

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215231	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/06/2024
NAME OF PROVIDER OR SUPPLIER  Clinton Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 9211 Stuart Lane Clinton, MD 20735	

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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50457</b></p> <p>Based on interviews and medical record reviews, it was determined that the facility failed to inform the residents responsible party of a new medical treatment plan. This deficient practice was evident during a complaint revisit.</p> <p>The findings include:</p> <p>The Resident #4 was admitted to [NAME] Healthcare Center on 01/28/25 with multiple diagnosis, including cognitive communication deficit, and dysphagia. A review of medical records on 02/06/25 revealed a physician's progress note from 02/05/25 documenting the resident history of dementia.</p> <p>On 02/06/25 at 10:22 AM, during an interview with Resident #4's responsible party (RP), they stated that during a visit on 02/5/25, a staff member asked if they had been notified of the resident's order for intravenous fluids due to abnormal labs. The RP responded that they had not been informed. The staff member then explained that a peripheral line were inserted, and intravenous fluid were administered to treat dehydration. The RP stated that no one had contacted them to inform them of the new treatment orders.</p> <p>On 02/06/25 at 12:18 PM, review of nursing progress notes dated 02/04/25 revealed that a 20-gauge peripheral line was inserted into the left hand of Resident #4, and sodium chloride intravenous solution was administered. No documentation to support that a staff member notified the residents' RP of new medical treatment.</p> <p>During an interview with the DON on 02/06/25, the surveyor inquired about a lab note documented on 02/03/25 at 8:49 AM. The surveyor asked if lab personnel would contact the residents RP concerning lab requests or new treatment orders. The DON explained that the facility staff is responsible for contacting the residents RP.</p> <p>On 02/06/25 at 1:26 PM, during an interview with the Administrator, Director of Nursing and Nurse Unit Manager, the surveyor explained that Resident #4's RP had not been notified of new treatment orders and peripheral line insertion. The surveyor requested documentation confirming that a staff member had informed the RP of the new treatment plan. The facility was unable to provide proof of notification.</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 0584</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</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** 40927</b></p> <p>Based on observation, record review and staff interview, it was determined that the facility failed to maintain a safe temperature of 71-81 degrees Fahrenheit (F). This was evident for 3 of 3 floors in the facility.</p> <p>The findings include:</p> <p>The Center for Disease Control's (CDC) Preventing Hypothermia publication on 2/7/24, read that victims of hypothermia are often: older adults with inadequate heat. <a href="http://www.cdc.gov">www.cdc.gov</a>.</p> <p>On 12/2/24 at 1:00 PM an observation in the lobby of the facility revealed it felt cold, and residents and staff were wearing coats, hats, and gloves.</p> <p>During an observation of the 1st floor nursing unit on 12/2/24 at 3:45 PM it felt cold on the unit. There were large heating units located sporadically in the hallways. Residents were observed wearing coats, hats, gloves, and some had extra blankets on the bed.</p> <p>During the observation Resident #1 was lying in bed wearing a sweatshirt with the hood pulled up and an extra fleece blanket covering them. The resident reported that they were cold. An observation in the hallway revealed there was no portable heating unit near this room.</p> <p>On 12/2/2024 at 4:05 PM an observation of Unit 2 revealed Resident #2 lying in bed with the covers on, but no extra blankets were on the bed. Resident #2 stated s/he was cold but was getting used to it. Furthermore, the resident reported that it was cold in the building when they were admitted to the facility before Thanksgiving Day. An observation of the hallway outside the resident 's room revealed there was no portable heater within sight of this room. On 12/2/24 around 7:50 PM the temperature of Resident #2 's room was taken and found to be 50 degrees F.</p> <p>On 12/2/24 at 4:30 PM the temperature logs the facility provided revealed that they were taking a temperature on each floor every hour and failed to check the resident 's room temperatures. The facility had the capacity to house 247 residents and there were 40 - 50 rooms on the 2nd and 3rd floors. The first floor had approximately 15 rooms. The surveyors conducted individual room temperatures on each unit with maintenance staff taking the temperatures on 12/2/24 at 7:50 PM. Temperatures were obtained on the 3rd floor in 51 resident rooms and 1 day room of the ceiling and the floor. The temperatures ranged from 45 - 61.1 degrees. room [ROOM NUMBER] had the coldest temperature of 45 degrees F. This room was occupied by 3 residents at the time the temperature was obtained.