed and placed near the nurses' station. RN3 started approximately 10 minutes later, R63 approached R39 and punched him in the face. She stated that R63 was immediately removed from the area and taken back to his room. RN3 stated R39 was assessed and no injuries were noted. She added that R39 was kept at the nurses' station for monitoring. RN3 confirmed that both resident representatives and physicians were contacted.</p> <p>RN3 was asked if she had reported the incident. She stated that she was not sure, but it was the facility's policy to report. She stated she believed she did report the incident but could not remember when or to whom she reported it.</p> <p>The Minimum Data Set Coordinator (MDSC), who was the Unit Manager (UM) of the 500-unit when the incident occurred, was interviewed on 10/30/29 at 2:57 PM. She stated she remembered hearing of the incident but was not present at the facility when this incident occurred. She stated that she was pretty sure the previous DON was notified of the incident. The MDSC stated that R63 was a high functioning dementia patient that could be triggered at times by the other residents on the unit.</p> <p>Geriatric Nursing Assistant (GNA) 8 was interviewed on 10/31/24 at 09:03AM. GNA8 confirmed that she witnessed the incident. GNA8 stated that R39 was a wanderer and had a habit of wandering into other residents' rooms. GNA8 stated that R39 could be difficult to redirect and was able to move fast. She stated that at the time of the incident, she did not witness R39 in R63's room, but she did see R63 approach R39 as he stood near the nurses' station and pinch punch [hit with a closed fist] R39 in the face. GNA8 stated that the residents were separated immediately, and the nurse on duty was advised of the incident. GNA8 was asked if she had received any formal abuse training given by the facility, and she confirmed that she had and knew who and where to report any abuse related concerns.</p> <p>Review of R39's Care Plan revealed a focus that stated that the resident wandered due to his diagnosis of dementia with behaviors. The interventions included offering pleasant diversions to distract the resident. The care plan also revealed a focus, dated 09/19/23, that R39 had the potential to be physically and verbally aggressive towards others. Interventions included providing medications as ordered and intervening before any escalations.</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 16177</p> <p>Based on review of the facility's investigations, medical record reviews, interviews, and policy review, the facility failed to fully implement their abuse policy for an allegation of physical abuse and verbal abuse and misappropriation of property three of five residents (Resident (R) 233, R11, and R232) reviewed for abuse out of a total sample of 31 residents. This failure to fully implement the abuse policy, including timely and thorough investigations and and timely reporting, increased the risk of continued abuse to residents.</p> <p>Findings include:</p> <p>Review of the facility policy, Abuse Neglect and Exploitation, dated 02/02/24, revealed abuse means the willful infliction of injury . intimidation . with resulting physical harm, pain, or mental anguish which can include staff to resident abuse and certain resident to resident altercations . instances of abuse of all residents . cause mental anguish . It includes verbal abuse . and mental abuse . alleged violation is a situation or occurrence that is observed or reported by staff, resident, or others but has not yet been investigated . mental abuse includes, but is not limited to . threats of punishment . misappropriation of resident property means the deliberate misplacement , exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent . physical abuse includes, but is not limited to hitting, slapping, punching . verbal abuse means the use of oral . or gestured communication or sounds that willfully includes disparaging . terms to residents . the facility will develop and implement written policies and procedures that prohibit and prevent abuse . and misappropriation of resident property; establish policies and procedures to investigate any such allegations . possible indicators of abuse include . physical abuse of a resident observed . sudden or unexplained changes in behaviors and/or activities such as fear of a person . an immediate investigation is warranted when suspicion of abuse . reports of abuse . identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations . providing complete and thorough documentation of the investigation . protection of resident . to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation . responding immediately to protect the alleged victim . the facility will have written procedures that include: reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g. law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made if the events that cause the allegation involve abuse or result in serious bodily injury.</p> <p>1. Review of the Facility Reported Incident (FRI) MD00201316 revealed R233 reported an allegation of physical and verbal abuse to Registered Nurse (RN)1 that Geriatric Nursing Assistant (GNA)15 was rough during care and threatened him if you touch your diaper you will regret it for the rest of your life and if I come back in the morning you better not have messed with your diaper.</p> <p>Review of the electronic medical record (EMR) Face Sheet revealed R233 was admitted to the facility on [DATE] status post stroke.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the EMR Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/16/23, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating R233 was cognitively intact. Further review of this MDS revealed R233 was dependent on staff for toileting and displayed no physical or verbal behaviors of agitation or refusal of care.</p> <p>Review of the facility's investigation, provided by the Administrator, revealed a Witness Statement, dated 01/08/24 and written by the former Director of Nursing (DON)2. The nature of the incident per the witness statement was alleged verbal abuse. The date of the incident was recorded as 01/06/24 on the 11PM-7AM shift. The statement read, Upon entering my office this am [sic], I had found a written statement that was slid under my door. The statement was regarding an abuse allegation against an aide on 11-7. I immediately notified the administrator [sic] of the facility and went to speak with the resident. The resident reported that the aide was allegedly very rough with him during his care and his arms and neck were sore as a result. He said he was threatened and was scared. He mentioned that she had allegedly told him if he kept playing with his diaper, he would 'regret it for the rest of his life.' I asked if he knew the name of the aide that was providing care and he told me he did not. I asked him to describe her and he told me she had glasses. I then looked at the schedule to see who was working on that unit overnight and scheduled aide for unit [number] was [GNA15]. I contacted [GNA15] and asked her to send me her statement in which she began to make statements about how she is being targeted by everyone, including myself [sic]. I also requested statements from other staff that were working at this time, awaiting those statements as well. Resident was evaluated by supportive care for mental health evaluation and placed on daily safety check to assure [sic] resident's safety and comfort within the facility. Resident reports he is not sleeping well as a result of this and is scared every time someone comes through the door.</p> <p>Further review of the facility's investigation revealed a Witness Statement, dated 01/11/24 and written by RN1. The nature of the incident per the witness statement was alleged abuse. The statement read, patient stated to me that his aide the previous night had threatened him. He asked if anything could be done about it, so I filled out the grievance form with him.</p> <p>Further review of the facility's investigation revealed a Concern Form. dated 01/07/24 and written for R233 by RN1. The description of the concern read, Per the resident-She came in and looked down my face and said, 'If you touch your diaper you will regret it for the rest of your life.' She said, 'I better not come in the morning and you've messed with your diaper.' I think she's mad because they brought me over here [to that unit]. She scared me a little bit, and I thought she was going to get a hold of me. The Concern Form was signed by R233 and RN1.</p> <p>Review of the Maryland Department of Health Office of Health Care Quality (OHCQ) Facility Reported Incident Initial Report Form, submitted by DON2 and dated 01/08/24 at 10:15 AM, revealed DON2 stated the alleged incident occurred on Saturday 1/6/24 11-7 shift (technically Sunday morning 11/7/24 [sic-1/7/24] but that she was made aware on 01/08/24 at 8:45 AM when she found the written statement under her office door.</p> <p>During a telephone interview on 10/30/24 at 4:45 PM, RN1 stated that he was told on 01/07/24 during the 3-11 PM shift by R233 that the previous night his aide was rough, threatened him, and he was afraid to go to sleep. RN1 stated, I texted the DON and she said to write a statement and slip it under her door, which I did. I didn't see the aide after that [her 11-7 shift on 01/07/24]. When asked when he texted the DON about the allegation, RN1 stated, That evening as soon as [R233] told me.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a telephone interview on 10/30/24 at 5:10 PM, DON2 stated she first found out about the abuse allegation on Monday morning (01/08/24) when she found the written statement under her door. After the interview, DON2 called this surveyor back on 10/30/24 at 5:23 PM and stated that RN1 did text her the evening of 01/07/24 and I told him to put a written statement under my door and to not allow that aide to take care of that resident [R233]. DON2 verified that she did not report the abuse allegation until Monday morning 01/08/24 although she was notified via text message on 01/07/24.</p> <p>Review of the Maryland OHCQ Facility Reported Incident Follow-Up Investigation Report Form, submitted by DON2 and dated 01/12/24 at 12:00 PM, revealed, Due to there being no visible injuries on the resident we could not confirm that the aide was rough with the resident during care despite resident reporting it and saying he was very sore. We also could not prove the verbal abuse as the statements [by the three staff] were contradictory and there was no other proof . Allegation unsubstantiated.</p> <p>Further review of the facility's investigation revealed written statements from GNA15, GNA16 (no longer employed by the facility), and RN2. All three staff statements denied any verbal or physical abuse during the 3PM-11PM or the 11PM-7AM shifts that GNA 15 worked on 01/06/24 - 01/07/24. There were no other staff statements or resident statements obtained as part of the investigation for the allegation of verbal and physical abuse against GNA15. Cross Reference: F609 Reporting, F610 Investigate Protect Alleged Violation.</p> <p>2. Review of FRI MD00196438 revealed missing narcotics for R11 (one oxycodone) and R232 (one oxycodone and one oxycontin) on 08/29/23. Final report. Medication became unaccounted for indefinitely. Employee states the medication was correct on count . Employee terminated . Nurses educated on narcotic count policy and safe handling of controlled medications. Facility is unable to determine what happened with the missing medication. However, residents remain safe and pain is controlled.</p> <p>Review of the EMR Progress Notes, Medication Administration Records (MARs), and Physician Orders for R11 and R232 verified that on 08/29/23 three pills total were unaccounted for but the residents did not have any complaints of unrelieved pain.</p> <p>Review of the Corrective Action Notice, provided by the facility and dated 08/26/23, revealed RN4 had three missing narcotics that were unaccounted for on shift change. [RN4] reports unsure of where they [missing narcotics] went. Agrees cart was correct during hand off. Nurse [RN4] walked out of the building with staff . Termination.</p> <p>During an interview on 11/01/24 at 3:00 PM, the Administrator and the [NAME] President of Clinical Operations (VPCO), were asked for all the documentation for this investigation. Review of the facility investigation, provided by the facility Administrator and the VPCO revealed no written statements from R11 or R232 or other residents or from staff concerning the missing narcotics. The investigation included an audit of all residents in the facility, background checks on RN4, in-services of the nursing staff on medication administration and narcotic counts, and a copy of an Attorney General Subpoena State of Delaware for information on RN4. Review of the documentation revealed the administrative staff at the time of the incident were no longer employed at the facility. The Interim DON was unfamiliar with the incident since she had been employed at the facility for a month prior to the survey. Cross Reference: F610 Investigate Protect Alleged Violation.</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34484</p> <p>16177</p> <p>Based on the facility's investigations, medical record reviews, interviews, and policy review, the facility failed to timely report allegations of physical abuse and verbal abuse for 5 (Resident (R) 233, R32, R28, R65, R62) of 31 residents reviewed for abuse. This failure increased the risk of continued abuse to these residents.</p> <p>Findings include:</p> <p>Review of the facility policy, Abuse Neglect and Exploitation, dated 02/02/24, revealed . abuse means the willful infliction of injury . intimidation . with resulting physical harm, pain, or mental anguish which can include staff to resident abuse and certain resident to resident altercations . instances of abuse of all residents . cause mental anguish . It includes verbal abuse . and mental abuse . alleged violation is a situation or occurrence that is observed or reported by staff, resident, or others but has not yet been investigated . mental abuse includes, but is not limited to . threats of punishment . physical abuse includes, but is not limited to hitting, slapping, punching . verbal abuse means the use of oral . or gestured communication or sounds that willfully includes disparaging . terms to residents . the facility will develop and implement written policies and procedures that prohibit and prevent abuse . establish policies and procedures to investigate any such allegations . possible indicators of abuse include . physical abuse of a resident observed . sudden or unexplained changes in behaviors and/or activities such as fear of a person . the facility will have written procedures that include: reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g. law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made if the events that cause the allegation involve abuse or result in serious bodily injury.