STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215217	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northampton Manor Nursing and Rehabilitation Cente	200 East 16th Street Frederick, MD 21701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 50573 Based on record review and staff interviews, it was determined that the facility failed to notify the primary care provider when there was a resident change of condition or a potential need to alter treatment. This was evident for 1 (Resident #28) of 6 residents reviewed for unnecessary medication. The findings include: Review of Resident #28's medical record on 8/29/24 revealed that the resident had a diagnosis of hypothyroidism and has had an order for levothyroxine once a day since 7/10/24. On 8/29/24 at 11:15 AM, review of Resident #28's medication administration revealed that the resident refused levothyroxine on 15 days between 7/12/24 and 8/3/24. Levothyroxine is a thyroid medication that is used to treat an underactive thyroid gland. The thyroid gland makes thyroid hormones which help to control energy levels and growth. When the medication is not taken, the thyroid level can be out of normal range. On 08/29/24 at 11:57 AM, review of Resident #28's medical record failed to reveal that the primary care provider was notified of the repeated medication refusal. On 8/29/24, review of Resident #28's medical record revealed on 8/6/24, the facility acknowledged a result from routine blood work that indicated an elevated thyroid level. The routine blood work order was placed on 7/10/24, the same day that the levothyroxine was ordered for the resident. On 08/29/24 at 01:28 PM, an interview with the Director of Nursing (DON) revealed that, when a resident frequently refuses medication, the expectation is that the primary care provider is contacted. On 08/29/24 at 01:42 PM, the surveyor reviewed concerns with the Director of Nursing (DON) regarding the failure to ensure THAT a provider was notified when a resident frequently refuses medication.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215217	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 40927 Based on records review and interviews, it was determined that the facility failed to protect residents from abuse. This was evident in 4 (Resident #9, #28, #104, and #424) of 21 residents reviewed for abuse. The findings include: The MDS (Minimum Data Set) is a complete assessment of the resident which provides the facility with the information necessary to develop a plan of care, provide the appropriate care and services to the resident, and to modify the care plan based on the resident's status. 1) On 8/22/24 at 8:53 AM, a review of the facility's investigation file for the facility reported incident #MD00182597 revealed a self-report form that documented a staff member had witnessed Resident #424 being abused on 4/20/22 at 2:30 PM by another staff member. Review of Physical Therapist (PT) #52's handwritten statement, dated 4/20/22, revealed that she had answered Resident #424's call light and the resident asked to go to bed. PT #52 reported that she asked the resident's assigned geriatric nursing assistant (GNA) #53 to assist her with the transfer. She stated that the resident was a sit to stand transfer with minimum assist, however, when the resident was in the standing position GNA #53 pushed the resident from the right side causing the PT to lose control of the resident and the resident fell halfway onto the bed. She reported that as she assisted the resident fully onto the bed, GNA #53 was mocking the resident as the resident was asking the GNA to leave the room. Review of Resident #424's statement, that was taken by the ADON, revealed the resident confirmed the incident that was reported by PT #52. The resident reported that s/he had asked GNA #53 about 50 minutes earlier to put him/her to bed and s/he had to wait. It was the second time the resident had put on their call light for assistance that PT #52 had answered the call light and asked GNA #53 to assist. The resident reported that GNA #53 had hurt his/her right arm and was bad. The facility called the police, notified the ombudsman, and reported GNA #53 to their licensing agency. Further review of the investigation file revealed that facility staff failed to have evidence of interviews and/or assessments of other residents who had been in the care of GNA #53 to ensure no one else had been abused. The facility failed to interview other staff who may have had knowledge of the incident, or the care provided to other residents by GNA #53. It was evident that the facility failed to conduct a thorough investigation of the incident. A medical record review for Resident #424 on 8/21/24 at 3:13 PM revealed a minimum data set (MDS), with an assessment reference date of 4/14/22. Review of the document revealed that the resident had no cognitivei mpairment (the ability to think and process information) or behaviors, and relied on the staff to provide activities of daily living (getting in and out of bed, personal care, toileting, and etc.). On 8/28/24 at 9:54 AM, the concerns were reviewed with the Director of Nursing and the Assistant Director of Nursing. Neither of them were in their current positions at the time of the incident. The Administrator, at the time of the incident, was no longer there. The DON was unable to find the original investigation file and had printed what they could find in the computer to recreate the file. (continued on next page)

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F 0600

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Cross Reference F610

2) A medical record review for Resident #170 on 8/27/24 at 11:11 AM revealed the resident had resided in the facility since 2021. Review of an attending physician's visit note, dated 1/16/24, revealed the resident suffered from chronic hip pain, knee pain, and major depressive disorder. Review of the MDS, with the assessment reference date of 1/18/24, revealed in section C that the resident had no cognitive impairment and in section GG the resident utilized a walker to ambulate.

A medical record review for Resident #104 on 8/27/24 at 12:47 PM revealed a discharge summary from the hospital in 12/2023 that documented the resident had dementia. The MDS, with an assessment reference date of 12/20/23, revealed the resident had moderate cognitive impairment. Section GG showed the resident also used a walker and required minimal assistance to get in and out of bed.

A review of the facility's investigation file for the self-reported incident #MD00202094 on 8/27/24 at 12:06 PM revealed a final self-report form that documented Resident #104's roommate was standing at the sink and heard some strange noises. When the roommate turned to see what was going on, s/he witnessed Resident #170 inappropriately touching Resident #104 while s/he laid in bed. The roommate stated that Resident #104 looked uncomfortable. The roommate told Resident #170 to leave the room and then went to report what s/he saw to the staff at the nurses' station. In the summary section, it was noted that Resident #104 was observed shaking and holding their head. Resident #104 told staff s/he wanted to call their spouse to take them home.

Review of the statement from Resident #170 revealed the resident admitted to touching the resident inappropriately, but stated it was an accident. The facility failed to have evidence that they interviewed other residents who may have been abused by this resident.

Further review revealed that local law enforcement were called and removed Resident #170 from the facility under an emergency protection order and the resident was subsequently charged with assault 2nd degree and sex offense 4th degree. The resident was not permitted to return to the facility.

An interview with the Director of Nursing on 8/27/24 at 1:54 PM, revealed that they had interviewed 2 residents who had been alert and oriented on that hallway and found the resident had not abused them. She reported that, after the incident, she talked with Resident #170's family who reported the resident had been at a hospital for mental illness, however the facility was unable to obtain records from the hospital. The DON reported they were monitoring Resident #104 for ill effects from the abuse and had offered victim support information, but the resident and family declined. This was confirmed with documentation in the medical record.

50573

3) Review of Resident #28's medical record revealed that Resident #28 is dependent on staff for Activities of Daily Living (ADLs) and had a diagnosis of dementia.

On 08/21/24 at 10:57 AM, review of the Facility Reported Incident Initial Report From, submitted to the State Survey Agency, for MD00206318, revealed that Resident #24, who was the only witness, reported that Geriatric Nursing Assistant (GNA, Staff #34) hit Resident #28 while she was feeding him/her.

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F 0600

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Review of the final report for MD00206318 on 8/21/24 revealed the facility did not substantiate the abuse because of insufficient information and that Resident #24 who reported the allegation had a Brief Interview for Mental Status (BIMS) of 7 and when the facility later interviewed her/him, they were unable to recall the incident.

A Brief Interview for Mental Status (BIMS) is a tool used to screen and identify the cognitive condition of residents in a long-term care facility. The BIMS score ranges from 0 to 15, with 0 indicating severe cognitive impairment and 15 indicating intact cognition.