</p> <p>Temperatures were obtained on the 2nd floor in 50 rooms of the ceiling and floor. The temperatures ranged from 46.3 - 69.3 degrees.</p> <p>The temperatures were obtained on the 1st floor in 15 rooms of the ceiling and the floor. The temperatures ranged from 56 - 66.4 degrees.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>An interview with the Divisional Facility Manager Staff #3 on 12/2/24 at 1:44 PM revealed he had typed a timeline of the events. Review of the timeline was conducted during the interview. According to the timeline following occurred: facility staff determined on 11/30/24 at 8:30 PM there was a leak in the boiler system causing the heat to go out; portable heaters were installed in the facility on 11/30/24 by 11:00 PM; on 11/30/24 at 9:15 PM the first attempt was made to fix the problem; on 12/1/24 at 10:00 AM the facility identified the boiler had low pressure and was still not working; On 12/1/24 at 7:00 PM, they determined a pipe was broken and needed to be replaced ; and on 12/1/24 at 9:00 PM they scheduled contractors to come to the facility and fix the pipe. Staff #3 reported that facility staff were obtaining room temperatures starting on 11/30/24 at 8:00 PM and continued to take them hourly. However, a later review of these temperatures on 12/2/24 at 4:30 PM revealed the temperatures were not taken in each room, but on each floor. On 11/30/24 starting at 8 pm and ongoing each hour the temperature ranges were as follows: 1st floor 60- 61 degrees, 2nd floor 58 - 61 degrees, and 3rd floor 57 - 60 degrees. On 12/1/24: 1st floor 51 - 62 degrees, 55 - 64 degrees, and 3rd floor 58 - 65 degrees.</p> <p>He reported that the contractors had identified the issue on 12/2/24 and was onsite fixing it at the time of this interview. Included in the timeline was that the Director of Nursing (DON) had interviewed all the residents, and they declined to evacuate, however this was later found to be inaccurate as he had interviewed 8 residents.</p> <p>On 12/2/24 at 2:33 PM An interview with the DON and Nursing Home Administrator (NHA) revealed he had interviewed a few residents on 11/30/24 to determine if they wanted to be evacuated from the building. He stated he had not documented this information in the resident ' s medical records but had recorded it on a census sheet that had been printed. A review of the census report he provided revealed he asked 8 of 233 residents. He failed to contact any resident representatives for residents who were incapable of making decisions and/or were unable to verbalize what they wanted. When asked what interventions he initiated to keep the residents safe, he stated they offered coats, hats, gloves, and blankets to the residents.</p> <p>An interview with Registered Nurse (RN) #7 on 12/2/24 at 8:30 PM revealed that she was working on the day the heat went out and reported there were no blankets to offer the residents, and they had to give them extra fitted sheets. She stated she was wearing her winter jacket to work on the unit over the weekend.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>A subsequent interview with the NHA on 12/2/24 at 3:19 PM revealed they failed to start the evacuation process until 12/2/24 at 8:30 PM and had evacuated 11 of their 233 residents at the time of the interview. When asked her rationale for waiting to evacuate residents from a building with no heat source she reported that all the residents had been interviewed and did not want to evacuate. When asked if she had called any resident representatives to ask them about evacuating their residents, she stated she had not. Reminded the NHA that in the previous interview with the DON, he reported he had only asked a few residents and did not call any resident representatives. The NHA stated that some residents told staff they would leave if the heat was not fixed by Monday, 12/2/24, and this was why she decided to evacuate today. However, the facility was unable to provide any documentation that residents had been asked about evacuation and said they would leave on Monday. She reported the evacuation plan was to send all the residents to sister facilities. She reported the sister facility had identified 100 beds, but they were still getting responses. She reported that if their sister facilities did not have enough beds, they would start reaching out to other facilities we have contracted with. However, they had not established any contracts with other local facilities for an evacuation if needed except for sister facilities. She reported they had not secured a place close by that would allow them to immediately evacuate all the residents to one place in the case of an emergency. Furthermore, she had not reached out to the local emergency management system for assistance. She was estimating that it would be 12/3/24, 3 days after the loss of their heat source, before all residents would be transferred out.