</p> <p>1. Review of the Facility Reported Incident (FRI) MD00201316 revealed R233 reported an allegation of physical and verbal abuse to Registered Nurse (RN)1 that Geriatric Nursing Assistant (GNA)15 was rough during care and threatened him if you touch your diaper you will regret it for the rest of your life and if I come back in the morning you better not have messed with your diaper. Cross Reference: F610 Investigate, Protect Alleged Violation.</p> <p>Review of the electronic medical record (EMR) Face Sheet revealed R233 was admitted to the facility on [DATE] status post stroke.</p> <p>Review of the EMR Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/16/23, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating R233 was cognitively intact. Further review of this MDS revealed R233 was dependent on staff for toileting and displayed no physical or verbal behaviors of agitation or refusal of care.</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>Review of the facility's investigation, provided by the Administrator, revealed a Witness Statement, dated 01/08/24 and written by the former Director of Nursing (DON)2. The nature of the incident per the witness statement was alleged verbal abuse. The date of the incident was recorded as 01/06/24 on the 11PM-7AM shift. The statement read, Upon entering my office this am [sic], I had found a written statement that was slid under my door. The statement was regarding an abuse allegation against an aide on 11-7. I immediately notified the administrator [sic] of the facility and went to speak with the resident. The resident reported that the aide was allegedly very rough with him during his care and his arms and neck were sore as a result. He said he was threatened and was scared. He mentioned that she had allegedly told him if he kept playing with his diaper, he would 'regret it for the rest of his life.' I asked if he knew the name of the aide that was providing care and he told me he did not. I asked him to describe her and he told me she had glasses. I then looked at the schedule to see who was working on that unit overnight and scheduled aide for unit [number] was [GNA15]. I contacted [GNA15] and asked her to send me her statement in which she began to make statements about how she is being targeted by everyone, including myself [sic]. I also requested statements from other staff that were working at this time, awaiting those statements as well. Resident was evaluated by supportive care for mental health evaluation and placed on daily safety check to assure [sic] resident's safety and comfort within the facility. Resident reports he is not sleeping well as a result of this and is scared every time someone comes through the door.</p> <p>Review of the Maryland Department of Health Office of Health Care Quality (OHCQ) Facility Reported Incident Initial Report Form, submitted by DON2 and dated 01/08/24 at 10:15 AM, revealed DON2 stated the alleged incident occurred on Saturday 1/6/24 11-7 shift (technically Sunday morning 11/7/24 [sic-1/7/24] but that she was made aware on 01/08/24 at 8:45 AM when she found the written statement under her office door.</p> <p>Review of the Maryland OHCQ Facility Reported Incident Follow-Up Investigation Report Form, submitted by DON2 and dated 01/12/24 at 12:00 PM, revealed, Due to there being no visible injuries on the resident we could not confirm that the aide was rough with the resident during care despite resident reporting it and saying he was very sore. We also could not prove the verbal abuse as the statements [by the three staff] were contradictory and there was no other proof. Allegation unsubstantiated.</p> <p>During a telephone interview on 10/30/24 at 4:45 PM, RN1 stated that he was told on 01/07/24 during the 3-11 PM shift by R233 that the previous night his aide was rough, threatened him, and he was afraid to go to sleep. RN1 stated, I texted the DON and she said to write a statement and slip it under her door, which I did. I didn't see the aide after that [her 11-7 shift on 01/07/24]. When asked when he texted the DON about the allegation, RN1 stated, That evening as soon as [R233] told me.</p> <p>During a telephone interview on 10/30/24 at 5:10 PM, DON2 stated she first found out about the abuse allegation on Monday morning (01/08/24) when she found the written statement under her door. After the interview, DON2 called this surveyor back on 10/30/24 at 5:23 PM and stated that RN1 did text her the evening of 01/07/24 and I told him to put a written statement under my door and to not allow that aide to take care of that resident [R233]. DON2 verified that she did not report the abuse allegation until Monday morning 01/08/24 although she was notified via text message on 01/07/24.</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>During an interview on 10/31/24 at 9:15 AM, the Administrator stated DON2 reported the allegation to her via telephone after RN1 texted DON2 on 01/07/24. The Administrator stated, I told [DON2] to pull her [GNA15] off the floor meaning [GNA15] did not have to leave the facility but could not be on the same unit as [R233] while the investigation was ongoing. I also told [DON2] to get statements from [GNA15] and the resident. When asked when an allegation of abuse should be reported to the State Agency, the Administrator stated, Within two hours of learning of the allegation.</p> <p>2. Review of R32's Admission Record, located under the Profile tab in the EMR, indicated that R32 was readmitted to the facility on [DATE] with diagnoses including dementia.</p> <p>During an initial observational tour of the facility on 10/29/24 at 12:30 PM, R32 attempted to be interviewed; however, R32 only looked up when her name was called, but was unable to answer any questions.</p> <p>Review of R32's quarterly MDS, assessment with an ARD of 08/06/24, indicated that R32 had short-term and long-term memory loss.</p> <p>Review of a facility provided Maryland Department of Health Office of Health Care Quality Facility Reported Incident Report Form (initial report), dated 06/10/24, indicated, . Allegation type: sexual . Director of Nursing (DON) notified on 06/10/24 at 3:34 PM, DON notified Administrator on 06/10/24 at 3:40 PM . Allegation was allegedly reported to [name of hospice nurse] by [R32] during her assessment . They raped me and it hurt, it did not feel good it hurt no matter what they say . Facility provider and Medical Director made aware. Resident interviewed to the best of our ability-[R32] has a history of dementia. Full head to toe assessment completed by two nurses. Family made aware.</p> <p>Review of a facility provided Maryland Department of Health Office of Health Care Quality Facility Reported Incident Follow-Up Investigation Report Form (5-day summary), dated 06/14/24, indicated, . [R32] was interviewed by Unit Manager . on 06/10/24. Notified Nurse Practitioner (NP) on 06/11/24 and Medical Doctor (MD) on 06/12/24. Neither of the interviewees were able to substantiate allegations . All support staff that provide care or worked on the unit with [R32] were interviewed. No one reported seeing or hearing anything that would substantiate [R32]'s claims. Five residents from [R32]'s unit were interviewed, none reported seeing or hearing anything that would substantiate claims of abuse. All nurses that provided care for [R32] were interviewed. None reported seeing or hearing that would substantiate [R32]'s claims .After interviews were completed from staff and residents, we were unable to substantiate claims of abuse made to hospice on the date in question.</p> <p>Review of the facility's investigation indicated no evidence that police were contacted about this allegation of sexual abuse.</p> <p>During an interview with the interim DON on 10/30/24 at 3:10 PM, she confirmed that the police were not contacted and indicated that the police should have been contacted.</p> <p>3. Review of the EMR for R28 revealed the resident was admitted to the facility on [DATE] with diagnoses that included dementia, Parkinson's disease, anxiety, and depression.</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>Review of a facility investigative file for R28 revealed that on 04/11/24 during the 3-11 shift, GNA7 noted that R28 had redness to her right eye. In a statement provided by GNA7, it was recorded GNA7 notified the nurse on duty, RN3. The statement recorded GNA7 then began to see swelling and darkening of the area, and GNA7 again reported the information to RN3. It was recorded that when GNA7 had reported the second time to RN3, RN3 responded by asking GNA7 what she would like for her to do about it because she (RN3) did not know what had happened. It was recorded an investigation was started on 04/12/24 after the family of R28 reported a concern regarding the bruising. A written statement by RN3, dated 04/13/24, recorded that she had been notified by staff that family had identified bruising and reported the bruising, but the statement did not record on what date the family had identified the bruising. The conclusion of the investigation was that the resident likely had an unwitnessed fall in her room. Review of the Facility Reported Incident (FRI) form revealed that the bruising of unknown origin was reported to the State Agency until 04/16/24.</p> <p>During an interview on 10/29/24 at 2:47 PM, the Administrator stated she was unaware of the bruising with R28 and the late reporting as DON2 would have been the person responsible for reporting.</p> <p>During an interview on 10/31/24 at 5:35 AM, RN3 stated she did not remember the situation, but she would have reported it if she had knowledge because that was facility policy.</p> <p>An interview was conducted with GNA7 on 10/31/24 at 2:40 PM. She stated that on 04/11/24, she reported redness to R28's right eye to the nurse on shift. GNA7 stated she believed she told RN3. GNA7 stated that she worked a double that day (3-11 &amp; 11-7 on 04/11/24), and during the 11-7 shift, she noticed the redness began to darken and swell. GNA7 stated that she told the nurse again but felt RN3 had not taken her seriously. GNA7 stated that she had the next day off and received a call from someone at the facility asking about the bruising that had been noticed by the family during a visit that day. GNA7 was advised that on her next shift she would need to write a statement. GNA7 confirmed the contents of her statement in the investigative file.</p> <p>25232</p> <p>37590</p> <p>4) On 10/29/24 at 11:34 AM a review of Resident #65's medical record revealed an 8/7/24 physician's progress note that documented Resident #65 was seen by the nurse practitioner the day prior and Resident #65's daughter noticed bruising and swelling of the right hand. The physician documented, no known new injury. There have been no reports of new falls. The physician documented that when he saw the resident the previous week he did not notice any pain, swelling, or bruising of the hands and the family was not concerned last week regarding the resident's hands. No notification by any nursing staff regarding patient having a new injury from now until my last visit. The</p> <p>patient is in no distress at this time. [He/She] tells me [he/she] has some mild discomfort of [his/her] right hand. [He/She] cannot answer me whether [he/she] fell or not. I again asked nursing staff and they report no known history of new injuries. X-ray was ordered by nurse practitioner yesterday and it came back showing a hairline nondisplaced fracture of the right second metacarpal. The physician documented there was musculoskeletal bruising and swelling over the dorsal surface of the right hand and mild pain with palpation of the right second metacarpal (finger).</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>On 10/29/24 at 2:30 PM the Director of Nursing stated there were no reportable incidents related to Resident #65.</p> <p>On 10/31/24 at 7:45 AM an interview was conducted with the Nursing Home Administrator (NHA) about reporting. The NHA stated she was told by Corporate that it wasn't a reportable because of the previous fall. The surveyor informed the NHA that the physician documented that no one knew how the resident got the bruise which was a week after the previous fall and the hand was swollen with a fracture. The NHA was asked how they could determine the cause of the bruise, swelling, and fracture if an investigation was not done. The NHA agreed that an investigation should have been done and it should have been reported to the state agency.</p> <p>31145</p> <p>5) Review of the investigation of Facility Reported Incident MD00206192 revealed the facility reported to OHCQ on 5/23/24, Resident #62 reported a missing bank card and gift card of unknown amount on 5/21/24. Review of a statement from Staff #15 on 5/22/24, revealed on 5/22/24 at 8:30 AM Resident #62 reported that when he/she returned from activities on 5/21/24 his/her bank card was missing.</p> <p>Review the submission to OHCQ revealed it was reported on 5/23/24 at 10:54 AM, not within the required 2 hours.</p> <p>Interview with the Administrator on 10/31/24 at 8:27 AM confirmed the facility staff failed to report an allegation of misappropriation of Resident #62's property to OHCQ in a timely manner.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 16177</p> <p>Based on review of the facility's investigations, medical record reviews, interviews, and policy review, the facility failed to investigate allegations of physical abuse, verbal abuse, and misappropriation of property timely and thoroughly for 4 of 31 residents (Resident (R) 233, R11, R232, and R65) reviewed for abuse.