Review of the investigative documentation provided by the facility related to this report revealed a hand written and signed statement by Staff #34, which stated, While I was feeding Resident #28's room number at the dinning room, she started spitting [his/her] food on me. I tapped on [his/her] left shoulder to stop it.

Further review of the final report failed to reveal indication that a written statement was made by the alleged staff member indicating that she did tap Resident #28 on the shoulder.

On 08/22/24 at 10:44 AM, a phone interview with GNA #34 revealed that Resident #28 was spitting her/his food out and the GNA told the resident to stop and the resident did not, so she tapped the resident on the shoulder to stop.

On 08/22/24 at 2:10 PM, review of a typed interview with GNA #34 dated 6/4/24 that was signed by the Director of Nursing (DON) and provided to the surveyor after the phone interview with GNA #34, stated .GNA #34 said Resident #28 was eating very slowly and she was trying to get Resident #28 to eat. [S/he] kept spitting out [his/her] food and she kept telling [him/her] not to spit out the food. She stated that she tapped [him/her] on the left shoulder as she was sitting in front to get [his/her] attention to eat. She tapped [him/her] with her fingers on the left shoulder and stated it was just a tap that she didn't hit her.

Review of the facility's agency Do Not Return list revealed Staff #34's name.

On 8/26/24 at 3:51 PM, the surveyor reviewed with the DON the concern that based on review of the documentation and surveyor interview with the GNA #34, abuse was substantiated.

48470

4) Resident #9 had been residing in the facility since 2017. The resident submitted a complaint related to MD00208809 that indicated 2 nurses refused to administer his/her medications on 8/11/24 and 8/14/24.

On 8/23/24 at 2 PM, Resident #9's care plan was reviewed and revealed problems that include refusal of care. The interventions for this problem included to monitor and document the behavior and to reattempt to give care.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/23/24 at 2:16 PM, Resident #9's administration history, that included but was not limited to behavior monitoring, medication administration, and treatment administration for August 11 and 14 of 2024 was reviewed. The review suggested that the nurse on duty on 8/11 for the 7-3 shift was licensed practical nurse (LPN Staff #57), and the nurse on duty on 8/14 for the 7-3 shift was LPN Staff #56. The review revealed: a) on 8/11/24, the area where the nurse on duty was supposed to document the behavior for refusal of care was blank; 14 routine medications were blank, 8 of which were once a day medication; and all 7 scheduled treatments were blank. b) On 8/14/24, Staff #56 documented 0 episodes of refusal of care; 4 routine medications were not administered and the nurse on duty documented under comment, resident ignored writer when attempted to administer. 1 of the 4 medications was scheduled to be administered once a day between 7 AM to 3 PM, and another was scheduled to be administered once a day at 12:30 PM only on Mondays, Wednesdays, and Fridays; all treatments were administered as scheduled. A subsequent review of Resident #9's electronic health record revealed a progress note from Staff #56 on 8/14/24 created at 4:51 PM, that stated When writer attempted to administer resident's 1300 medications, resident was at the time sitting in her room, eating lunch. Upon knocking and entering room, writer addressed resident by her name and resident did not respond but continued to eat lunch. Resident an hour later came to the nurses offices as writer was on break, demanding medications and eye drops. Management already made aware of refusal and refusal documented. Further review of the progress notes revealed no evidence of documentation from the nurse on duty on 8/11/24. On 8/23/24 at 2:53 PM, the Director of Nursing (DON) was interviewed about medication administration and her expectation from staff when a resident refuses or declines a medication. The DON reported that she expects staff to document the refusal by documenting in the electronic Medication Administration Record (eMAR) and progress notes, and to notify the provider and responsible party. On 8/26/24 at 9:41 AM, a review of the daily staff post documentation confirmed that Staff #57 and Staff #56 were the nurses on duty at the time of the allegation event. In an interview with the DON and the Assistant DON on 8/26/24 at 11:01 AM, both staff confirmed that Resident #9 had brought to their attention an issue with a nurse who refused to administer his/her medications. The DON reported that the resident had left a message on her cell phone to report the 8/14/24 incident, but not the 8/11/24 incident. Both staff indicated that they immediately investigated the concern on 8/14/24 while Staff #56 was still on duty. However, there was no evidence of the investigation conducted by the DON and the ADON. The findings in Resident #9's administration history was discussed with both staff where Staff #57 failed to administer 14 medications along with treatments, and no documentation of refusal of care; and Staff #56 failed to administer or reattempt to give the resident's medications when s/he was asking for them as evidenced by her progress note. Subsequently on the same day at approximately 4 PM, the DON reported that she will start a facility reported incident regarding the deprivation of services by the nurses to Resident #9. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/29/24 at 11 AM, the concern was discussed with the DON, ADON, and the Corporate Clinical Nurse (Staff #2) regarding the deprivation of goods and services to a resident on 2 occasions. Staff #2 indicated that Staff #56's action did not make sense since the resident was already asking for his/her medications and questioned why didn't she just give them after her break? No explanation was offered by the DON or the ADON.

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F 0607

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

Develop and implement policies and procedures to prevent abuse, neglect, and theft.

48470

Based on records review and interviews, it was determined that the facility failed to implement their abuse policies and procedures by 1) failing to report all allegations of abuse to the state agency and the facility's abuse coordinator and 2) failing to conduct a thorough investigation of all allegations of abuse. This was evident for 1 of 1 policies and procedures reviewed for abuse, neglect, exploitation, or mistreatment and has the potential to affect all residents of the facility.

The findings include:

A review of the facility's abuse, neglect, exploitation or mistreatment policies and procedures was conducted on 8/26/24 at 2:19 PM. The policies and procedure indicated in the bottom of the document that it had a complete revision on 11/1/2017.

In the section under Policy, item number 2. indicated that if the events that cause the allegation involve abuse, the facility shall report immediately, but no later than 2 hours after the allegation is made to the administrator of the facility and to other officials (including state survey agency) in accordance with the state law. Item number 3. stated, The facility's Leadership will conduct a prompt investigation of any allegation received of suspected abuse, neglect or exploitation or mistreatment and will implement immediate action to safeguard resident. And item number 5. stated The facility's Leadership will designate a staff member to oversee the abuse prohibition policy (Facility Abuse Coordinator)

During the survey process, the surveyor had identified 3 occurrences through interviews and records review where residents had reported allegations of abuse to staff, but the facility's leadership failed to report the incident to the state agency and failed to conduct a thorough investigation of the allegation.

The 3 occurrences were:

1) On 8/15/24 at 3:50 PM, while in an interview with Resident #19, s/he reported a Geriatric Nursing Assistant (GNA) who allegedly called him/her numerous names. The allegation was reported to the Director of Nursing (DON) and the GNA was taken off the floor and was not allowed to care for Resident #19 anymore.

The DON was interviewed on 8/26/24 at 1:12 PM. The DON confirmed Resident #19's report and indicated that when the incident happened, 2 GNA's were with the resident and both staff reported that the allegation was not true. Since 2 staff members confirmed with her that the allegation did not happen, she did not do a facility report.