</p> <p>On 12/2/24 at 1:07 PM Regional Nurse Staff #1 reported they had 103 residents who had DC Medicaid and was waiting for approval from DC Medicaid to move the residents to a facility that did not accept DC Medicaid. In addition, they were reviewing the resident ' s insurance coverage to send them to a facility that accepted the insurance. These delays were later found to be because they had not set up provisions for an emergency evacuation plan as required.</p> <p>A review of the evacuation plan on 12/2/24 at 4:30 PM revealed that the NHA had the authority to evacuate the residents. However, the facility had failed to set up contracts with other locations to allow for immediate evacuation of their residents in case of an emergency, such as a gymnasium or community center until they could relocate each resident to another nursing care facility. Furthermore, their plan failed to include contracts with local facilities that could take their residents to provide care in the case of an emergency regardless of their payor source.</p> <p>As a result of these findings, a state of immediate jeopardy (IJ) was declared on 12/2/24 at 9:15 PM and an IJ summary tool was provided to the facility at that time. The facility submitted a plan to remove the immediacy on 12/3/24 at 1:00 AM and the facility ' s written plan to remove the immediacy was accepted on 12/3/24 at 1:12 AM with an alleged date of compliance of 12/3/24.</p> <p>The provisions of the plan to remove the immediacy included the following:</p> <ol style="list-style-type: none"> <li>1) Residents in rooms number 247, 117 and 335 were moved to a warmer area of the facility.</li> <li>2) Assessments of current residents completed by regional and divisional teams to assure residents had no signs and symptoms of vascular changes related to temperatures.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>3) The Executive Director [Nursing Home Administrator] will educate all current staff (nursing, rehab, EVS, laundry, maintenance, dietary, laundry, administrative) to organization Emergency Preparedness Plan, Relocation Plan, Extreme Cold Temperature Protocol, Temperature monitoring of facility, temperature monitoring of residents, and HVAC mediation plan, Notification of change to residents, physicians, and resident representatives. Education to be completed by 12/3/24.</p> <p>4) We have relocated approximately 50 residents while repairs to our heating system have been made. We now feel we can maintain proper temperatures throughout the facility.</p> <p>5) Remaining residents will be located in rooms that have reached the range of 71-81 degrees Fahrenheit by 12/3/2024 at 3 a.m. Current resident temperatures will be monitored hourly and documented on the unit census sheet by Unit Managers. Facility environmental temperatures will be monitored hourly and documented on a temperature log by the Maintenance Director. If it is found that we are still experiencing temperature issues we will look to relocate our remaining residents.</p> <p>6) Executive Director to review audits daily x 12 weeks to assure temperatures of facility and residents remain within acceptable temperature parameters.</p> <p>On 12/4/24 and 12/5/24, an onsite visit was conducted. After validation of the implementation of the facility ' s plan of removal, which included staff interviews, record reviews and direct observation, it was determined the facility met the minimum standards of compliance to remove the findings of an Immediate Jeopardy on 12/5/24 at 5:30 PM with a compliance date of 12/5/24 and not 12/3/24 as stated in the plan.</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40927</b></p> <p>Based on observations, record review, and interview it was determined that the facility failed to 1) use their resources appropriately to ensure the safety of their residents when they lost their primary heat source in the winter and 2) ensure that their facility assessment included all populations of residents, and the resources needed in the case of an emergency. This was evident during the survey and had the potential to affect all residents.</p> <p>The findings include:</p> <p>The Center for Disease Control's (CDC) Preventing Hypothermia publication on 2/7/24 read that victims of hypothermia are often: older adults with inadequate heat. <a href="http://www.cdc.gov">www.cdc.gov</a>.</p> <p>1) On 12/2/24 at 1:00 PM an observation in the lobby of the facility revealed it felt cold, and residents and staff were wearing coats, hats, and gloves.