</p> <p>The findings include:</p> <p>1. Review of the Facility Reported Incident (FRI) MD00201316 revealed R233 reported an allegation of physical and verbal abuse to Registered Nurse (RN)1 that Geriatric Nursing Assistant (GNA)15 was rough during care and threatened him if you touch your diaper you will regret it for the rest of your life and if I come back in the morning you better not have messed with your diaper.</p> <p>Review of the electronic medical record (EMR) Face Sheet revealed R233 was admitted to the facility on [DATE] status post stroke. Review of the EMR Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/16/23 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating R233 was cognitively intact. Further review of this MDS revealed R233 was dependent on staff for toileting and displayed no physical or verbal behaviors of agitation or refusal of care.</p> <p>Review of the EMR Care Plan tab revealed no care plan for behaviors was initiated upon admission. Further review of the EMR Care Plan tab revealed a care plan for Stressful Life Experience Resident has experienced a stressful life experience related to abuse allegation from 1/7/2024 Date Initiated: 01/08/2024 Created on: 01/10/2024 Resident will verbalize a sense of control and safety Interventions/Tasks: Actively listen to resident as they describe life's stressful events . Encourage verbalization of feelings, perceptions, and fears . Explore with resident previous methods of dealing with stress . Identify and avoid triggers for stresses (specify) .</p> <p>Review of the facility's investigation, provided by the Administrator, revealed a Witness Statement, dated 01/08/24 and written by the former Director of Nursing (DON)2. The nature of the incident per the witness statement was alleged verbal abuse. The date of the incident was recorded as 01/06/24 on the 11PM-7AM shift. The statement read, Upon entering my office this am [sic], I had found a written statement that was slid under my door. The statement was regarding an abuse allegation against an aide on 11-7. I immediately notified the administrator [sic] of the facility and went to speak with the resident. The resident reported that the aide was allegedly very rough with him during his care and his arms and neck were sore as a result. He said he was threatened and was scared. He mentioned that she had allegedly told him if he kept playing with his diaper, he would 'regret it for the rest of his life.' I asked if he knew the name of the aide that was providing care and he told me he did not. I asked him to describe her and he told me she had glasses. I then looked at the schedule to see who was working on that unit overnight and scheduled aide for unit [number] was [GNA15]. I contacted [GNA15] and asked her to send me her statement in which she began to make statements about how she is being targeted by everyone, including myself [sic]. I also requested statements from other staff that were working at this time, awaiting those statements as well . Resident was evaluated by supportive care for mental health evaluation and placed on daily safety check to assure [sic] resident's safety and comfort within the facility. Resident reports he is not sleeping well as a result of this and is scared every time someone comes through the door.</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 - Some</p>	<p>Further review of the facility's investigation revealed a Witness Statement, dated 01/11/24 and written by RN1. The nature of the incident per the witness statement was alleged abuse. The statement read, patient stated to me that his aide the previous night had threatened him. He asked if anything could be done about it, so I filled out the grievance form with him.</p> <p>Further review of the facility's investigation revealed a Concern Form, dated 01/07/24 and written for R233 by RN1. The description of the concern read, Per the resident-She came in and looked down my face and said 'If you touch your diaper you will regret it for the rest of your life.' She said 'I better not come in the morning and you've messed with your diaper.' I think she's mad because they brought me over here [to that unit]. She scared me a little bit, and I thought she was going to get a hold of me. The Concern Form was signed by R233 and RN1.</p> <p>Further review of the facility's investigation revealed written statements from GNA15, GNA16 (no longer employed by the facility), and RN2. All three staff statements denied any verbal or physical abuse during the 3PM-11PM or the 11PM-7AM shifts that GNA 15 worked on 01/06/24 - 01/07/24. There were no other staff statements or resident statements obtained as part of the investigation for the allegation of verbal and physical abuse against GNA15.</p> <p>Review of the Maryland Department of Health Office of Health Care Quality (OHCQ) Facility Reported Incident Initial Report Form, submitted by DON2 and dated 01/08/24 at 10:15 AM, revealed DON2 stated the alleged incident occurred on Saturday 1/6/24 11-7 shift (technically Sunday morning 11/7/24 [sic-1/7/24] but that she was made aware on 01/08/24 at 8:45 AM when she found the written statement under her office door.</p> <p>Review of the Maryland OHCQ Facility Reported Incident Follow-Up Investigation Report Form, submitted by DON2 and dated 01/12/24 at 12:00 PM, revealed Due to there being no visible injuries on the resident we could not confirm that the aide was rough with the resident during care despite resident reporting it and saying he was very sore. We also could not prove the verbal abuse as the statements [by the three staff] were contradictory and there was no other proof . Allegation unsubstantiated.</p> <p>During a telephone interview on 10/30/24 at 4:45 PM, RN1 stated that he was told on 01/07/24 during the 3-11 PM shift by R233 that the previous night his aide was rough, threatened him, and he was afraid to go to sleep. RN1 stated, I texted the DON and she said to write a statement and slip it under her door, which I did. I didn't see the aide after that [her 11-7 shift on 01/07/24]. When asked when he texted the DON about the allegation, RN1 stated, that evening as soon as [R233] told me.</p> <p>During a telephone interview on 10/30/24 at 5:10 PM, DON2 stated she first found out about the abuse allegation on Monday morning (01/08/24) when she found the written statement under her door. After the interview, DON2 called this surveyor back on 10/30/24 at 5:23 PM and stated that RN1 did text her the evening of 01/07/24 and I told him to put a written statement under my door and to not allow that aide to take care of that resident [R233]. DON2 verified that she did not start an investigation of the abuse allegation until Monday morning 01/08/24 although she was notified via text message on 01/07/24. DON2 verified that she was not aware that GNA15 was not in the facility after her 11PM-7 AM shift on 01/07/24 when she instructed RN1 to not allow GNA15 to take care of R233. DON2 verified that since the investigation was not started immediately to determine what happened and who the alleged perpetrator was, R233 and other residents were at risk for being abused.</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 - Some</p>	<p>During an interview on 10/31/24 at 9:15 AM, the Administrator stated DON2 reported the allegation to her via telephone after RN1 texted DON2 on 01/07/24. The Administrator stated, I told [DON2] to pull her [GNA15] off the floor meaning GNA15 did not have to leave the facility but could not be on the same unit as R233 while the investigation was ongoing. I also told DON2 to get statements from [GNA15] and the resident. When asked how she ensured that GNA15 was not still working with R233, the Administrator stated, I hope she [GNA15] was pulled [removed from caring for F233] because that was a directive.</p> <p>During a telephone interview on 10/31/24 at 10:15 AM, GNA15 denied being rough and threatening R233. GNA15 stated she provided incontinence care for R233 on 01/07/24 (review of the task report on 01/07/24 showed care provided by GNA15 at 2:27 AM) without an issue. GNA15 stated she went home sick on 01/07/24 at 6:00 AM and did not return to the facility until after her planned surgery on 02/04/24. GNA15 stated she was not told she was on administrative leave until 01/10/24, three days after the abuse allegation against her.</p> <p>Review of the Progress Notes tab in the EMR revealed the following notes:</p> <p>01/08/24 11:15 AM . At this time resident reports that he is feeling safe at this time but is scared for her to come back.</p> <p>01/08/24 12:21 PM DAILY SAFETY CHECK This writer went to check on resident due to pending abuse allegations. Resident anxious and reports that he did not sleep well last night. He is reporting that he is scared every time someone comes in the door it will be her. He does not want to be threatened anymore . Primary Care Provider Feedback: Primary Care Provider responded with the following feedback: A. Recommendations: Daily safety checks and urgent mental health evaluation.</p> <p>Review of a psychiatric evaluation, provided by the facility, date 01/08/24, revealed in the history, [R233] . presents for evaluation of potential abuse. Patient reports that an aide has been very rude to him and handles him roughly when she helps him with ADLs [activities of daily living]. Patient reports that yesterday morning, she threatened that if he touched his diaper again, he would 'regret it.' . He is frightened of her and is anxious she will come in the room again. Not sleeping well either as a result . Suspected aide is on administrative leave pending investigation .</p> <p>Further review of the EMR Progress Notes revealed the following:</p> <p>01/9/24 at 1:08 PM Note Text: patient safety check: spoke with patient, upon approaching, patient noted to pull back as if afraid of approaching nurse. Asked patient how he was feeling, maintained distance so patient felt safe and ease in presence of nurse. listened to patients concerns regarding incident over weekend. patient confided that he was scared that he would be hurt and retaliated against. patient stated he is afraid someone would come in his room and rummage through and take his things. this nurse listened to patients fears and concerns, was able to reassure patient that he was safe and would not be retaliated against . patient visibly shaken and upset regarding event. reassured patient that if he had any other concerns to please let myself [sic] know and that it would be handled appropriately and timely. patient thanked me and smiled, confided that he felt safe at this time.</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 - Some</p>	<p>During an interview on 10/30/24 at 4:22 PM, Licensed Practical Nurse (LPN) 2 verified she wrote the note dated 01/09/24 at 1:08 PM. LPN2 stated, He [R233] was very pleasant and never withdrawn and I came in one day and there was an allegation that an aide had been rough with him, so they wanted us to do safety checks on him. He seemed very withdrawn, and he pulled back when I approached him and that was a new behavior . I remember him being afraid of staff [after the allegation of abuse was made].</p> <p>Further review of the EMR Progress Notes revealed the following:</p> <p>01/11/24 at 11:13 AM Note Text: Daily Safety Check. This writer spoke with resident this am [sic] with administrator present regarding how he is feeling. Resident states 'I ain't ever going to get over that, I could have been dead'. I asked if resident feels safe and comfortable in the building today, he states 'yes, thank god [sic] there isn't anyone else coming in and doing that.' Reports he slept a little better last night and wants to thank everybody for all that they have done for him.</p> <p>01/11/24 at 3:00 PM DISCHARGE NOTE . GENERAL CONDITION OF RESIDENT UPON DISCHARGE: Resident clean, calm and cooperative. Alert and oriented x3. R233 was discharged to another nursing facility.</p> <p>2. Review of FRI MD00196438 revealed missing narcotics for R11 (one oxycodone) and R232 (one oxycodone and one oxycontin) on 08/29/23. Final report. Medication became unaccounted for indefinitely. Employee states the medication was correct on count . Employee terminated . Nurses educated on narcotic count policy and safe handling of controlled medications. Facility is unable to determine what happened with the missing medication. However, residents remain safe and pain is controlled.</p> <p>Review of the EMR Progress Notes, Medication Administration Records (MARs), and Physician Orders for R11 and R232 verified that on 08/29/23 three pills total were unaccounted for but the residents did not have any complaints of unrelieved pain.</p> <p>Review of the Corrective Action Notice, provided by the facility and dated 08/26/23, revealed RN4 had three missing narcotics that were unaccounted for on shift change. [RN4] reports unsure of where they [missing narcotics] went. Agrees cart was correct during hand off. Nurse [RN4] walked out of the building with staff . Termination.</p> <p>During an interview on 11/01/24 at 3:00 PM, the Administrator and the [NAME] President of Clinical Operations (VPCO), were asked for all the documentation for this investigation. Review of the facility investigation, provided by the facility Administrator and the VPCO, revealed no written statements from R11 or R232 or other residents or from staff concerning the missing narcotics. The investigation included an audit of all residents in the facility, background checks on RN4, in-services of the nursing staff on medication administration and narcotic counts, and a copy of an Attorney General Subpoena State of Delaware for information on RN4. Review of the documentation revealed the administrative staff at the time of the incident were no longer employed at the facility. The Interim DON was unfamiliar with the incident since she had only been employed at the facility for a month prior to the survey.</p> <p>31145</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 - Some</p>	<p>3) On 10/29/24 at 11:34 AM a review of Resident #65's medical record revealed an 8/7/24 physician's progress note that documented Resident #65 was seen by the Nurse Practitioner the day prior and Resident #65's daughter noticed bruising and swelling of the right hand. The physician documented, no known new injury. There have been no reports of new falls. The physician documented that when he saw the resident the previous week he did not notice any pain, swelling, or bruising of the hands and the family was not concerned last week regarding the resident's hands. No notification by any nursing staff regarding patient having a new injury from now until my last visit. The</p> <p>patient is in no distress at this time. [He/She] tells me [he/she] has some mild discomfort of [his/her] right hand. [He/She] cannot answer me whether [he/she] fell or not. I again asked nursing staff, and they report no known history of new injuries. X-ray was ordered by Nurse Practitioner yesterday and it came back showing a hairline nondisplaced fracture of the right second metacarpal. The physician documented there was musculoskeletal bruising and swelling over the dorsal surface of the right hand and mild pain with palpation of the right second metacarpal (finger).</p> <p>On 10/29/24 at 2:30 PM the Director of Nursing stated there were no reportable incidents related to Resident #65, therefore there was no investigation.</p> <p>On 10/31/24 at 7:45 AM an interview was conducted with the Nursing Home Administrator (NHA) about investigation of the new injury. The NHA stated she was told by Corporate that it wasn't a reportable because of the previous fall, therefore it was not investigated. The surveyor informed the NHA that the physician documented that no one knew how the resident got the bruise which was a week after the previous fall and the hand was swollen with a fracture. The NHA was asked how they could determine the cause of the bruise, swelling, and fracture if an investigation was not done. The NHA agreed that an investigation should have been done.</p>		