2) On 8/20/24 at 1:43 PM, Resident #9 reported an allegation of abuse against a male GNA that had happened about 3 weeks ago. The resident indicated that s/he had reported it to the Unit Manager (Staff #30), the DON, and the scheduler. Then the resident stated, But then they scheduled him again this Saturday night and I went off! Resident #9 further reported that the nurse on duty calmed him/her down and helped facilitate in assigning a different staff member to put him/her back to bed.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 8/20/24 at 2:28 PM, the DON was interviewed about the resident's allegation and she confirmed that it was brought to her attention. The DON was asked if she reported and investigated the allegation and she replied, No I did not, because it's usually he said s/he said, and I don't have any report against that staff from other residents. A subsequent interview with the DON on 8/21/24 at 12:49 PM, the concern was discussed that the resident's allegation was not reported to the state agency. The DON indicated that the resident was always reporting things and did not like agency staff. The resident was known for making stuff up and was care planned for it as well. The DON acknowledged the concern and reported that she would report all allegations from now on. 3) On 8/20/24 at 4:45 PM, the surveyor received a complaint intake information submitted by Resident #9 related to MD00208809. The resident reported 2 nurses who refused to administer his/her medications on 8/11/24 and 8/14/24. In an interview with the DON and the Assistant DON on 8/26/24 at 11:01 AM, both staff confirmed that Resident #9 had brought to their attention an issue about a nurse who refused to administer his/her medications. The DON reported that the resident had left a message on her cell phone to report the 8/14/24 incident but not the 8/11/24 incident. Both staff indicated that they immediately investigated the concern on 8/14/24. However, there was no evidence of the investigation conducted by the DON and the ADON. Subsequently on the same day at approximately 4 PM, the DON reported that she will start a facility reported incident regarding the deprivation of services by the nurses to Resident #9. In an interview with the Nursing Home Administrator (NHA) on 8/27/24 at 9:55 AM, he reported that he was the facility's abuse coordinator. The DON sends reports on behalf of the facility. The NHA reported the facility's process when an abuse allegation is made and indicated that all allegations are reported to him prior to investigations and him reporting the event to regional staff. In a subsequent interview with the NHA on the same day at 3:07 PM, the 3 allegations identified above was discussed. The NHA reported that he does not recall the incident with Resident #19, he was not aware initially about Resident #9's allegation against the GNA who was assigned to him/her on 8/17/24 and confirmed that refusing to administer medications was a type of abuse and a reportable offense. The NHA acknowledged the concern that the DON had not reported and thoroughly investigated all the allegations being brought to her attention. On 8/29/24 at 11 PM, the concern was discussed with the DON, ADON, and the Corporate Clinical Nurse (Staff #2) that the facility failed to implement its policies and procedures for the prevention of abuse as evidenced by allegations made by residents were not reported to the facility's abuse coordinator, not reported to the state agency, and no thorough investigations were conducted on several occasions. All 3 staff acknowledged the concern. Cross reference F609, F610

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 37276 Based on records review and interviews, it was determined that the facility failed to 1) have an effective system in place to ensure that all allegations of abuse are reported to the state agency, 2) to ensure that reports are sent within the mandated timeframe, and 3) to report the results of the investigation no later than 5 working days after the incident. This was evident in 6 (Resident #19, #9, #6, #25, #67, and #92) of 21 residents reviewed for abuse. The findings include: 1) On 8/26/24 at 2:50 PM, a review of facility reported incident MD00200510 revealed that, on the morning of 12/12/23, Resident #25 reported to a staff member that a GNA (geriatric nursing assistant) had made a movement like s/he was going to hit the resident. On the self-report form, the facility documented the date of the incident was 12/11 to 12/12/23 and reported by the resident on 12/12/23. The facility's initial self-report indicated the allegation of abuse was reported to the state agency on 12/12/23 at 12:40 PM and the final report was reported to the state agency on 12/19/23 at 1:50 PM. During an interview on 8/28/24 at 3:54 PM, the Director of Nursing (DON) stated she thiought that she was made aware of the allegation of abuse the morning of 12/12/23, around 9:00 AM, that she could not recall the exact time, but it was before the morning meeting. The time the facility reported the allegation to the state office was past the 2-hour required timeframe. In addition, the facility failed to report the results of the investigation no later than 5 working days after the incident. The concerns with the late reporting of an allegation of abuse were discussed with the DON at that time, and the DON verbalized understanding. 48168 2). On 8/26/24 at 9:00 AM, a review of complaint #MD00208610 revealed an allegation that staff yelled at and hit Resident #67. On 8/26/24 at 12:10 PM, an interview with the Assistant Director of Nursing (ADON) was conducted. When asked if there were any FRIs for Resident #67, the ADON said she did not have any. On 8/26/24 at 4:21 PM in an interview with Unit Manager (Staff #5), she said she was aware of an allegation of abuse for Resident #67. She thought it happened on a weekend. Staff #5 further explained that she informed the Director of Nursing (DON) of the allegation and thought the DON did an investigation. When asked what the process was for reporting alleged abuse, Staff #5 said that the DON was immediately notified, anytime 24/7, even if it was the weekend, and that the ADON and DON alternated taking call on the weekends. When asked if she remembered the date of the alleged incident, she said she could not remember. When asked if she has record of it, she said she did not. She further explained that sometimes she helped investigate allegations, but she did not investigate this incident. (continued on next page)

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F 0609

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

On 8/27/24 at 1:44 PM an interview with the DON was conducted. The DON stated she learned of the allegation of abuse for Resident #67 from the unit manager, who had a phone message left on her unit manager phone on a weekend. The DON said she asked the resident, who said the incident did not happen, and since the resident denied the occurrence, the facility did not do an investigation or make a report. The DON confirmed that this did not meet the regulatory requirements to report and investigate all allegations of abuse.

3). On 8/28/24 at 1:16 PM, a review of the FRI #MD00191798 revealed an allegation that Resident #92 was abused by another resident (Resident #77) on 4/18/23. A review of the facility's investigation file revealed an Initial Self-Report report to the Office of Health Care Quality (OHCQ) dated 4/26/23 at 5:30 PM with a corresponding email confirmation. The facility's investigation file also contained a typed witness statement, dated 4/18/23, by Licensed Practical Nurse (LPN #37) who witnessed the incident.

On 8/28/24 at 2:54 PM an interview with the DON was conducted to review the FRI #MD00191798 report, the facility's investigation file, and the timing of the facility's self-report. The DON confirmed that, since the incident occurred on 4/18/23 but was not reported to OHCQ until 4/26/23, the facility was not compliant with reporting regulations.

48470

4) Resident #19 had been residing in the facility since 2015. In an interview with the resident on 8/15/24 at 3:50 PM, the resident reported that a Geriatric Nursing Assistant (GNA) who still worked for the facility was calling him/her numerous names, including being referred to as the devil. The resident indicated that this happened about 5-6 months ago, and that it had been reported to the Director of Nursing (DON).

The DON was interviewed on 8/26/24 at 1:12 PM. The DON confirmed Resident #19's report and

indicated that, when the incident happened, 2 GNA's were with the resident and both staff reported that the allegation was not true. Since 2 staff members confirmed with her that the allegation did not happen, she did not do a facility report.

On 8/27/24 at 8:09 AM, the Corporate Clinical Nurse (Staff #2) reported to the surveyor that she would be interviewing the resident, and that the facility had started a formal investigation of the allegation.

5a) On 8/20/24 at 1:43 PM, Resident #9 reported an allegation of abuse against a male GNA that had happened about 3 weeks ago. The resident indicated that s/he had reported it to the Unit Manager (Staff #30), the DON, and the scheduler. Then the resident stated, But then they scheduled him again this Saturday night and I went off! Resident #9 further reported that the nurse on duty calmed him/her down and helped facilitate in assigning a different staff member to put him/her back to bed.