</p> <p>An observation on the 1st floor nursing unit on 12/2/24 at 3:45 PM revealed it was cold on the unit. There was large heating units located sporadically in the hallways. Residents were observed wearing coats, hats, gloves, and some had extra blankets on the bed. Resident #1 was observed lying in bed wearing a sweatshirt with the hood pulled up and an extra fleece blanket covering them. The resident reported that they were cold. An observation in the hallway revealed there was no portable heating unit near this room.</p> <p>On 12/2/2024 at 4:05 PM an observation of Unit 2 revealed Resident #2 lying in bed with the covers on, but no extra blankets were on the bed. An interview with Resident #2 at the time of the observation revealed that s/he was cold but was getting used to it. An observation of the hallway outside the resident's room revealed there was no portable heater within sight of this room. On 12/2/24 around 7:50 PM the temperature of Resident #2's room was taken and found to be 50 degrees F.</p> <p>A review of a facility reported incident #MD00212304 on 12/3/24 at 12:00 PM revealed that the facility lost their main source of heat on 11/30/24 and had not evacuated their residents.</p> <p>An interview with Divisional Facility Manager # on 12/2/24 at 1:44 PM, revealed they had not fixed the heating system at the time of interview.</p> <p>An interview with the Nursing Home Administrator (NHA) and the Director of Nursing (DON) on 12/2/24 at 2:33 PM revealed the DON had discovered the loss of heat on 11/30/24 around 7:00 PM when multiple residents complained of being cold. When asked why the facility had not been evacuated, the NHA reported she had not evacuated residents at the time of the incident because they refused to evacuate. The DON reported he had only asked a few residents and had not talk to any resident representatives of the residents who were incapable of making decisions. Review of the census sheet provided by the DON revealed he had talked with 8 of 233 residents about evacuation.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>A review of the evacuation plan on 12/2/24 at 4:30 PM, revealed the NHA and DON had the responsibility to determine when an evacuation was needed. However, they failed to start evacuating residents until 12/2/24 at 8:30 AM, 36 hours after the heat went out.</p> <p>On 12/2/24 at 7:50 PM the surveyors observed temperatures being taken of all resident's rooms in the facility and the temperatures ranged between 45 - 61 degrees Fahrenheit.</p> <p>The NHA reported on 12/2/24 at 9:00 PM, 72 hours after losing heat, they were able to relocate 36 of their 233 residents.</p> <p>12/2/24 at 9:15 PM the concerns were reviewed with the NHA, Regional Nurse #2, Regional Nurse #2, and the DON.</p> <p>50573</p> <p>2) On 12/3/24 at 2:12 PM, review of the facility assessment titled [NAME] Healthcare Center requested by the surveyor and provided by the Nursing Home Administrator (NHA) revealed section titled, Other on page 47, which read, List contracts, memoranda of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies. Consider including a description of your process for overseeing these services and how those services will meet resident needs and regulatory, operational, maintenance, and staff training requirements.</p> <p>On 12/3/24 at 2:12 PM, further review of the facility assessment titled [NAME] Healthcare Center revealed a section titled, All Hazards Risk Analysis and Emergency / Disaster Plan, which read, Provide your facility-based and community-based risk assessment, utilizing an all-hazards approach (an integrated approach focusing on capacities and capabilities critical to preparedness for a full spectrum of emergencies and natural disasters). Note that it is acceptable to refer to the risk assessment of your emergency preparedness plan (483.73), and focus on high-volume, high risk areas.</p> <p>On 12/3/24 at 2:20 PM, further review of both sections of the facility assessment, Other and All Hazards Risk Analysis and Emergency / Disaster Plan, failed to reveal information that was prompted nor information that would indicate it was facility specific to [NAME] Healthcare Center.</p> <p>On 12/4/24 at 9:46 AM, an interview with the Nursing Home Administrator (NHA) revealed when the surveyor presented the section of the facility assessment provided titled, Other and All Hazards Risk Analysis and Emergency / Disaster Plan, she indicated that it was not the correct copy of the facility assessment. She used her laptop present during the interview to look at the copy she had saved and indicated that it was the same, incorrect copy that the surveyor obtained.