

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215174	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2024
NAME OF PROVIDER OR SUPPLIER Ginger Cove		STREET ADDRESS, CITY, STATE, ZIP CODE 4000 River Crescent Drive Annapolis, MD 21401	

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 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>34484</p> <p>Based on medical record review and interview it was determined that the facility failed to have a process in place to ensure that residents and resident representatives received a notice of transfer in writing. (Resident #40 and #246). This was evident in 2 of 3 residents reviewed for hospitalization during the survey.</p> <p>The findings include:</p> <p>1. Review of Resident #40's medical record on 5/29/24 revealed the Resident was transferred to the hospital on 1/9/24.</p> <p>Further review of Resident #40's medical record revealed the Resident had 2 physician certifications of incapacity.</p> <p>Review of the facility's hospital transfer documents on 5/29/24 revealed no written notification to the Resident's representative of the transfer to the hospital on 1/9/24.</p> <p>On 6/3/24 at 11:05 AM, Interview with the Director of Nursing (DON) confirmed the facility staff failed to provide written notification to Resident #40's Representative of transfer to the hospital on 1/9/24.</p> <p>40927</p> <p>2. An attempt to review the electronic medical record (EMR) on 5/31/24 at 10:30 AM revealed Resident #246 could not be viewed by the surveyor.</p> <p>A review of Resident #246's closed medical record on 6/4/24 at 7:45 AM revealed a progress note printed from the EMR that was dated 5/20/24. The note read that the resident was transferred to the local acute care hospital for emergent treatment. The resident was nonresponsive at the time of transfer and family were made aware of the transfer via a phone call. Further review failed to reveal a written notice of transfer was given to the resident and the resident's representative.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview with Licensed Practical Nurse (LPN) #18 on 6/4/24 at 7:59 AM revealed that a transfer form was completed when a resident was sent to the hospital and copy was given to the emergency medical services (EMS) staff and not to the resident. She was not aware of it being sent to the resident representative as they were verbally made aware either in person or over the phone.</p> <p>An interview with LPN #19 on 6/4/24 at 8:18 AM revealed that the transfer form was completed when a resident was sent to the hospital and a copy was given to EMS staff. She was not aware that it was given to the resident unless the resident was alert and oriented with capacity to make health care decisions. She reported she was not aware that the transfer form was sent to the resident's representative, but that they will call them when a resident was transferred to the hospital.</p> <p>On 6/4/24 at 11:09 AM the concerns were discussed with the Director of Nursing (DON) and she confirmed that the notice of transfer was not provided to Resident #246 or to their representative as soon as possible after a hospital transfer.</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>34484</p> <p>Based on record review and staff interview it was determined that the facility failed to have a process in place to ensure that residents and resident representatives received the bed hold policy in writing within 24 hours after being sent to the hospital (Resident #40 and #246). This was evident for 2 of 3 resident records reviewed for hospitalization during an annual survey.</p> <p>The findings include:</p> <p>Bed hold notice includes providing written information to the resident; and bed charges, including the duration, during which the resident is permitted to return and resume residence in the nursing facility.</p> <p>1. Review of Resident #40's medical record on 5/29/24 revealed the Resident was transferred to the hospital on 1/9/24.</p> <p>Further review of Resident #40's medical record revealed the Resident had 2 physician certifications of incapacity.</p> <p>Review of the facility's hospital transfer documents on 5/29/24 revealed no evidence that the Resident or representative received a bedhold notice on 1/9/24.</p> <p>Interview with the Director of Nursing on 6/3/24 at 11:05 AM confirmed the facility staff failed to provide bedhold notice to Resident #40's representative on 1/9/24.</p> <p>40927</p> <p>2. An attempt to review the electronic medical record (EMR) for Resident #246 on 5/31/24 at 10:30 AM revealed the resident was not showing up in the system.</p> <p>During a closed record review for Resident #246's on 6/4/24 at 7:45 AM a copy of a progress note printed from the EMR was reviewed. The note read that Resident # 246 was transferred to the local acute care hospital for emergent treatment in 5/20/24. The resident was nonresponsive at the time of transfer and family were aware of the transfer via a phone call. Further review failed to reveal a notice of transfer for the resident and the resident representative.</p> <p>An interview with Licensed Practical Nurse (LPN) #18 on 6/4/24 at 7:59 AM revealed that a copy of the bed hold policy was given to the emergency medical services (EMS) staff when a resident was sent to the hospital and not to the resident. She reported that the resident or resident representative signs a bed hold policy at the time of admission. Furthermore, she reported that she will make a copy of the signed form and change the date on it. She was not aware that it was given to the resident or resident representative each time the resident was sent to the hospital.</p> <p>(continued on next page)</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview with LPN #19 on 6/4/24 at 8:18 AM revealed that a copy of the bed hold policy was given to EMS staff at the time a resident was transferred to the hospital. She was not aware that it was given to the resident unless the resident was alert and oriented with capacity to make health care decisions. She was unaware of whether the bed hold policy was sent to the resident's representative at the time of each transfer because it was signed on admission and a copy was in the chart.</p> <p>On 6/4/24 at 11:09 AM the concerns were discussed with the Director of Nursing (DON) and she confirmed that the bed hold policy was not provided to the resident or the resident representative within 24 hours after a hospital transfer.</p>		

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<p>F 0661</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge.</p> <p>40927</p> <p>Based on record review and staff interview it was determined that the facility failed to ensure that a discharge summary was complete and accurate. This was evident for 1 (#42) of 3 closed records reviewed.</p> <p>The findings include:</p> <p>A medical record review for Resident #42 on 5/30/24 at 11:18 AM revealed a history and physical visit conducted by the attending physician on the day of the resident's admission. The physician noted that the resident had progressing weakness, reoccurring falls, Parkinson's disease, and worsening dementia. The plan for treatment was noted as physical and occupational therapy, continue the same medications, and repeat labs. The physician noted that the resident's potential for rehab was fair, and the resident had a poor prognosis. A review of the discharge summary revealed that the physician documented the resident had completed their course of treatment and was being discharged back to independent living with family. The physician failed to include the medications that the resident was on and which one that should be continued after discharged .</p> <p>An interview with the Social Worker (SW) #6 on 5/30/24 at 1:50 PM that the resident's family initiated the discharge.</p> <p>During an interview with the Director of Nursing (DON) on 5/30/24 at 2:15 PM she confirmed that Resident #42's discharge was initiated by family. She stated that there were safety concerns for the resident residing in independent living. The resident had been falling frequently while at home which was the reason s/he had been sent to the hospital before their admission to the facility. The facility felt the resident was better suited for long term care.</p> <p>An interview with the attending physician on 6/4/24 at 8:56 AM revealed that he was aware that the discharge summary includes a narrative of significant events during the resident's stay however, he failed to accurately document that the resident's discharge was initiated by family and that 24-hour supervision had been recommended due to the likelihood of the resident continuing to have falls. Lastly, he was aware that the resident's medications should be listed and which medications he wanted the resident to continue after discharge. However, he stated that if the facility form allows for this information, he will document it, but if a resident was on multiple medications he may not.</p>		