On 8/20/24 at 2:28 PM, the DON was interviewed about the resident's allegation and she confirmed that it was brought to her attention. The DON was asked if she reported and investigated the allegation and she replied, No I did not, because it's usually he said s/he said, and I don't have any report against that staff from other residents.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215217	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
NAME OF PROVIDER OR SUPPLIER: Northampton Manor Nursing and Rehabilitation Cente		STREET ADDRESS, CITY, STATE, ZIP CODE: 200 East 16th Street Frederick, MD 21701	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In a subsequent interview with the DON on 8/21/24 at 12:49 PM, the concern was discussed that the resident's allegation was not reported to the state agency. The DON indicated that the resident was always reporting things and did not like agency staff. The resident was known for making stuff up and was care planned for it as well. The DON acknowledged the concern and reported that she would report all allegations from now on. 5b) On 8/20/24 at 4:45 PM, the surveyor received a complaint intake information submitted by Resident #9 related to MD00208809. The resident reported 2 nurses who refused to administer his/her medications on 8/11/24 and 8/14/24. In an interview with the DON and the Assistant DON on 8/26/24 at 11:01 AM, both staff confirmed that Resident #9 had brought to their attention an issue about a nurse who refused to administer his/her medications. The DON reported that the resident had left a message on her cell phone to report the 8/14/24 incident, but not the 8/11/24 incident. Both staff indicated that they immediately investigated the concern on 8/14/24. However, there was no evidence of the investigation conducted by the DON and the ADON. Subsequently on the same day at approximately 4:00 PM, the DON reported that she would start a facility reported incident regarding the deprivation of services by the nurses to Resident #9. 6) Resident #6 was admitted into the facility in late 2023. A facility reported incident (FRI) investigation packet related to MD00207289, regarding abuse, was reviewed on 8/23/24 at 10:52 AM. The review revealed that the allegation was reported to the wound nurse (Staff #58) by the resident on 7/1/24 at approximately 9:00 AM. Further review of the investigation packet revealed the FRI initial report form that stated the form was submitted on 7/2/24 at 7:00 PM. The confirmation email that the initial report was submitted was dated 7/2/24 at 7:37 PM. The DON was interviewed on 8/23/24 at 12:09 PM and the concern was discussed that the initial report for an allegation of abuse was sent approximately 34 hours after the facility was made aware. The DON acknowledged the concern and offered no explanation. A review of the facility's abuse, neglect, exploitation or mistreatment policies and procedures was conducted on 8/26/24 at 2:19 PM. The review revealed a section titled Reporting/Response and item number 1 stated, All alleged violations concerning abuse, neglect, or misappropriation of property are reported immediately to Abuse coordinator, NHA, other officials in accordance with the state law including state survey and certification agency. On 8/29/24 at 11:00 AM, the findings were reviewed with the DON, ADON, and the Corporate Clinical Nurse (Staff #2) and the concern was discussed that allegations of abuse must be reported to the state agency and that reports must be submitted within the mandated timeframe. All staff verbalized understanding and acknowledged the concern.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Respond appropriately to all alleged violations. 48168 Based on record review and staff interview, it was determined that facility staff failed to conduct a thorough investigation of abuse and maintain evidence of the investigation. This was evident for 7 (#424 #19, #9, #41, #92 #322, #67) of 21 residents reviewed for abuse and for 3 facility reported incidents reviewed for abuse (FRIs) (#MD00194834, and #MD00207292, and #MD00191798), of 34 FRIs investigated during the recertification survey. The findings include: 1). On 8/27/24 at 12:03 PM a review of the Office of Health Care Quality (OHCQ) report #MD00194834 revealed an allegation that staff mistreated Resident #322 on 7/27/23 when they ripped the remote control from the resident's hand. On 8/27/24 at 12:10 PM, the facility's investigation file was obtained and reviewed. Although the file contained a suspension notice for a Geriatric Nursing Assistant (GNA #38), the file lacked 1) any staff witness statements, 2) evidence that Resident #322 had a physical assessment done after the incident, and 3) assignment sheets of staff on duty at the time of the incident. 4) demographic and clinical information regarding the resident and the resident's care needs at the time, 5) any evidence of education provided to staff after the alleged incident. The file also contained a skin assessment for Resident #322, dated 7/29/24. On 8/27/24 at 1:31 PM, an interview with the Director of Nursing (DON) was conducted to review the facility's investigation file. The DON confirmed that there were no staff statements, no resident information or assessment, no evidence of education or follow up other than the suspension notice, and that the clinical documentation, dated 7/29/24, could not have been part of the investigation because it occurred more than one year later. On 8/27/24 at 3:19 PM, an interview with the Nursing Home Administrator (NHA) was conducted and he was informed of the incomplete investigation. He said he had only worked at the facility for 10 months, and that he understood the investigation was not thorough. 2). On 8/26/24 at 3:18 PM, a review of the FRI #MD00207292 revealed an allegation that, on 6/30/24, a male Geriatric Nursing Assistant (GNA #11) grabbed Resident #41's leg and left a mark on it. On 8/26/24 at 3:20 PM, a review of the facility's investigation file revealed that, although the alleged perpetrator wrote a statement on his suspension notice, there were no other staff statements in the file. A typed statement by the Assistant Director of Nursing (ADON) indicated that she conducted resident and staff interviews, but did not indicate who was interviewed, nor was there a list of staff on duty at the time. And although the ADON wrote a statement that she spoke with the Resident #41, who indicated being safe, there was no statement from Resident #41 about the actual incident. The file also lacked the 5-day final report to OHCQ and lacked any evidence of education provided to staff about abuse prevention and reporting. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 8/27/24 at 1:20 PM, the DON was interviewed about the facility's investigation of the alleged abuse of Resident #41. When asked about the lack of pertinent information in the investigation file, the DON stated she might have some additional information in her computer, but she did not have time to make sure it was complete before giving it to the survey team, and she also confirmed that the investigation should have included names of staff and residents who were interviewed. The DON confirmed that the investigation file was incomplete. On 8/27/24 at 3:19 PM, an interview with the NHA was conducted regarding the incomplete investigation and he validated that this was a deficiency. 3). On 8/28/24 at 1:16 pm a review of the FRI #MD00191798 revealed that Resident #92 made an allegation of abuse against Resident #77 on 4/18/23. On 8/28/24 at 2:00 PM a review of the facility's investigation file revealed a staff witness statement by Licensed Practical Nurse (LPN #37) which described an incident that occurred on 4/18/23 around 7 PM. The typed statement was dated 4/18/23 and contained an illegible signature, and indicated it was an interview of LPN #37. The file lacked 1) any clinical or identifying information for either resident involved, 2) no other staff or resident witness statements, 3) no roster of residents on the unit, and 4) no list of staff on duty at the time. The file also contained the 5-day Final Report which included a statement that Resident #92 wanted to press charges against Resident #77, but there was no police report case number or officer name listed in the file. On 8/28/24 at 2:54 PM an interview with the DON was conducted regarding the facility's investigation of the allegation that Resident #92 was abused by Resident #77. When asked, the DON said the typed interview statement of LPN #37 was written by the facility Social Worker (SW #39) who no longer worked at the facility, although her name was not legible on the document. The DON also confirmed that the facility's investigation file lacked other staff or resident witness statements, lacked a roster of resident census or staff duty assignment, lacked documentation of follow up of resident's aggressive behavior, lacked evidence of education provided to the staff after incident, and lacked evidence of a police report filed per Resident #92's request. The DON validated that the investigation was incomplete. 48470 4) Resident #19 had been residing in the facility since 2015. In an interview with the resident on 8/15/24 at 3:50 PM, the resident reported that a Geriatric Nursing Assistant (GNA) who still works for the facility was calling him/her numerous names including being referred to as the devil. The resident indicated that this happened about 5-6 months ago and that it had been reported to the Director of Nursing (DON). The DON was interviewed on 8/26/24 at 1:12 PM. The DON confirmed Resident #19's report and indicated that when the incident happened, 2 GNA's were with the resident and both staff reported that the allegation was not true. Since 2 staff members confirmed with her that the allegation did not happen, she did not do a facility report. On 8/26/24 at 1:29 PM, a review of Resident #19's medical records failed to reveal evidence that the allegation was investigated and unsubstantiated. No record was found to indicate that the resident and/or other residents were interviewed, and staff were interviewed. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the facility's abuse, neglect, exploitation or mistreatment policies and procedures was conducted on 8/26/24 at 2:19 PM. The review revealed a section titled Guidelines for Investigation and stated in item G Interview individuals having first-hand knowledge of the incident and write summaries of the interviews. NOTE: Employees/witnesses are not to write out statements. Employees/witnesses will be interviewed by designated facility staff and interviewer will record all witness accounts in a document, written, dated and signed by the interviewer. On 8/27/24 at 8:09 AM, the Corporate Clinical Nurse (Staff #2) reported to the surveyor that she would be interviewing the resident, and that the facility had started a formal investigation of the allegation. On 8/29/24 at 11:00 AM, the concern was discussed with the DON, Assistant DON, and the Corporate Clinical Nurse (Staff #2) that an allegation of abuse was not thoroughly investigated. All staff acknowledged the concern. 5) Resident #9 had been residing in the facility since 2017. The resident's medical records indicated that s/he was cognitively intact with a BIMS of 15. BIMS : stands for Brief Interview for Mental Status. The BIMS test is used to get a quick snapshot of how well you are functioning cognitively at the moment. During the survey process, the surveyor had identified allegation of abuse that involved Resident #9. These allegations were: a) On 8/20/24 at 1:43 PM, Resident #9 reported an allegation of abuse against a male GNA that had happened about 3 weeks ago. The resident indicated that s/he had reported it to the Unit Manager (Staff # 30), the DON, and the scheduler. Then the resident stated, But then they scheduled him again this Saturday night and I went off! Resident #9 further reported that the nurse on duty calmed him/her down and helped facilitate in assigning a different staff member to put him/her back to bed. On 8/20/24 at 2:28 PM, the DON was interviewed about the resident's allegation and she confirmed that it was brought to her attention. The DON was asked if she reported and investigated the allegation and she replied, No I did not, because it's usually he said s/he said, and I don't have any report against that staff from other residents. In a subsequent interview with the DON on 8/21/24 at 12:49 PM, she reported that she reviewed the GNA's schedule to see which residents were assigned to the staff. None of the other residents had any complaints or concern with the staff and that Resident #9 was always reporting things and did not like agency staff. The resident was known for making stuff up and was care planned for it as well. b) On 8/20/24 at 4:45 PM, the surveyor received a complaint intake information submitted by Resident #9 related to MD00208809. The resident reported 2 nurses who refused to administer his/her medications on 8/11/24 and 8/14/24. In an interview with the DON and the ADON on 8/26/24 at 11:01 AM, both staff confirmed that Resident # 9 had brought to their attention about a nurse who refused to administer his/her medications. The DON reported that the resident had left a message on her cell phone to report the 8/14/24 incident but not the 8/11/24 incident. Both staff indicated that they immediately investigated the concern on 8/14/24. However, there was no evidence of the investigation conducted by the DON and the ADON. (continued on next page)