</p> <p>Further interview with the NHA at the same time on 12/4/24 revealed that she would have to reach out to corporate for the updated facility assessment which would include facility specific details completed by the interdisciplinary team under sections titled, Other and All Hazards Risk Analysis and Emergency / Disaster Plan. She further indicated that the facility is a part of a larger organization and that, it often falls on corporate.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 12/4/24 at 3:26 PM, an interview with the NHA revealed that she did not take an active part in the review of the facility assessment for 2024 and was unable to identify who was present for the review and update.</p> <p>During the same interview on 12/4/24, another surveyor present asked if the NHA read the facility 's facility assessment, and she indicated that she read everything except the bottom two sections (Other and All Hazards Risk Analysis and Emergency / Disaster Plan)</p> <p>On 12/4/24 at 3:31 PM, an interview with Regional Nursing Home Administrator (Staff #5) revealed that the expectation was for the Nursing Home Administrator (NHA) to take part in the review and update of the facility assessment. He further indicated that the facility uses a platform called Team Link, which the NHA had access to.</p> <p>On 12/6/24 at 11:15 AM, the surveyor reviewed the concern with the Nursing Home Administrator (NHA).</p>		

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<p>F 0838</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies.</p> <p>50573</p> <p>Based on record review and interview, it was determined that the facility failed to address the specific resources needed for their resident population. This was evident 103 and of 233 residents.</p> <p>The findings include:</p> <p>The facility assessment is a tool for the facility to evaluate its resident population and identify the resources needed to provide the necessary care and services that residents require.</p> <p>On 12/4/24 at 11:50 AM, review of the most updated copy of the facility assessment provided by the Nursing Home Administrator (NHA) failed to reveal they had addressed the population of residents that had DC Medicaid (DC Medicaid is a healthcare program that pays for medical services for qualified people residing in DC. It helps pay for medical services for low-income and disabled people. These residents are unique in that they do not have Medicaid in the state (Maryland) in which they are temporarily residing and not all nursing homes accept this payer source). Therefore, they had not identified resources for them in the case of an emergency and they needed to be evacuated.</p> <p>An interview with Regional Nurse #1 on 12/2/24 at 1:07 PM revealed the facility had 103 residents with DC Medicaid and she was waiting on approval from DC Medicaid to relocate the residents to facilities that did not accept DC Medicaid.</p> <p>A subsequent interview with Regional Nurse #1 12/2/24 at 5:23 PM revealed that they had received approval, however, was unable to evacuate the residents until the following day to give them time to find places for the residents.</p> <p>On 12/4/24 at 3:26 PM, an interview with the NHA revealed that she did not take an active part in the review of the facility assessment for 2024 and was unable to identify who was present for the review and update. She reported she had reviewed the plan and failed to recognize these residents had not been included. Furthermore, she failed to review the sections for Other and All Hazards Risk Analysis and Emergency / Disaster Plan to ensure they included all resources need in the event of an emergency.</p>		

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<p>F 0843</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have an agreement with at least one or more hospitals certified by Medicare or Medicaid to make sure residents can be moved quickly to the hospital when they need medical care.</p> <p>40927</p> <p>Based on record review and interview it was determined that the facility failed to have a transfer agreement. This was evident during the complaint survey and had the potential to affect all residents.</p> <p>The findings include:</p> <p>On 12/5/24 the Nursing Home Administrator (NHA) was asked to provide a copy of their transfer agreement. On 12/5/24 at 2:44 PM a review of the documentation provided revealed they had not included the transfer agreement.</p> <p>On 12/6/24 at 8:16 AM an interview with the NHA, revealed she provided the agreements with facilities in the case of an evacuation. NHA was asked to bring the transfer agreement with local hospital(s) in the event a resident needed acute care services.</p> <p>The NHA reported on 12/6/24 at 11:05 AM, that she was unable to locate a transfer agreement and was contacting their corporate office to see if they had one on file.</p> <p>During the exit conference on 12/6/24 at 11:29 AM, Regional Nurse #1 reported the facility had a transfer agreement, however was unable to locate it.</p>