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<p>F 0640</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 37590</p> <p>Based on record review, interview, review of the Resident Assessment Instrument (RAI manual and policy review, the facility failed to ensure one resident (Resident (R) 75) out of 31 sampled Minimum Data Set (MDS) assessments was transmitted in a timely manner.</p> <p>Findings include:</p> <p>Review of R75's Electronic Medical Record (EMR) revealed the resident was admitted to the facility on [DATE] and died in the facility on [DATE].</p> <p>Review of R2's MDS with Assessment Reference Date (ARD) of [DATE] revealed the Death in Facility MDS was completed timely. Further review revealed this assessment was transmitted on [DATE] and should have been transmitted by [DATE]</p> <p>During an interview on [DATE] at 08:20AM, the MDS Coordinator (MDSC) confirmed that the facility sends their assessments to their corporate offices, and they transmit the assessments in batches. She added that she does not know when they submitted the assessment, but that she sent it to them immediately.</p> <p>Review of Center for Medicare and Medicaid Services (CMS) Long-term Care Facility Assessment Instrument 3.0 User's Manual, version 1.19.1, dated [DATE], revealed, Chapter 2: Assessments for the Resident Assessment Instrument, 2.6: Required OBRA Assessments for the MDS .RAI OBRA-required assessment summary for Death in Facility assessment . Transmission date no later than MDS death date + 14 calendar days .</p> <p>Review of the facility's policy, MDS Completion and Submission Timeframes revised [DATE] indicated, Our facility will conduct and submit resident assessment in accordance with current federal and state submission timeframes.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 16177</p> <p>Based on observations, interviews, and record review, the facility failed to develop a written care plan with interventions and goals for the use and discontinuation of an indwelling urinary catheter for one of one resident (Resident (R)11) reviewed for urinary catheters out of a sample of 31 residents. This failure resulted in R11 having an indwelling urinary catheter in place for seven months without a written comprehensive plan to discontinue the use of the urinary catheter.</p> <p>Findings include:</p> <p>A policy for care plan development was requested but not provided by the exit of the survey.</p> <p>Review of the electronic medical record (EMR) Face Sheet revealed R11 was admitted to the facility on [DATE].</p> <p>Review of the EMR quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/13/24 revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15 indicating R11 was cognitively intact.</p> <p>During an interview and observation on 10/29/24 at 10:30 AM, R11 was observed to have a urinary catheter collection bag attached to their bed frame. R11 stated they were not sure when or why they got the Foley catheter placed. R11 did state that their physician had recently ordered the Foley to be removed but the resident asked to wait a couple of days until they were feeling better.</p> <p>Review of the EMR Progress Notes revealed a physician's note dated 03/07/24 stating, Urine retention urine Foley catheter placed. Neurogenic bladder versus obstructive uropathy in [sic] the differential. Urinalysis and urine culture ordered along with Urology consultation for a followup [sic]. The patient reports continued to have burning with urination despite finishing another course of antibiotics. She/he states that she is having difficulty getting urine out .</p> <p>Review of the EMR Progress Notes revealed a nurse practitioner note dated 03/08/24 stating, urinary retention most likely due to current infection. Will await us [urinalysis and culture] results and then plan for voiding trial after adequate treatment for UTI. consult to urology.</p> <p>Review of the EMR Orders tab revealed a physician's order dated 03/07/24 to Insert Foley for retention one time only for 1 day. Further review of the EMR Orders tab revealed multiple orders from 03/07/24 to 10/30/24 for Foley catheter care and replacement as needed.</p> <p>Review of the EMR Orders tab revealed a physician's order dated 03/07/24 for a urology consult to rule out possible neurogenic bladder (urinary bladder problems due to disease or injury to the nerves that control urination).</p> <p>Review of the EMR Miscellaneous and Evaluations tabs revealed no urology consult was done on 03/07/24. This was verified by the Director of Nursing (DON) on 11/01/24 at 4:00 PM.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the EMR Evaluations tab revealed a urology consult done on 10/01/24 stating, [R11] . was referred to me for assessment for recurrent urinary tract infections . She/he states that she has a history of urinary urge incontinence [leakage of urine] which is currently treated with a chronic indwelling Foley catheter . I advised the patient that as long as she/he has an indwelling Foley catheter she/he is going to have recurrent urinary tract infections . I would also advise her primary doctors to only treat a UTI when she/he has systemic symptoms as she/he will always grow out positive urine cultures due to colonization [when bacteria are present without causing illness] .</p> <p>Review of the EMR Orders tab revealed a physician's order dated 10/29/24 to discontinue Foley catheter NOW. Monitor for voiding for next 24 hours. If no void in 8 hours call MD [physician]</p> <p>During an interview on 10/29/24 at 1:42 PM, Licensed Practical Nurse (LPN)3 verified that she/he had removed the Foley catheter just a few minutes prior to the interview.</p> <p>During an interview on 11/01/24 at 12:07 PM, the Attending Physician stated that he originally ordered the Foley to be placed because R11 was complaining of not being able to empty her bladder. The Attending Physician stated he was waiting for the urology consult before making a decision on whether to remove the catheter.</p> <p>During an interview on 11/01/24 at 1:28 PM, the Medical Director reviewed R11's medical record and stated that there was no medical indication for the prolonged use of a Foley catheter. The Medical Director stated that resident complaints of not emptying their bladder is not an appropriate justification for the use of a Foley catheter, that a voiding trial should have been attempted earlier and that the urology consult should not have taken seven months to occur.</p> <p>Review of the EMR Care Plan tab revealed no care plan had been developed for the assessment for an appropriate indication, continued use, and/or attempts to discontinue an indwelling urinary catheter that was originally to be for one day after R11 complained of urinary retention on 03/07/24. The failure to develop a care plan with interventions and goals for the use and discontinuation of a urinary catheter resulted in R11 having a Foley catheter without an appropriate indication for seven months.</p> <p>During an interview on 11/01/24 at 4:11 PM, the DON verified that there was no care plan for the use of an indwelling urinary catheter in R11's medical record.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 25232</p> <p>Based on record review, interviews, hospice contract review, and facility policy reviews, the facility failed to ensure that one out of one resident (Resident (R) 32) reviewed for hospice had a care plan to include hospice out of a sample size of 31 residents. In addition, the facility failed to ensure that all necessary interdisciplinary team (IDT) members and outside resources were invited to participate in one of one resident (R32) care conferences, out of a sample size of 31 residents. Also, facility staff failed to have quarterly care plan meetings for residents (Resident #19, #45 and #65). This was evident for 3 of 33 residents reviewed during an annual survey. These failures had the potential to affect resident care.</p> <p>Findings include:</p> <p>Review of the facility's policy titled, Care Plan Revisions Upon Status Change, dated 02/13/24, indicated, . The comprehensive care plan will be reviewed, and revised as necessary .The Minimum Data Set (MDS) Coordinator and the IDT [Interdisciplinary Team] will discuss the resident condition and collaborate on intervention options .The care plan will be updated with the new or modified interventions.</p> <p>Review of facility policy titled, Comprehensive Care Plans, dated 02/13/24, indicated, The comprehensive care plan will be prepared by an IDT, that includes, but is not limited to: the attending physician or non-physician practitioner, a registered nurse (RN) with responsibility for the resident, a nurse aide with responsibility for the resident, a member of the food and nutrition services staff, the resident and the resident's representative, to the extent practicable, other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</p> <p>Review of facility provided Agreement Between [name of the facility] and [name of hospice], dated 12/12/22, indicated, .2.4: Coordination of Care .(c) Modifications to Plan of Care. The facility will assist with periodic review and modification of the Plan of Care. Facility will not make any modifications to the Plan of Care without first consulting Hospice. Hospice retains the sole authority for determining the level of hospice care provided to each Hospice Patient.</p> <p>Review of R32's Admission Record, under the Profile tab in the electronic medical record (EMR) indicated, R32 was readmitted to the facility on [DATE] with a diagnosis of dementia.</p> <p>Review of R32's significant change in status Minimum Data Set (MDS) located under the MDS tab in the EMR, with Assessment Reference Date (ARD) of 05/06/24, indicated hospice while a resident in the facility.</p> <p>Review of R32's Care Plan located under the Care Plan tab in the EMR indicated no evidence of hospice being integrated into the resident's care plan.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with Licensed Social Worker (LSW) on 10/30/24 at 3:30 PM, she confirmed that there was no hospice care plan and that not all IDT team members were participating in care planning meetings. She said that either a nurse from the floor and/or the unit manager, activities, dietary, social work, family, residents, and outside sources such as hospice should be invited to the care plan meetings. The LSW Confirmed that a nurse aide was not invited to the meetings.</p> <p>During an interview with Hospice Nurse on 10/30/24 at 4:27 PM, she confirmed that she was never invited to R32's care plan meetings.</p> <p>During an interview with the Social Services Assist (SSA) on 10/31/24 at 2:56 PM, she said that she was unaware of inviting a hospice representative and/or nurse aide to care planning meetings. The SSA confirmed that she invites the resident, family, activities, sometimes nursing and sometimes the physician and/or Nurse Practitioner (NP).</p> <p>34484</p> <p>Once the facility staff completes an in-depth assessment (MDS) of the resident, the interdisciplinary team meet and develop care plans. 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 assure the resident's needs are attended to. The care plan is to be reviewed and revised at each assessment time of the resident to ensure the interventions on the care plan is accurate and appropriate for the resident. Care plan meetings are held each quarter and as needed.</p> <p>2. Review of Resident #19's medical record on 10/29/24 revealed the Resident was admitted to the facility on [DATE].</p> <p>Further review of Resident #19's medical record revealed the last quarterly care plan meeting was in July 2024. The facility staff failed to have a quarterly care plan meeting in October 2024.</p> <p>Interview with Social Services Assistant on 10/30/24 at 9:40 AM confirmed the facility staff failed to have a quarterly care plan meeting in October 2024.</p> <p>Interview with the Director of Nursing on 10/31/24 at 2:20 PM confirmed the facility staff failed to have a quarterly care plan meeting for Resident #19 in October 2024.</p> <p>3. Review of Resident #45's medical record on 10/29/24 revealed the Resident was admitted to the facility on [DATE].</p> <p>Further review of Resident #45's medical record revealed the last quarterly care plan meeting was in June 2024. The facility staff failed to have quarterly care plan meetings in December 2023, March 2024 and September 2024.