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	215217	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northampton Manor Nursing and Rehabilitation Cente	200 East 16th Street Frederick, MD 21701

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Subsequently on the same day at approximately 4:00 PM, the DON reported that she will start a facility reported incident regarding the deprivation of services by the nurses to Resident #9. On 8/29/24 at 11:00 AM, the allegations made by Resident #9 was discussed with the DON, ADON, and the Corporate Clinical Nurse (Staff #2) and the concern was discussed that there was no evidence that the allegations were investigated. All staff verbalized understanding and acknowledged the concern. 40927 6) On 8/22/24 at 8:53 AM, a review of the facility's investigation file for the facility reported incident #MD00182597 revealed a self-report form that documented a staff member had witnessed Resident #424 being abused on 4/20/22 at 2:30 PM by another staff member. Further review of the investigation file revealed that facility staff failed to maintain evidence that they had interviewed and/or assessed other residents who had been in the care of GNA #53 to ensure no one else had been abused. They facility failed to interview other staff who may have had knowledge of the incident, or the care provided to other residents by GNA #53. The facility also failed to maintain a completed investigation and evidence as to when it was sent to the state agency. On 8/28/24 at 9:54 AM, the concerns were reviewed with the Director of Nursing and the Assistant Director of Nursing. Neither of them were in their current positions at the time of the incident. The Administrator, at the time of the incident, was no longer there. The DON was unable to find the original investigation file and had printed what they could find in the computer to recreate the file. Cross Reference F600

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 37276 Based on observation, medical record review and resident and staff interview, it was determined the facility failed to implement interventions based on a resident's comprehensive care plan. This was evident for 1 (#25) of 3 residents reviewed for communication/sensory and 1 (#108) of 4 residents reviewed for accidents. The findings include: A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care 1) On 8/16/24 at 11:16 AM, during an interview, Resident #25 appeared hard of hearing and had difficulty hearing the surveyor. When asked if the resident attended activity programs, Resident #25 stated s/he did not attend activity programs because s/he could not hear. Resident #25 also reported that the resident could not hear at all in one of his/her ears, and s/he was hard of hearing in the other ear. Resident #25 also reported s/he had hearing aids that had not been worn since forever. On 8/21/24 at 11:25 AM, a review of Resident #25's medical record revealed a communication care plan, [Resident #25] may have difficulty understanding others R/T (related to) hearing loss with chronic wax build-up, that had the goal, will hear and comprehend communication, demonstrated by being able to follow simple 1 step directions through the review date, with approaches that included, Hearing aides are kept in the med cart. They are to be put in with AM care and removed at HS (hours of sleep). Review of Resident #25's July 2024 Medication Administration Record (MAR) revealed a 1/24/23 physician order to place hearing aids in the resident's bilateral (both sides) ears in the AM [9:00 AM], and off in the PM [9:00 PM], and place the hearing aids in a cup in the top drawer of medicine cart. Following the order, the MAR documented hearing aids were not placed in Resident #25's ears on 8 (7/7, 7/19, 7/24, 7/26, 7/27, 7/28, 7/30, 7/31) out of 31 days in July 2024, and that a hearing was placed only in the left ear on 4 (7/3, 7/9, 7/4, 7/16) days in July 2024. Review of Resident #25's August 2024 MAR revealed the same 1/24/23 physician order to place hearing aids in the resident's bilateral (both sides) ears in the AM, and off in the PM and place the hearing aids in a cup in the top drawer of medicine cart. Following the order, the MAR documented that hearing aids were not placed in Resident #25's ears on 13 (8/1, 8/2, 8/3, 8/4, 8/6, 8/7, 8/8, 8/9, 8/10, 8/12, 8/13, 8/15, 8/25) of 26 days in August 2024, and that a hearing was placed only in the left ear on 3 (8/14, 8//18, 8/26) days in August 2024. The facility failed to follow the care plan by failing to implement the approach, for the hearing aids to be put in with AM care and removed at HS. The concerns with failing to implement the care plan were discussed with the Director of Nursing (DON) on 8/28/24 at approximately 3:20 PM. The DON acknowledged the concerns at that time, and no further comments were offered. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	48470 2) A review of Resident #108's medical records indicated that s/he was admitted to the facility in June of 2024. The Resident was transferred from the hospital after a fall that s/he suffered from home. On 8/22/24 at 9:45 AM, a subsequent review of Resident #108's medical record revealed that s/he had fallen 12 times since being admitted to the facility. Furthermore, a facility reported incident (FRI) related to MD00207141 was sent to the Office of Healthcare Quality that investigated the falls that had occurred. At the conclusion of the FRI, it indicated that the corrective actions the facility had implemented included a review of all interventions to verify that they are appropriate. This was submitted by the Director of Nursing (DON) on 7/5/24 at 6:30 PM. In reviewing Resident #108's care plan on 8/22/24 at 11:46 AM, it revealed that the resident was identified as a fall risk. The care plan had interventions to prevent and protect the resident from falls that include the utilization of a fall mat to be placed on the right side of the bed. Resident #108's room was observed on 8/15/24 at 12:40 PM, 8/21/24 at 11:03 AM, and 8/22/24 at 12:28 PM. 3 of the 3 observations failed to show evidence that a fall mat was put in place as stated in the resident's care plan. On 8/22/24 at 12:41 PM, Resident #108's orders, including discontinued and completed orders, were reviewed and failed to reveal evidence that an order to utilize a fall mat was instituted. In an interview with the DON on 8/22/24 at 2:12 PM, she was asked if Resident #108 used a fall mat and if a doctor's order was needed for this intervention. The DON replied yes to both questions and indicated that the fall mat was on the right side of the bed. The DON was reviewing the resident's medical record and was asked if she was able to find the order for the fall mat. The DON reported that she could not find the order and indicated that staff might have forgotten to put the order back when the resident was hospitalized . Following the review of the order history of Resident #108 by the DON, she confirmed that the fall mat was never ordered. The surveyor also discussed with the DON that there was no observation of the fall mat in the resident's room, and that she had documented in the FRI follow up report that all interventions were evaluated to be appropriate, but failed to implement them. On 8/29/24 at 11 AM, the concern was discussed with the DON, Assistant DON, and the corporate clinical nurse that the facility failed to implement a care plan regarding the fall mat use to protect the resident from falls. All staff verbalized understanding and acknowledged the concern.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 40927 Based on record review and interview, it was determined that the facility failed to 1) have a process in place to monitor resident's air pressure mattress settings and ensure that they were appropriate for the resident's current weight which resulted in a harm to Resident #3 and 2) ensure that a resident's change in condition was evaluated by a primary care provider. This was evident for 1 (#3) of 8 residents reviewed for falls and 1 (#110) of 2 residents reviewed for skin conditions. The findings include: Low air loss mattresses are designed to distribute the patient's body weight over a broad surface area and help prevent skin breakdown. Air continually flows through tiny laser-made air holes in the top of the mattress surface so that the user floats on a soft cushion of air. (https://homecarehospitalbeds.com). A control box is placed on the footboard that controls the air flow into the mattress. A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care. 1) A medical record review for Resident #31 on 8/28/24 at 11:35 AM revealed a history and physical examination conducted by the attending physician on 2/1/23 that documented the resident had been admitted from home because of care needs. According to the weights, the resident weighed 214.8 lbs. (pounds) at the time of admission. However, the resident experienced weight loss and was down to 178.8 lbs. , by 5/2023 and was ordered a low air loss mattress because the resident had some pressure areas and was refusing to get out of bed. The air flow settings for the mattress were based on the resident's weight. Further review revealed that the resident experienced a significant weight loss of 35.7 lbs. over an 11-month period. Further review of the medical record revealed there was an order for the low air loss mattress, but no documentation of the air flow settings or orders to monitor the settings. Review of the resident's care plan for pressure ulcers revealed an intervention for an APM [air pressure mattress] however, the settings were not included in the intervention. Also, there was no intervention to monitor the settings to ensure they were correct. On 8/27/24 at 9:55 AM, a review of the facility's investigation file for the facility reported incident #MD00205907 revealed a statement from Geriatric Nursing Assistant (GNA) #50 taken by Licensed Practical Nurse (LPN) #30 that she heard the resident scream and went to the room to find the resident lying on the floor. According to the statement, the resident was lying on their back with their legs bent sideways with obvious trauma to the one leg. The resident was placed back into bed with a mechanical lift. A review of the final investigation report revealed the resident was dependent on staff to roll them back and forth, making it unlikely that the resident rolled out of the bed. The facility had determined that the low air loss mattress was set on a 5, and with the resident's current weight it should have been on a 3. This caused over inflation of the air mattress which caused the resident to slide out of bed. (continued on next page)

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F 0684

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Further review revealed diagnostic imaging reports for x-rays taken of the pelvis and the right lower leg. The resident suffered a hip fracture and a fracture of the proximal tibia and fibula (two bones in the lower leg). Review of the orthopedic consultation on 4/26/24, revealed that it was recommended to have surgical intervention for the broken hip, however, there were greater risks associated with the surgery due to the resident's medical condition. Review of a progress note, dated 4/29/24, revealed that the resident and family opted to have the surgery.

An interview with the DON on 8/28/24 at 9:30 AM confirmed that the fall had been due to the low air loss mattress being over inflated and the resident fell out of bed. The DON further reported that once a week, they meet to discuss residents with weight loss, pressure sores, and falls. However, they had not been reviewing the low air loss mattress settings when the resident had weight loss. In addition, she confirmed that there were no orders for monitoring the air flow settings on the control box to ensure they were correct and ensure the safety of the resident. Furthermore, she reported that when a resident had the machine with the knob control, the controls could be moved accidentally, but the ones with a button control would not be easily moved. She stated that, when a resident was placed on the low air loss mattress, they would obtain a weight and give that information to the maintenance director who would set the air flow based on the manufacturer's guidelines, and he would put the setting on a sticker and place it on the control box. Once it was set, there was no process in place to check the settings to ensure they had not been moved or when a resident lost weight to check the manufacturer's guidelines to change the settings as needed. After the incident occurred, the residents with weight loss and a low air loss mattress were checked to ensure that the settings were appropriate for their current weight.

During an interview with the Maintenance Director on 8/29/24 at 11:44 AM, he reported that, as he was conducting audits to make sure that the low air loss mattress settings matched the setting that he wrote on the sticker on the control box, he found the settings were being changed. He reported that sometimes, the residents will lean on the low air loss mattress control box that hangs on the end of the bed and it will change the level accidentally.

A subsequent interview with the DON on 8/29/24 at 12:04 PM revealed she was aware that the Maintenance Director was finding settings that had been changed accidentally during his audits. With these findings, facility staff failed to put an intervention into place to monitor the settings to ensure that they remained on the correct air flow level to prevent this incident in the future.

50573

On 08/15/24 at 03:29 PM, an interview with Resident #110's responsible representative revealed that the nursing staff had informed her of a mass on the resident's groin earlier in the week and had indicated that the Nurse Practitioner (NP) would be seeing the resident but when she came to the facility today staff had no knowledge of the resident being seen by the NP. The responsible representative also reported she has addressed this issue with the Director of Nursing (DON).