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with Social Services Assistant (SSA) on 10/30/24 at 9:40 AM confirmed the facility staff failed to have quarterly care plan meetings in December 2023, March 2024 and September 2024 for Resident #45. At that time the SSA stated he/she asked the Resident to meet but the Resident declined. Review of the medical record revealed no documentation the Resident was invited to a care plan meeting or the facility staff held a care plan meeting without the Resident in December 2023, March 2024 and September 2024.</p> <p>Interview with the Director of Nursing on 10/31/24 at 2:20 PM confirmed the facility staff failed to have quarterly care plan meetings for Resident #45 in December 2023, March 2024 and September 2024.</p> <p>31145</p> <p>4. On 10/29/24 at 11:34 AM complaint MD00201918 was reviewed and revealed an allegation that the facility had not had a care plan meeting with Resident #65's family in a year.</p> <p>Review of Resident #65's medical record revealed the resident was admitted to the facility in August 2023. Review of documentation provided to the surveyor from the Director of Nursing (DON) on 10/31/24 at 4:15 PM revealed Resident #65's signature acknowledging care plans on 9/25/23.</p> <p>Further review of the medical record failed to produce documentation that a care plan meeting had been held between 9/25/23 and 8/6/24.</p> <p>On 10/31/24 at 10:30 AM an interview was conducted with the Social Services Assistant who stated they had not had any care plan meetings since 9/25/23. SSA stated in April 2024 the family was not available to attend and in July 2024 the family canceled and rescheduled. However, there was no documentation that the IDT (interdisciplinary team) had a care plan meeting. A care plan meeting was held on 8/6/24.</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 25232</p> <p>Based on record review and interview, the facility failed to ensure that one of one resident (Resident (R) 3) reviewed for weight loss had weekly weights completed as ordered by the physician, out of a total sample of 31 residents. This had the potential to have increased weight loss for R3.</p> <p>Findings include:</p> <p>Review of R3's Admission Record, under the Profile tab in the electronic medical record (EMR) indicated R3 was readmitted to the facility on [DATE] with a diagnosis of dysphagia.</p> <p>Review of R3's Order Summary Report, dated 10/31/24, located under the Orders tab in the EMR indicated, . Weekly weights .for four weeks, start date of 10/14/24.</p> <p>Review of Weights and Vitals, located under the tab Weights in the EMR indicated:, 10/11/24: 115, 09/15/24: 128.6, 08/05/24: 124.6, 07/02/24: 121.8, 06/27/24: 125, and 05/31/24: 120.3. There was no documentation that R3 was weighed on 10/14/24 and/or 10/21/24.</p> <p>Review of Registered Dietitian (RD) Note-Nutrition/Dietary Note, dated 10/11/24, found under tab Notes in the electronic medical record (EMR), indicated, .Weight loss of 14 pounds (11%) x 30 days, this weight loss follows previously noted weight gains of roughly same quantity, weight remains within usual body weight (UBW): 100-147 pounds .Will recommend weekly weights for closer monitoring.</p> <p>Review of R3's Treatment Administration Record (TAR), for October 2024, located under the Orders tab in the EMR, indicated that there was no evidence of weekly weights for 10/14/24, and/or 10/21/24.</p> <p>During an interview with the Interim Director of Nursing (DON) on 10/31/24 at 6:11 PM, she confirmed that weekly weights were not completed on 10/14/24 or 10/21/24. She said that she would expect staff to complete physician orders as written.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 25232</p> <p>Based on observations, interviews, record review and facility policy review, the facility failed to ensure that two of two residents (Resident (R) 15, and R33) reviewed out of 33 sampled residents, for activities of daily living (ADL) received the necessary services to maintain appropriate grooming. This failure has the potential to affect R15 and other residents residing at the facility's highest practicable physical, mental, and psychosocial well-being by not providing necessary ADL care to dependent residents.</p> <p>Findings include:</p> <p>Review of the facility's policy titled, Activities of Daily Living, dated 02/02/24, indicated, The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices . Care and services will be provided for the following activities of daily living: bathing .A resident who is unable to carry out ADL's will receive the necessary services to maintain good .grooming.</p> <p>Review of R15's Admission Record, under the Profile tab in the electronic medical record (EMR) indicated, R15 was readmitted to the facility on [DATE] with a diagnosis of morbid obesity.</p> <p>During the initial observational tour of the facility and resident interview on 10/29/24 at 1:00 PM, R15 was in her bed, wearing a hospital gown and her hair appeared greasy with white flakes throughout her hair. R15 said that since she is too big by two inches on each hip to fit into the shower chair and does not like the shower bed. R15 stated that she gets bed baths; however, her hair does not get washed.</p> <p>Review of R15's quarterly Minimum Data Set (MDS) assessment, located under the MDS tab in the EMR, with Assessment Reference Date (ARD)of 08/30/24 indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R15 was cognitively intact. The MDS indicated that R15 was dependent on staff for bathing/hygiene.</p> <p>During observation on 10/31/24 at 10:00 AM, R15 was in her bed, dressed in a hospital gown and R15's greasy hair was up in a ponytail with white flakes in the hair.</p> <p>Review of the October 2024 Plan of Coordination (POC) Response History, located under the EMR tab Tasks, indicated no evidence that showers were offered and/or declined. Further review indicated not applicable (n/a) was marked on the following dates: 10/07/24, 10/10/24, 10/12/24, 10/17/24, 10/18/24, 10/21/24, and 10/29/24.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/31/24 at 6:35 PM, the Interim Director of Nursing (DON) said that R15 does not like the shower chair because she had expressed that she feels that staff cannot get her bottom clean enough and that she does not want to sit that long. The Interim DON confirmed that she measured R15 last week and that R15 was two inches in each hip bigger than the facility's shower bed. She said that the previous maintenance director was looking into obtaining a larger shower bed. She could not recall that R15 has been offered a shower and her hair washed in the past month. The Interim DON was shown R15's bathing history: for October 2024, she confirmed that that R15 was not offered showers.</p> <p>31145</p> <p>2). Review of complaint MD00206688 and MD00199271 alleged that Resident #33 was not receiving showers.</p> <p>On 10/29/24 at 2:20 PM Resident #33's medical record was reviewed and revealed Resident #33 was admitted to the facility in June 2023 with a history of having a stroke and had weakness and paralysis on the left side of the body as a result of the stroke.</p> <p>The MDS is part of the Resident Assessment Instrument that was Federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned based on those individualized needs, and that the care is provided as planned to meet the needs of each resident.</p> <p>Review of the admission MDS assessment with an assessment reference date of 6/28/23 documented that Resident #33 was totally dependent on staff for bathing.</p> <p>Review of Resident #33's GNA (geriatric nursing assistant) Kardex documented Resident #33 was assigned to receive showers on Tuesdays and Fridays.</p> <p>Review of Resident #33's ADLs documented that the resident did not receive any showers in October 2024 from 10/1/24 to 10/29/24. There was documentation of bed baths and resident refusals.</p> <p>Review of Resident #33's Documentation for bathing for June 2024, July 2024, August 2024, and September 2024 revealed the resident did not receive a shower, only bed baths.</p> <p>On 10/30/24 at 11:27 AM an interview was conducted with Licensed Practical Nurse, LPN #10 who stated that the resident's shower days were Tuesday and Friday and that she normally sees the resident getting a bed bath. LPN #10 stated, I feel at one point it was because there wasn't a bariatric shower bed. They did get a bariatric shower bed and the appropriate slings.</p> <p>On 10/30/24 Resident #33 was interviewed and stated, they tell me that the shower sling has to come out from under me during the shower. I don't want it taken out. I am afraid I will fall when they turn me from side to side. Both shower beds are broken and missing a pin. The GNA always says there is not enough staff or there are call outs so they can't give me a shower. Yesterday during the day, they were going to give me a shower but again they said they have to take the sling out from under me because they don't want to get wet. So, I refuse.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/30/24 at 2:19 PM an interview was conducted with LPN #8 who stated that Resident #33 was offered a shower but refused. LPN #8 stated, at first [he/she] refused but then changed [his/her] mind. The GNA took the shower bed in there and the pin was loose, so she didn't feel it was safe to put [him/her] on there. The surveyor asked if the shower bed was fixed, and LPN #8 stated she did not know. The surveyor asked if anyone was notified of the broken pin and LPN #8 stated she was not sure. The surveyor then asked if she followed up with the GNA and LPN #8 stated, I told her to put it in TELS. TELS is the computerized system where staff can put repair orders in for maintenance.</p> <p>On 10/30/24 at 2:24 PM an interview was conducted with GNA #9. GNA #9 was asked if she gave Resident #33 a shower on 10/29/24 and she stated, at first, [he/she] said no and then I went back a little later and [he/she] said OK. I took the shower bed in there, but the pin on the bed was broke. The surveyor asked if she told anyone, and she said she told LPN #8. When asked what LPN #8 stated, she said that LPN #8 would put it in TELS. When asked about the sling on the shower bed, GNA #9 stated she took it off because, you get wet because it won't drain right.</p> <p>On 10/30/24 at 2:27 PM an interview was conducted with the Regional Maintenance Director (RMD) and the Director of Nursing (DON) in the shower room while looking at the shower bed. The RMD showed the surveyor and the DON the broken pin and he proceeded to fix the pin during the interview. The DON was explaining how the sling worked on the shower bed, however the surveyor expressed concern that staff were telling the resident and the surveyor that the sling had to be removed because the staff was getting wet when the sling was left on the shower bed.</p> <p>On 10/30/24 at 2:31 PM, with the DON, Resident #33 was interviewed again and Resident #33 informed the DON that he/she did not feel safe being rolled to the side while on the shower bed and while the GNA was trying to pull the sling out from under him/her. The DON asked Resident #33 when the last time he/she had a shower and he/she said, a long time. I have only been getting bed baths. Resident #33 also stated that the he/she prefers to get showers on the day shift because the evening shift always has excuses about being short staffed, therefore bed baths had to be given.</p> <p>The DON was informed on 10/30.24 that LPN #8 did not follow through with the status of the broken shower chair.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35690</p> <p>Based on observations, interviews, record review and policy review, the facility failed to ensure that the designated smoking area was safe for one of one resident (Resident (R) 29) reviewed for smoking. R29 was the only smoker in the facility. Specifically, the facility failed to ensure there was an accessible metal container with a self-closing cover where the ashtrays could be emptied, that did not contain trash and there was no protective cover over the smoking area to protect R29 from rain and snow.</p> <p>Findings include:</p> <p>Review of the facility policy titled, Resident Smoking dated 02/11/24 revealed, It is the policy of this facility to provide a safe and healthy environment for residents, visitors, and employees, including safety as related to smoking .Smoking is prohibited in all areas except the designated smoking areas .Safety measures for the designated smoking are will included, but not limited to: Protection from weather conditions, accessible metal containers with self-closing covers into which ashtrays can be emptied.</p> <p>Review of R29's Admission Record, located under the Profile tab of the Electronic Medical Record (EMR), revealed R29 was admitted to the facility on [DATE] with diagnoses that included Hemiplegia, Chronic Obstructive Pulmonary Disease and Major Depression.</p> <p>Review of R29's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/04/24 and located under the MDS tab of the EMR, revealed R29 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS), which indicated R29 was cognitively intact. The MDS did not report any mood or behavior concerns.</p> <p>Review of R29's Smoking assessment dated [DATE] revealed R29 smoked 10+ cigarettes per day, during the morning, afternoon, and evening. Based on the assessment, R29 was safe to smoke with or without supervision.</p> <p>During an interview and observation of the smoking area on 10/31/24 at 12:03 PM with the Regional Director of Labor, the Maintenance Director (MD),the Administrator in Training (AIT), the Regional Director of Labor, the MD and the AIT agreed there was no protective covering over the smoking area, only a plastic strip attached to the wall above the door that appeared to once have had something attached to it that could provide protection, and a small metal container with self-closing cover full of trash. Both the Regional Director of Labor, the MD and AIT agreed that this did not follow the facility's smoking policy and had the potential to be unsafe when the smoking area was in use.</p> <p>During an interview on 10/31/24 at 3:30 PM, R29 said he will typically smoke six cigarettes per day and will smoke at all three designated smoking times. He said he had never had any type of accident related to smoking.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview/observation on 11/01/24 at 12:15 PM, the Administrator observed the smoking area and agreed there was no cover over the smoking area to provide protection for R29. The Administrator observed the trash in the metal covered container and stated the metal can should be free of trash prior to R29 smoking.