On 08/19/24 at 09:00 AM, record review revealed that on 08/09/2024 at 12:35 AM, a progress note was completed by Licensed Practical Nurse (LPN, Staff #9) which indicated the resident was swollen in the upper thigh/groin area and that report would be given to the day nurse to follow up with the Nurse Practitioner.

(continued on next page)

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	215217	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northampton Manor Nursing and Rehabilitation Cente	200 East 16th Street Frederick, MD 21701

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/26/24 at 12:55 PM, review of the door access log revealed that Nurse Practitioner (Staff #41) was in the facility on 8/12/24. Further review of the medical record failed to reveal documentation to indicate the swelling to the groin was reported to the nurse practitioner or other primary care provider until a SOAP note was completed by the Director of Nursing (DON) on 8/15/24 which indicated the primary care provider was notified. A SOAP note is a written document that healthcare workers use to record information about patient encounters in a structured way. Record review on 8/29/24 at 10:10 AM revealed a progress note completed by Registered Nurse (Staff #42) on 8/15/24 which indicated an antibiotic was ordered for the abscess. Further record review, revealed a progress note by Licensed Practical Nurse (Staff #32), dated 08/16/2024 at 10:52, which indicated that Nurse Practitioner (Staff #41) looked at the resident's abscess and wrote a new order for a different antibiotic to treat the cellulitis diagnosis. Cellulitis is a bacterial infection that affects the skin's deeper layers and underlying tissue. Further review of the medical record failed to reveal documentation written by the NP about the area on the resident's groin until 8/21/24. On 08/26/24 at 10:10 AM, record review revealed a note by Nurse Practitioner (Staff #41) dated 8/21/24, for the mass on Resident #110's groin area. This is more than a week after nursing first identified swelling in the resident's groin area on 8/9/24. On 08/26/24 at 03:51 PM, the surveyor reviewed the concern that there was a progress note on 8/9/24 indicating swelling in the groin area and the facility did not notify the provider until 8/15/24. The DON responded oh yeah I did the SOAP note but that was 8/15/24. On 8/26/24 at 3:51 PM, the surveyor reviewed with the Director of Nursing (DON) regarding the failure to ensure that a resident's change in condition was reported and evaluated by a primary care provider.

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NAME OF PROVIDER OR SUPPLIER Northampton Manor Nursing and Rehabilitation Cente		STREET ADDRESS, CITY, STATE, ZIP CODE 200 East 16th Street Frederick, MD 21701	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 40927 Based on record review and interview, it was determined that the facility failed to ensure that residents with an elopement risk had the appropriate interventions in place to prevent an elopement. This was evident for 1 (#109) of 10 residents reviewed for elopement. Evidence was provided by the facility that an action plan was developed, and corrective measures were implemented on 4/30/24, immediately after the incident, to remove the immediacy of the noncompliance and correct the deficient practice. On 8/20/24, a determination of immediate jeopardy was made regarding the deficient practice with the potential for past non-compliance. The Director of Nursing and Corporate Clinical Director Nurse #2 were informed at 5:45 PM. Review of all facility corrective actions implemented prior to the survey start date, revealed that the facility had met minimum standards for plans of correction and the concern was therefore deemed past noncompliance. The findings include: A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care. The MDS (Minimum Data Set) is a complete assessment of the resident which provides the facility information necessary to develop a plan of care, provide the appropriate care and services to the resident, and to modify the care plan based on the resident's status. Brief Interview of Mental Status (BIMS) is a standardized test used to get a quick snapshot of the cognitive function and is a required screening tool used in nursing homes to assess cognition. A score of 13-15 points indicates an intact cognition, 8-12 points indicates moderately impaired cognition, and 0-7 points indicates severely impaired cognition. Elopement occurs when a resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so A medical record review for Resident #109 on 8/20/24 at 11:26 AM revealed a hospital discharge summary that documented the resident was living at home and found to have lewd and erratic behavior, so the family took the resident to the hospital. The resident was found to have a UTI and worsening dementia. The resident was admitted to the facility in 2/2024. A review of the resident ' s admission MDS with an assessment reference date of 3/6/24, documented the resident had a BIMS of 11/15 (moderate cognitive impairment) and was independent for indoor ambulation with a walker. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/29/24, an elopement assessment was opened by Licensed Practical Nurse (LPN) #7 and the assessment indicated the resident was an elopement risk (Elopement occurs when a resident leaves the premises or a safe area without authorization and/or any necessary supervision to do so) and a wander guard device (a device that is placed on the resident which causes an alarm to sound when they get too close to a door that is armed) was recommended. However, the assessment was not closed until 4/24/24 by the Director of Nursing (DON) and it was unclear which sections were completed by the LPN versus the DON. Review of the physician's orders revealed that the wander guard was not ordered until 5/1/24. Review of the care plan revealed that no care plan had been initiated for the elopement risk. There was no evidence in the medical record that the wander guard device was placed on the resident at the time of the assessment on 2/29/24. Further review of the medical record revealed the attending physician's history and physical visit notes, dated 3/6/24, the physician documented the resident was alert and oriented to themselves only. He also noted the resident was upset about being at the facility and wanted to be discharged another indication this resident was an elopement risk. Facility staff failed to implement the wander guard device following this physician's visit. During a review of the facility's investigation file for the facility reported incident #MD00205031 on 8/20/24 at 12:15 PM, it was revealed that Resident #109 had eloped from the facility on 4/24/24. According to Receptionist #8 's statement, the resident told her they were going to meet their daughter. The receptionist advised the resident to wait inside because it was windy out and she thought the resident was a FYI (an abbreviation that indicated the resident should not go outside alone). The receptionist further documented that, at 3:45 PM, she was checking in another resident and their son who had returned from an appointment (taking their temperatures). She wrote that when she turned back around, she did not see the resident and went outside and did not see the resident. She called upstairs to check if the resident went back upstairs and once confirmed the resident had not, a code for elopement was called. Review of a statement written by the Business Office Manager (BOM) revealed that, in response to the code, she was searching for the resident to the right of the building. She located the resident walking with their walker towards a housing development adjacent to the facility and brought the resident back to the facility at 3:52 PM. Review of a statement from the DON revealed she had interviewed LPN #7 on 4/25/24 and he reported that he had assessed Resident #109 and found the resident to be at risk for elopement. However, he could not locate a wander guard to put on the resident. He reported he had forgotten to pass the information to the oncoming nurse. Further review of the investigation file revealed the facility's corrective actions. The facility had determined the root cause of the elopement was due to LPN #7's failure to follow through with implementation of interventions following an elopement assessment. The facility took the following steps to correct the deficient practice: the resident was reassessed for elopement, a care plan was developed, and a wander guard placed on the resident; LPN #7 received 1:1 education regarding the need to immediately implement the wander guard when indicated; the current residents ' elopement assessments were reviewed for accuracy; the wander guard list and elopement notebook (containing a picture of each resident at risk for elopement) were reviewed and updated; all nurses were educated on how to complete the elopement assessment accurately; and implemented that all residents were assessed for elopement upon admission, with quarterly and annual reviews, and with any change in condition. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/20/24 at 1:08 PM, a review of 8 new admissions to the facility in the last 30 days revealed there were no concerns regarding their elopement assessments. An interview with LPN #7 on 8/20/24 at 1:20 PM revealed that he had completed the elopement assessment for Resident #109 on 2/29/24, confirmed the resident was an elopement risk and needed a wander guard. He stated that the admission was on evening shift however, he was unable to find a wander guard, so he did not put one on the resident. He could not remember if he passed the information to the oncoming nurse at the end of his shift. The DON was interviewed on 8/20/24 at 4:14 PM regarding the elopement and the corrective actions taken by the facility. She reported that, during an interview with LPN #7, she determined that the nurse had completed the assessment accurately, however, was unable to find a wander guard and failed to report that to the oncoming nurse. She reported that the wander guards had been kept in the supply closets for security reasons. After the incident, they were placed in the Unit Manager's office on each unit and there were two bracelets available for each unit. She confirmed that all the nurses have access to the Unit Manager's office after hours. She reported another step that they added was to have the unit managers review each new admission's elopement assessment to ensure accuracy and to double check that the interventions were implemented immediately. A second check was completed by the clinical team during their morning meeting following the new admission. A corrective action plan was developed and started on 4/24/24: Staff interviews were conducted to determine the details of the elopement and root cause analysis. An inventory of available wander guards was completed. Wander guards were ordered and available if an indication for use was identified. Licensed nursing staff will be re-educated on completion of Elopement Risk Assessment at the time of admission, readmissions, with change in condition, and periodically as indicated. If the Elopement Risk assessment indicates proceed interventions need to be implemented immediately to ensure resident safety. Staff will be re-educated regarding residents at risk for elopement and the method for identifying these residents to include the wander guard book kept at the front desk, elopement policy and drills, and code silver protocols. An audit of elopement risk evaluations was conducted to identify active residents who wander and those with existing wander guard devices in place. The elopement book [at the front desk] was updated to reflect residents at risk and residents with wander guard devices. New admissions, re-admissions, and residents with changes in condition will be reviewed in clinical morning meeting Monday - Friday to review elopement risk assessments for completion, accuracy, and immediate implementation of interventions as indicated. Quarterly assessments will be reviewed as part of the MDS/Care plan process. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Director of Nursing and/or designee will randomly audit a minimum of 5 elopement risk assessments weekly for 4 weeks, monthly for 2 months to validate accuracy. Any concerns identified will be addressed at the time of discovery. Elopement drills to be conducted 1 per quarter as per facility policy. An ad hoc Quality Assurance Performance and Improvement (QAPI) committee meeting was held on 4/25/24. The Medical Director was notified on 4/25/24. This process will be reviewed for QAPI for 3 months. From 8/21/24 - 8/28/24, the facility's action plan and implementation of interventions were reviewed. Review of 8 residents newly admitted to the facility in the previous 30 days were reviewed, interviews with multiple staff, review of facility documentation including education, policies and procedures on elopement and elopement drills, as well as observation of the main lobby doors and the wander guard system, and staff practices confirmed that the above interventions were implemented by the facility. It was determined that the date of compliance was 4/30/24.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 48168 Based on record review and interview, it was determined that the facility failed to ensure adequate administrative oversight of 1) nursing staffing, 2) reporting of allegations of abuse, 3) Geriatric Nursing Assistant (GNA) and Licensed Practical Nurse (LPN) training, and 4) clinical services. This was evident for 1) non-compliance with 2 (S670, S680) of 2 state staffing regulations, 2) 6 residents (#6, #9, #19, #25, #67, #92) of 6 residents who alleged abuse, and 3) 6 staff (GNA #11, GNA #13, GNA #14, LPN #9, LPN #10, and LPN #12) of 6 staff reviewed for required in-service training, and 4) 2 complaints (#MD00208809 and #MD00208775) of 7 complaints and for 5 (#MD00206318, #MD00202094, #MD00182597, #MD00205031, MD#00205130) of 34 facility reported incidents (FRIs), reviewed during the recertification survey. These findings had the potential to affect all residents. The findings include: On 8/27/24 at 2:52 PM, the survey team identified substandard quality of care which triggered an extended survey investigation. On 8/27/24 at 3:19 PM, an interview with the Nursing Home Administrator (NHA) was conducted. He stated that he had been in his position for 10 months. When asked how many surveys he had participated in, he replied 40. When asked about his interaction with the governing body, he replied that he gave the governing body monthly reports on all aspects of the facility which were discussed by phone. He explained that he routinely met with marketing, clinical and operational regional staff by phone and sometimes in person. He further stated that the corporation operated 11 facilities in Maryland. When the NHA was asked about how the Director of Nursing (DON) was able to perform all the functions assigned to her, he said that this was her first experience as a DON, and that a more experienced DON would be able to handle all the responsibilities expected of her. He further explained that he just walked into the situation and that he would be leaving soon for personal reasons. 1). When the NHA was asked if he was aware that the facility was non-compliant with state regulations regarding staffing, he said he was unaware of it but that he had submitted a request for competitive wages and referral bonuses to the corporate office. Cross Reference S670, S680 2). When the NHA was asked if he knew the facility did not comply with regulations regarding reporting allegations of abuse, he said he was unaware of it. Cross Reference F607, F609, F610 3). When the NHA was asked if he knew that facility staff lacked required training, he said he was unaware of it. Cross Reference F940, F941, F943, F949. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4). Lack of clinical services oversight was evidenced by findings of 5 incidents of resident abuse or neglect (complaint #MD00208809, and complaint #MD00208775) and (FRI #MD00206318, FRI #MD00202094, and FRI #MD00182597), an incident of immediate jeopardy of resident harm (FRI #MD00205031), and an incident of actual resident harm (FRI MD#00205130). Cross reference F600, F684, F689

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 48168 Based on record review and interview, it was determined that the facility failed to ensure that staff members complete abuse and neglect training. This was evident for 4 Geriatric Nursing Assistants (GNA #11, GNA #13, GNA #14, and GNA #34) of 4 GNAs reviewed, and 3 Licensed Practical Nurses (LPN #9, LPN #10, and LPN #12) of 3 LPNs reviewed during the annual and extended survey investigation. The findings include: 1) On 8/20/24 at 10:00 AM, training records for GNA #11, GNA #13, GNA #14, LPN #9, LPN #10, and LPN #12 were requested. On 8/20/24 at 1:18 PM, a review of the employee training records revealed that staff lacked annual abuse and neglect training. GNA #11 and GNA #13 lacked abuse and neglect training in 2022. LPN #10 and LPN #12 lacked abuse and neglect training in 2021 and 2022. GNA #14 lacked abuse and neglect training in 2022, and 2024. And LPN #9 lacked abuse and neglect training in 2020, 2021, 2022, 2023, and 2024. On 8/27/24 at 3:53 PM, an interview with the Human Resources Director (Staff #24) was conducted and she was asked for any additional evidence of abuse and neglect training for GNA #11, GNA #13, GNA #14, LPN #9, LPN #10, and LPN #12. On 8/29/24 at 11:14 AM, an interview with the Director of Nursing, Assistant Director of Nursing, and the Corporate Nurse (Staff #2) was conducted to review the lack of evidence of training for GNA #11, GNA #13, GNA #14, LPN #9, LPN #10, and LPN #12. They were asked to provide any additional evidence that they may have, but no further evidence was provided by the end of the survey. 50573 2) On 08/21/24 at 11:58 AM, review of Geriatric Nursing Assistant Staff #34's (GNA) employee record failed to reveal documentation that abuse training was completed. On 08/21/24 at 11:59 AM, an interview with Human Resources (Staff #24) revealed the GNA was an agency GNA, they do not have paper records and that what was provided was all she could see online. On 08/27/24 at 02:07 PM, the Director of Nursing confirmed that what was provided is all the facility has. The surveyor reviewed the concern regarding the failure to ensure that nurse aides completed abuse training.