</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 16177</p> <p>Based on observations, interviews, and record review, the facility failed to attempt a voiding trial and to discontinue an indwelling urinary catheter after multiple urinary tract infections for one of one resident (Resident (R)11) reviewed for urinary catheters out of a total sample of 31 residents. This failure increased the risk of continued urinary tract infections and antibiotic usage.</p> <p>Findings include:</p> <p>A policy for urinary catheter use was requested but not provided by the time of exit of the survey.</p> <p>1. Review of the electronic medical record (EMR) Face Sheet revealed R11 was admitted to the facility on [DATE]. Review of the EMR quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/13/24 revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15 indicating R11 was cognitively intact.</p> <p>During an interview and observation on 10/29/24 at 10:30 AM, R11 was observed to have an indwelling urinary catheter collection bag attached to her bed frame. R11 stated she was not sure when or why she got the Foley catheter placed. R11 did state that her physician had recently ordered the Foley to be removed but the resident asked to wait a couple of days until she was feeling better.</p> <p>Review of the EMR Orders tab revealed a physician's order dated 10/29/24 to discontinue Foley catheter NOW. Monitor for voiding for next 24 hours. If no void in 8 hours call MD [physician]</p> <p>During an interview on 10/29/24 at 1:42 PM, Licensed Practical Nurse (LPN)3 verified that she had removed the Foley catheter just a few minutes prior to the interview.</p> <p>Review of the EMR Progress Notes revealed a physician's note dated 03/07/24 stating, Urine retention urine Foley catheter placed. Neurogenic bladder versus obstructive uropathy in [sic] the differential. Urinalysis and urine culture ordered along with Urology consultation for a followup [sic]. The patient reports continued to have burning with urination despite finishing another course of antibiotics. She states that she is having difficulty getting urine out .</p> <p>Review of the EMR Progress Notes revealed a Nurse Practitioner note dated 03/08/24 stating, urinary retention most likely due to current infection. Will await us [urinalysis and culture] results and then plan for voiding trial after adequate treatment for UTI. consult to urology.</p> <p>Review of the EMR Orders tab revealed a physician's order dated 03/07/24 for a urology consult to rule out possible neurogenic bladder (urinary bladder problems due to disease or injury to the nerves that control urination).</p> <p>Review of the EMR Miscellaneous and Evaluations tabs revealed no urology consult was done on 03/07/24. This was verified by the Director of Nursing (DON) on 11/01/24 at 4:00 PM.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the EMR Orders tab revealed a physician's order dated 03/07/24 to Insert Foley for retention one time only for 1 day. Further review of the EMR Orders tab revealed multiple orders from 03/07/24 to 10/30/24 for Foley catheter care and replacement as needed.</p> <p>Review of the EMR Progress Notes revealed a Nurse Practitioner note dated 03/14/24 stating, staff reported that the foley catheter fell out this AM. Patient currently on abx [antibiotic] for UTI [urinary tract infection] . orders to replace foley catheter.</p> <p>Review of the EMR Results tab revealed the following:</p> <p>Microbiology Report dated 03/30/24 of a UTI that was treated with the antibiotic Cipro 500mg (milligram) twice a day for seven days.</p> <p>Microbiology Report dated 05/30/24 of a culture report that showed two different bacterial organisms in R11's urine.</p> <p>Microbiology Report dated 07/12/24 of a UTI from E. coli ESBL (a bacteria that is resistant to commonly used oral antibiotics such as penicillin). Further review of this report revealed that the physician ordered an antibiotic to be administered by injection once a day for seven days.</p> <p>Microbiology Report dated 09/18/24 of a UTI that was treated with the antibiotic Macrobid 100mg twice a day for seven days.</p> <p>Microbiology Report dated 10/26/24 of a UTI that was treated with the antibiotic Macrobid 100mg twice a day for seven days.</p> <p>Review of the EMR Evaluations tab revealed a urology consult done on 10/01/24 stating, [R11] . was referred to me for assessment for recurrent urinary tract infections . She states that she has a history of urinary urge incontinence [leakage of urine] which is currently treated with a chronic indwelling Foley catheter . I advised the patient that as long as she has an indwelling Foley catheter she is going to have recurrent urinary tract infections . I would also advise her primary doctors to only treat a UTI when she has systemic symptoms as she will always grow out positive urine cultures due to colonization [when bacteria are present without causing illness] .</p> <p>During an interview on 11/01/24 at 12:07 PM, the Attending Physician stated that he originally ordered the indwelling urinary catheter to be placed because R11 was complaining of not being able to empty her bladder. The Attending Physician stated he was waiting for the urology consult before making a decision on whether to remove the catheter. He was concerned about the number of UTIs and that the bacteria was becoming resistant to antibiotics. He stated that he followed the McGeers criteria for antibiotic use and because R11 complained of pain and blood in the urine, he ordered antibiotics.</p> <p>During an interview on 11/01/24 at 1:28 PM, the Medical Director reviewed R11's medical record and stated that there was no medical indication for the prolonged use of an indwelling urinary catheter. The Medical Director stated that if a resident complains of not emptying their bladder it is not an appropriate justification for the use of a Foley catheter, that a voiding trial should have been attempted earlier and that the urology consult should not have taken seven months to occur.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Review of the facility's policy titled, Catheter Care, dated 02/15/24, indicated, .Female: 9. Gently separate the labia to expose the urinary meatus, 10. Wipe from front to back with a clean cloth moistened with water and perineal cleaner (soap), 11. Use a new part of the cloth or different cloth for each side, 12. With a new moistened cloth, starting at the urinary meatus moving out, wipe the catheter making sure to hold the catheter in place so as to not pull on the catheter, 13. Dry are with towel.</p> <p>Review of R65's Admission Record, under the Profile tab in the EMR indicated R65 was readmitted to the facility on [DATE] with a diagnosis of obstructive and reflux uropathy.</p> <p>During initial tour observation on 10/29/24 between 10:35 AM-2:00 PM, R65 was in bed, with an indwelling urinary catheter bag hanging on the right side of the bed.</p> <p>Review of R65's Physician Orders, dated 07/06/24, located under the EMR tab Orders, indicated Foley care every shift.</p> <p>During an observation on 10/31/24 at 8:49 AM, Geriatric Nursing Assistant (GNA)4 prepared to provide R65's incontinence care. GNA4 removed R65's incontinent brief, and with a washcloth washed the top of R65's perineal area. GNA4 then with an upwards and downwards motion, washed R65's left side of the perineal area, several times without changing the direction of the washcloth. GNA4 did not wash R65's right side of the perineal area nor did she separate the labia and wash the area. GNA4 placed the washcloth back into the basin, without changing her gloves, obtained another washcloth from the basin and rinsed the left side of R65's perineal area in an upward and downward motion, without changing the direction, several times. GNA4 washed and rinsed the indwelling urinary catheter tubing in a back-and-forth motion several times and patted dry.</p> <p>During an interview on 10/31/24 at 9:30 AM, GNA4 stated that she always changes the direction of the washcloth during catheter care and cleans the labia area.</p> <p>During an interview with the Interim DON on 10/31/24 at 6:00 PM, she confirmed that staff should have cleaned R65's labia and should have changed the direction of the washcloth and/or obtain another washcloth.</p> <p>25232</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>35690</p> <p>Based on observations, staff and resident interviews, record reviews, and facility policy review, the facility failed to ensure sufficient staffing was scheduled to meet the needs of the 81 residents in the facility. Five residents (Resident (R) 55, R48, R15, R44, and R48) and staff members, Geriatric Nurse Aide (GNA 11, GNA4, GNA9, GNA6, GNA3, GNA8, GNA5, GNA7, and GNA10), Registered Nurse (RN1), the Administrator, the Director of Nursing (DON), and the Regional Director of Labor Management voiced concerns regarding sufficient staffing, and the facility exhibited multiple failures related to a lack of sufficient staffing throughout the survey.</p> <p>Findings include:</p> <p>1. Failure to Ensure that Residents Reviewed for Activities of Daily Living (ADL) Care Cross-reference F677: ADL</p> <p>Care Provided for Dependent Residents.</p> <p>The facility failed to ensure that R15 reviewed for ADLs received the necessary services to maintain appropriate grooming.</p> <p>2. Failure to Ensure that Residents Reviewed for Weight Loss had Weekly Weights Cross-reference F658: Quality of Care.</p> <p>The facility failed to ensure that R3 reviewed for weight loss had weekly weights completed as ordered by the physician. This had the potential to have increased weight loss for R3 and the potential to place other residents residing in the facility at risk for weight loss.</p> <p>Review of the Nursing Services and Sufficient Staff Policy dated 02/08/24, revealed It is the policy of this facility to provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The facility's census, acuity and diagnoses of the resident population will be considered based on the facility assessment.</p> <p>3. During an interview on 10/29/24 at 1:00 PM, R15 said there is not enough staff, and said that she required two staff to provide her care.</p> <p>Review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/30/24 indicated a Brief Interview for Mental Status (BIMS) score of 15 put pf 15 which indicated R15 was cognitively intact.</p> <p>During an interview on 10/29/24 at 2:00 PM, R44 said she gets showers on Wednesday and Saturday in the evening time. She said that due to not having enough staff, she sometimes does not get her bath on Saturdays, especially if there is only one or two GNAs working.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of R44's annual MDS with an ARD of 07/17/24 indicated a BIMS score of 14 out of 15, which indicated R44 was cognitively intact.</p> <p>During an interview on 10/29/24 at 3:39 PM, R55 said there were not enough staff on the weekends, and it was difficult to get her call light answered.</p> <p>Review of R55's quarterly MDS with an ARD of 09/23/24 indicated a BIMS score of 15 out of 15 which indicated R55 was cognitively intact.</p> <p>During an interview on 10/30/24 at 9:15 AM, R48 stated he gets aggravated when the staff insist on providing care when he is not ready. R48 stated the staff want to provide care when they have time since they have so many residents to care for.</p> <p>4. During an interview on 10/31/24 at 9:03 AM, GNA8 and GNA5 said it was difficult to complete all their assignments and ensure the safety of all of the residents. GNA8 said she thought the GNAs were able to complete 75% of their assignments. GNA8 said if both aides were working with residents or in resident rooms, they would not be able to prevent or redirect wandering residents. GNA5 confirmed she usually worked on the 500-unit. She said with only two GNAs it is difficult to monitor every resident.</p> <p>During an interview on 10/31/24 at 2:40 PM, GNA7 said additional staffing would be beneficial when caring for the residents. GNA7 said she had worked in the 500-unit as the only assigned aide in the past. She said having only one GNA feels it potentially could hinder residents from receiving care. She said she cannot provide a resident a shower and also watch the other residents on the unit.</p> <p>During an interview on 10/31/24 at 2:46 PM, GNA 11, GNA4, GNA9, GNA6, and GNA3 said they were always short staffed. They said typically there was one GNA on the 400 hall and one on the 300 hall and one GNA that would be split between both halls. The GNAs agreed it was difficult to attend to everyone timely because there were not enough GNA and the 300 multiple residents that required a mechanical lift and two people for transfers and Activities of Daily Living (ADL) assistance.</p> <p>During an interview on 10/31/24 at 3:21 PM, RN1 said that he did not think there was enough staff to do a good job and he worries if something were to happen without enough staff things could be difficult. He said he works the afternoon and night shift. He said two days a week he works a double shift. He said on 09/24/24 he was the only nurse working the night shift and that caused him to be very nervous.</p> <p>During an interview on 10/31/24 at 6:20 PM, the DON the facility was short staffed and currently the assigned Unit Managers are consistently assigned to a medication cart.</p> <p>During an interview on 11/01/24 at 1:31 PM, the Regional Director of Labor Management, the Administrator, the DON and GNA 10 (also the scheduler) agreed the facility was short staffed. The Regional Director of Labor Management and GNA11 said they are always offering staff bonuses, gift cards, and negotiating days to get GNAs to cover shifts. The Administrator said they were at a point where we had to take what we could get. They said they would also pull from other departments to help GNAs on the floor.</p>		

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<p>F 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>35690</p> <p>Based on interviews and personnel files review, the facility failed to ensure a performance review was completed for five of five Geriatric Nurse Aides (GNA)5, GNA7, GNA13, GNA4, GNA 14) once every 12 months. The failure to ensure annual performance reviews were completed had the potential to impact all 80 residents in the facility related to safety, person-centered environment, and the number of adverse events or other resident complications.</p> <p>Findings include:</p> <p>Review of five GNAs' personnel files revealed: GNA5 with a start date of 11/01/22; GNA7 with a start date of 02/15/22; GNA13 with a start date of 03/27/23; GNA4 with a start date of 11/01/22; and GNA14 with a start date of 09/14/21, revealed they had not received an annual performance review in the past 12 months.</p> <p>During an interview on 11/01/24 at 3:27 PM, the Human Resources (HR) Director said GNA annual performance reviews were not being completed because of nurse leadership turnover.</p> <p>During an interview on 11/01/24 at 4:59 PM, the Administrator, and the Director of Nursing (DON) both confirmed that annual GNA evaluations were not being completed.</p> <p>During an interview on 11/01/24 at 5:05 PM, the Chief Nursing Officer (CNO) confirmed that her expectation was that annual GNA performance evaluations should be completed. She said she had implemented the directive when she started in her role in January 2024.</p> <p>During an interview on 11/01/24 at 5:15 PM, the [NAME] President of Clinical Operations (VPCO) confirmed annual GNA evaluations were not being completed.</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>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>37590</p> <p>Based on interview, record review and policy review, the facility failed to ensure medication regimens was free from unnecessary medications. The facility failed to ensure an as needed (PRN) psychotropics were not prescribed beyond 14 days without documented rational, for one (Resident (R)17) of five residents reviewed for unnecessary medications.</p> <p>Findings include:</p> <p>Review of R17's electronic medical record (EMR), revealed R17's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/18/24, indicated the resident has a Brief Interview for Mental Status (BIMS) of 10 out of 15 which indicated R17's cognition was moderately impaired. The EMR also revealed diagnosis of anxiety disorder.</p> <p>Review of R17's Care plan in the EMR under the Care Plan tab revealed a focus related to R17's use of psychotropic medications initiated 12/27/23. The goal indicated be/remain free of psychotropic drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction or cognitive/behavioral impairment through review date. Interventions included administering medications as ordered.</p> <p>Review of R17's physician orders located in the EMR under Physician Orders tab, revealed Lorazepam .0. 25ml [milliliters] by mouth every 6 hours as needed for anxiety dated 08/20/24.</p> <p>Review of R17's Medication Administration Record (MAR) dated September 2024 indicated the resident received the medication on 09/01/24 at 01:55PM, 09/29/24 at 09:48AM, and on 09/30/24 at 12:59AM.</p> <p>Review of the facility's policy titled, Medication Regimen Review (MRR) dated 02/15/24, revealed, drug regimen of each resident reviewed at least once a month by a licensed pharmacist and includes a review of the resident's medical chart.</p> <p>Interview on 11/01/24 at 3:09 PM, the Director of Nursing (DON) confirmed that the facility does not have a psychotropic medication policy that addresses PRN (as needed) orders for psychotropic drugs are limited to 14 days.</p> <p>Interview with the Medical Director on 11/01/24 at 04:13PM, he stated the consultant pharmacy made the recommendation on 10/25/24, to discontinue R17's PRN Lorazepam antipsychotic that should have been limited to 14 days. The Medical Director confirmed that the pharmacist's recommendation was overlooked.</p> <p>Review of the facility's policy titled, Medication Regimen Review (MRR) dated 02/15/24, revealed, drug regimen of each resident reviewed at least once a month by a licensed pharmacist and includes a review of the resident's medical chart.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>16177</p> <p>25232</p> <p>37590</p> <p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>Based on interviews, document review and observations, the facility failed to ensure food was served at a palatable and appetizing temperature for two of two meal tray observations. This deficient practice had the potential to affect the meal consumption for all 80 of 80 residents who consumed food prepared from the facility's kitchen.</p> <p>Findings include:</p> <p>During the initial screening on 10/29/24 several residents made comments regarding the taste and temperature of the food provided by the facility.</p> <p>During an interview on 10/29/24 12:53 PM, Resident (R) 339 stated that the food was not good at the facility and that the eggs for breakfast were not appetizing. Review of R339's electronic medical record (EMR) revealed R339's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/18/24 with a Brief Interview for Mental Status (BIMS) of 13 out of 15 indicated R339's cognition was intact.</p> <p>During an interview on 10/29/24 at 2:10 PM, R336 stated he will get a piece of hard meat and half-baked toast. Review of R336's EMR revealed the admission MDS with an ARD of 10/24/24 and a BIMS score of 15 out of 15, which indicated R336's cognition was intact.</p> <p>During the group meeting on 10/31/24 at 01:36PM, R62's annual MDS with an ARD of 09/08/24, with a BIMS score of 15 out of 15, which indicated R62's cognition was intact stated that the food was typically cold and was tasteless. Other residents in attendance at the meeting included R4 who's quarterly MDS with an ARD of 08/08/24, R18 who's quarterly MDS with an ARD of 10/02/24, and R55 who's quarterly MDS with an ARD of 09/23/24 all had a BIMS score of 15 out of 15 which indicates the residents' cognition was intact stated that the food was cold and tasteless.</p> <p>Review of the facility's resident council minutes from October 2023 through October 2024, revealed residents attending the meetings complained of food for nine of the 13 meetings.</p> <p>A second tray observation on 10/31/24 at 12:16PM revealed the meal consisted of ham, a sweet potato, green beans, and cake for dessert. There was cranberry juice and a salt and pepper packet on the tray as well. The ham was warm and salty. The sweet potato and green beans were hot but had no taste. The cake was dry and tasteless.</p> <p>Review of the facility's policy titled, Food and Nutrition Services revised October 2017 indicated, Each resident is provided with a nourishing, palatable, well-balanced diet .taking into consideration the preferences of each resident.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>37590</p> <p>Based on observations, interviews, document review, policy review and review of the Federal and Drug Administration (FDA) Food Code, the facility failed to ensure food was served and prepared under sanitary conditions. The facility failed to ensure floors, baseboards, walls, appliances, hood vent and ice machine were kept clean and in good working condition. The facility also failed to ensure dietary staff adhered to sanitary requirements related to hair restraints. The deficient practice has the potential to affect 80 of 80 residents who received meals prepared in the facility kitchen.</p> <p>Findings include:</p> <p>Observation during the initial kitchen tour on 10/29/24 at 09:20AM, revealed the ice machine compressor was on top of the ice chest. The seam at the base of the compressor was covered with a white powdery substance. This substance could also be observed on the floor. Observation of the floor around the ice machine revealed trash, debris, a powdery white substance, and spider webs. The ice scoop was in a holder that was covered with a lid and attached to the ice chest. Inside of the holder was a scoop and at the base of the holder was approximately a quarter inch or water, that had a brown colored, gritty appearance. Inside the ice chest revealed a blackish-brown, gritty substance that was wiped from the black splash panel located at the roof of the ice chest bin.</p> <p>Observation of the floor around and underneath the reach-in refrigerators, range, steam oven, shelf/table/stand holding a mixer and meat slicer, the shelf between the range and steam table along with the steam table, had discolored tile and grout along with a greasy, dark colored sticky substance around the legs of the kitchen equipment and along the baseboards. There was also trash, silverware, and cups found underneath the range, reach-in refrigerators, and the shelf/table/stands. The tile grout throughout the kitchen appeared black in color. The tile grout underneath the shelving in the dry storage room was white.</p> <p>Observation of the facility hood vent, during the initial kitchen tour on 10/29/24 at 09:20AM, revealed it was last cleaned in February of 20024 and was due August of 2024. There was a visible buildup of grease on the filters.</p> <p>Review of the TELS maintenance schedule advises that the hood vent filters be cleaned quarterly.</p> <p>The Dietary Manager (DM) was interviewed during the initial tour on 10/29/24 at 09:20AM and he was asked who was responsible for ensuring the ice machine being clean and maintained. The DOM stated that it was the responsibility of the maintenance director. The DM stated that he and his staff clean and wipe down the ice machine daily.</p> <p>During an interview with the Regional Director of Maintenance (RDM) on 11/01/24 at 11:31AM, he confirmed that many of the scheduled maintenance items have not been completed as scheduled. When asked if he was aware of the maintenance team was responsible for maintaining the inside of the ice machine, he said that he was aware of the task and that it required to be done monthly, per the manufacturer's recommendation.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of the Dietary Cleaning Schedule, provided by the DM revealed that the floors should be swept and mopped daily, along with the storage shelves wiped down daily.</p> <p>During an observation of the tray line on 10/31/24 at 07:21AM, dietary staff dietary aide (DA) 1, who was responsible for ensuring the drinks were ready and placed on the residents' meal tray was wearing a hair restraint but was not wearing a facial hair restraint.</p> <p>Interview on 10/31/24 at 09:19AM, the Registered Dietitian (RD) confirmed that the DM was responsible for issues related to dietary department and staffing.</p> <p>Review of the FDA Food Code 2022, under section 2-402 Hair Restraints, states FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES.</p> <p>Review of the undated facility's policy titled, Ice Machines and Portable Ice Carts, revealed that It is the policy of the facility to ensure that ice machines/carts are working in proper order, cleaned, and maintained . manufacturer's instruction and current standards of practice can be prone to microbial contamination due to improper handling or storage of ice, poor cleaning, or maintenance of equipment or through ice handling equipment.</p>		

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Dispose of garbage and refuse properly.</p> <p>37590</p> <p>Based on observations, interviews, document review, and policy review, the facility failed to ensure garbage and refuse was properly disposed of in that the facility did not ensure dumpsters were maintained in a sanitary condition. This deficient practice had the potential to affect all residents in the facility,</p> <p>Findings include:</p> <p>During the initial kitchen tour with the Dietary Manager (DM) on 10/29/24 at 9:20AM, observation of the garbage and refuse area revealed three separate green dumpsters, on a pad of grass. In the grass, at the front and sides of the dumpsters were multiple disposable gloves. At the rear of the dumpsters was a clear plastic trash bag that had a hole and contained disposable gloves, napkins and food wrappers Interview at this time, the DM was asked who was responsible for maintaining the garbage and refuse area. The DM stated that it was a housekeeping task but added that the dietary staff will pick up around the dumpster if they find trash on the ground.</p> <p>The DM provided a cleaning schedule for the dietary staff, and it did not indicate that they had any responsibility for maintaining the garbage and refuse area.</p> <p>Interview on 10/29/24 at 1:55 PM, Housekeeper (HK)1 was asked who was responsible for maintaining the garbage and refuse area. HK1 stated that she believed it was maintenance but added that all staff should clean around the dumpster area.</p> <p>During an interview with the Administrator on 10/30/24 at 10:35AM, she was asked who was responsible for maintaining and cleaning the garbage and refuse area. She stated that she believed it was the dietary staff and housekeeping.</p> <p>Review of the facility's policy titled, Disposal of Garbage and Refuse dated 01/15/24 revealed, . Surrounding area shall be kept clean so that accumulation of debris and insect/rodent attractions are minimized .Garbage should not accumulate or be left outside the dumpster.</p>

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<p>F 0840</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 16177</p> <p>Based on observations, interviews, and record review, the facility failed to obtain a urology consult timely to assess the continued need for an indwelling urinary catheter for one of one resident (Resident (R)11) reviewed for indwelling urinary catheters out of a total sample of 31 residents. This failure resulted in the continued use of an indwelling urinary catheter without an appropriate indication for the catheter.</p> <p>Findings include:</p> <p>A policy for outside consultations was requested but not provided by the survey exit.</p> <p>Review of the electronic medical record (EMR) Face Sheet revealed R11 was admitted to the facility on [DATE].</p> <p>Review of the EMR quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/13/24 revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15 indicating R11 was cognitively intact.</p> <p>During an interview and observation on 10/29/24 at 10:30 AM, R11 was observed to have an indwelling urinary catheter collection bag attached to her bed frame. R11 stated she was not sure when or why she got the catheter placed. R11 did state that her physician had recently ordered the Foley to be removed but the resident asked to wait a couple of days until she was feeling better.</p> <p>Review of the EMR Progress Notes revealed a physician's note dated 03/07/24 stating, Urine retention urine Foley catheter placed. Neurogenic bladder versus obstructive uropathy in [sic] the differential. Urinalysis and urine culture ordered along with Urology consultation for a followup [sic]. The patient reports continued to have burning with urination despite finishing another course of antibiotics. She states that she is having difficulty getting urine out .</p> <p>Review of the EMR Progress Notes revealed a Nurse Practitioner note dated 03/08/24 stating, urinary retention most likely due to current infection. Will await us [urinalysis and culture] results and then plan for voiding trial after adequate treatment for UTI. consult to urology.</p> <p>Review of the EMR Orders tab revealed a physician's order dated 03/07/24 for a urology consult to rule out possible neurogenic bladder (urinary bladder problems due to disease or injury to the nerves that control urination).</p> <p>Review of the EMR Miscellaneous and Evaluations tabs revealed no urology consult was done on 03/07/24. This was verified by the Director of Nursing (DON) on 11/01/24 at 4:00 PM.</p> <p>(continued on next page)</p>		

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<p>F 0840</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the EMR Progress Notes revealed a physician's note dated 09/11/24 stating, The patient stated that she was supposed to see Urology last week, but she is not sure what happened, if the appointment was canceled or not. Hematuria [blood in the urine] urinalysis and urine culture ordered to rule out UTI. I notified the Unit Manager regarding Urology appointment to see when her Urology appointment is as it was supposed to be last week, and it appears to have been canceled.</p> <p>Review of the EMR Evaluations tab revealed a urology consult done on 10/01/24 stating, [R11] . was referred to me for assessment for recurrent urinary tract infections . She states that she has a history of urinary urge incontinence [leakage of urine] which is currently treated with a chronic indwelling Foley catheter . I advised the patient that as long as she has an indwelling Foley catheter she is going to have recurrent urinary tract infections . I would also advise her primary doctors to only treat a UTI when she has systemic symptoms as she will always grow out positive urine cultures due to colonization [when bacteria are present without causing illness] .</p> <p>Review of the EMR Orders tab revealed a physician's order dated 10/29/24 to discontinue Foley catheter NOW. Monitor for voiding for next 24 hours. If no void in 8 hours call MD [physician]</p> <p>During an interview on 10/29/24 at 1:42 PM, Licensed Practical Nurse (LPN)3 verified that she had removed the Foley catheter just a few minutes prior to the interview.</p> <p>During an interview on 11/01/24 at 12:07 PM, the Attending Physician stated that he originally ordered the Foley to be placed because R11 was complaining of not being able to empty her bladder. The Attending Physician stated he was waiting for the urology consult before making a decision on whether to remove the catheter. The Attending Physician did not know why the urology consult did not occur for seven months.</p> <p>During an interview on 11/01/24 at 1:28 PM, the Medical Director reviewed R11's medical record and stated that the urology consult should not have taken seven months to occur.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 16177</p> <p>25232</p> <p>Based on observations, interviews, record review and facility policy review, the facility failed to wear the appropriate PPE when providing catheter care for one of one resident (Resident (R) 65) observed during catheter care out of a total sample of 31 residents. In addition, the facility failed to ensure that one resident (R65) had personal protective equipment (PPE) readily available to use during catheter care that was on enhanced barrier precautions (EBP) and failed to ensure that staff used EBP for two of three residents (R11, and R33) during care. This failure has the potential to place R65, R11 and R33 at risk for infection to the urinary tract. In addition, the facility failed to have a water management program. This failure has the potential to place all 80 residents residing in the facility at risk for Legionella.</p> <p>Findings include:</p> <p>Review of the facility's policy titled, Personal Protective Equipment (PPE), dated 01/31/24, indicated, .4. Indications/considerations for PPE use: a. Gloves: .ii. Perform hand hygiene before donning gloves after removal. Gloves are not a substitute for hand hygiene .iv. Change gloves and perform hand between clean and dirty tasks, when moving from one body part to another, when heavily contaminated, or when torn.</p> <p>Review of the facility's policy titled, Enhanced Barrier Precautions (EBP), revised 03/26/24, indicated, .Policy Explanation and Compliance Guidelines: It is the policy of this facility to implement enhanced barrier precautions [EBP] for the prevention of transmission of multi-drug resistant organisms . Enhanced Barrier Precautions refer to an infection control intervention . that employs targeted gown and gloves [sic] use during high contact resident care activities . 2. Initiation of EBP: .b. An order for EBP will be obtained for residents with any of the following: i. Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with a multi-drug resistant organism (MDRO) .3. Implementation of EBP: a. Make gowns and gloves available immediately near or outside of the resident's room .b. PPE for EBP is only necessary when performing high-contact care activities and may not need to be donned (place on) prior to entering the resident's room .4. High-contact resident care activities include .e. changing linens .g. device care or use: .urinary catheters.</p> <p>1. Review of R65's Admission Record, under the Profile tab in the EMR indicated, R65 was readmitted to the facility on [DATE] with a diagnosis of obstructive and reflux uropathy.</p> <p>During initial tour observation on 10/29/24 between 10:35 AM-2:00 PM, observed R65 lying in bed, with an indwelling urinary catheter bag hanging on the right side of the bed.</p> <p>Review of R65's Physician Orders, dated 07/06/24, located under the EMR tab Orders, indicated, Enhanced barrier precautions every shift.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During R65's indwelling urinary catheter care observation on 10/31/24 at 8:49 AM, Geriatric Nursing Assistant (GNA) 4, wore only gloves for her PPE and did not wear a gown while providing R65's catheter care.</p> <p>During an interview with GNA4 on 10/31/24 at 9:30 AM, stated that she was unaware that R65 should be on EBP due to having an indwelling urinary catheter.</p> <p>During an interview with the Interim Director of Nursing (DON) on 10/31/24 at 6:00 PM, she said that EBP is used for indwelling urinary catheters and draining wounds. The appropriate PPE should be in a bin outside of resident's room. She was unaware that R65 did not have PPE outside the door. The Interim DON stated that when staff go from a dirty area to a clean area, gloves should be changed and that for EBP, staff should wear gowns and gloves when providing direct resident care.</p> <p>2. Review of the electronic medical record (EMR) Face Sheet revealed R11 was admitted to the facility on [DATE].</p> <p>Review of the EMR quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/13/24 revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15 indicating R11 was cognitively intact.</p> <p>During an interview and observation on 10/29/24 at 10:30 AM, R11 was observed to have a catheter collection bag attached to her bed frame.</p> <p>Observation on 10/29/24 at 10:39 AM revealed no signage to indicate R11 was under EBP due to the use of an indwelling urinary catheter.</p> <p>During an interview on 10/29/24 at 11:30 AM, Licensed Practical Nurse (LPN)3 stated that R11 was not on EBP and stated, I think it may have been discontinued.</p> <p>Review of the EMR Orders tab revealed a physician's order dated 07/30/24 for EBP for foley cath [catheter] use. Further review of the EMR Orders tab revealed no order to discontinue the EBP.</p> <p>Review of the EMR Orders tab revealed a physician's order dated 10/29/24 to discontinue Foley catheter NOW. Monitor for voiding for next 24 hours. If no void in 8 hours call MD [physician]</p> <p>During an observation and interview on 10/29/24 1:26 PM, GNA17 was observed leaving R11's room. When asked, GNA17 verified that she had just provided incontinence care without wearing a gown. GNA17 stated, was I supposed to?</p> <p>During an observation and interview on 10/29/24 at 1:42 PM, LPN3 verified that she did not wear a gown for enhanced barrier precautions when removing the indwelling urinary catheter.</p> <p>3. Review of the EMR Face Sheet revealed R33 was admitted to the facility on [DATE] with diagnosis of status post stroke.</p> <p>Review of the EMR MDS with an ARD of 09/26/24 revealed a BIMS score of 13 out of 15 indicating R33 was cognitively intact. Further review of this MDS revealed R33 required substantial/maximal assistance with bathing.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of the EMR Orders revealed a physician's order dated 06/09/24 for ESBL [a drug resistant bacteria] UTI [urinary tract infection]. Further review of the Orders revealed no order to discontinue the EBP.</p> <p>Observation on 10/29/24 at 11:10 AM, revealed signage for EBP on the wall next to the door for R33's room. Also, observed was a container of gowns and gloves in the hallway next to R33's room.</p> <p>During an observation and interview on 10/29/24 at 11:51 AM, GNA6 was observed coming out of R33's. GNA6 was asked if she had worn a gown when providing R33's bath. GNA6 verified that she had not. GNA6 stated, I don't know why it is there [gowns and gloves] since he doesn't have anything [infectious] that I am aware of.</p> <p>During an interview on 11/01/24 at 12:17 PM, the Attending Physician stated he expected the staff to follow the requirements for EBP.</p> <p>4. During review of the infection control program, there was no evidence that the facility had a water management plan.</p> <p>Interview on 11/01/24 at 3:49 PM, Regional Director of Maintenance confirmed that the facility does not have a water management plan. He confirmed that he has no knowledge of concerns with legionella.</p>		

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<p>F 0909</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame.</p> <p>37590</p> <p>Based on observation, interviews, document review and record review, the facility failed to ensure a resident's bed was inspected and maintained for one (Resident (R) 2) of 31 residents in the sample.</p> <p>Findings include:</p> <p>During an observation and interview on 10/30/24 at 10:25AM, R2 stated her bed was broken, A physical check of the electric bed revealed that the headboard and footboard were not securely attached to the bed. This resulted in a gap of approximately three to five inches between the mattress and the headboard and the footboard.</p> <p>Review of R2's electronic medical record (EMR), annual Minimum Data Set (MDS)' with an Assessment Reference Date (ARD) of 08/16/24, has a Brief Interview of Mental Status (BIMS) score of 15 out of 15 which indicated the resident's cognition was intact.</p> <p>The Regional Director of Maintenance (RDM) was advised of this concern during an interview on 10/30/24 at 10:30AM. He confirmed that the loose headboard and footboard were a safety hazard. He added that the expectation was that residents' equipment was checked in accordance with the facility's maintenance management TELS system. He stated that these things have not been completed in over six months.</p> <p>Review of the TELS scheduled maintenance checklist provided by the Administrator, revealed, electric beds revealed the electric beds were to be inspected monthly.</p> <p>Interview on 10/30/24 at 10:35AM, the Administrator stated that the electric bed was to be inspected monthly since the beds could be a safety hazard.</p>

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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 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>35690</p> <p>Based on interviews, personnel files review and policy review, the facility failed to ensure 12 hours of required in-service training for five of 5 Geriatric Nurse Aides (GNA)5, GNA7, GNA13, GNA4, GNA14) was provided to ensure continuing competencies. The failure to ensure an effective training program was in place had the potential to impact 80 residents in the facility related to safety, person-centered environment, and the number of adverse events or other resident complications.</p> <p>Findings include:</p> <p>Review of the facility's policy titled, Required Training, Certification and Continuing Education of Nurse Aides dated 09/16/24 revealed, The facility will provide at least 12 hours of in-service training annually, based on the employment date, not calendar year.</p> <p>Review of five GNA personnel folders revealed: GNA5 with a start date of 11/01/22; GNA7 with a start date of 02/15/22; GNA13 with a start date of 03/27/23; GNA4 with a start date of 11/01/22; and GNA14 with a start date of 09/14/21, revealed they had not completed their 12 hours of required in-service training to ensure continuing competencies.</p> <p>During an interview on 11/01/24 at 3:27 PM, the Human Resources (HR) Director stated that the clinical staff were not providing the GNAs the required in-service training.</p> <p>During an interview on 11/01/24 at 4:59 PM, the Administrator and the Director of Nursing (DON) confirmed 12 hours of competency training were not being provided to the GNAs.</p> <p>During an interview on 11/01/24 at 5:05 PM, the Chief Nursing Officer (CNO) confirmed that her expectation was that all nursing staff should have started their skills fair and competency training in June.</p> <p>During an interview on 11/01/24 at 5:15 PM, the [NAME] President of Clinical Operations (VPCO) confirmed 12 hours of competency training were not being provided to GNAs.</p>