STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215273	A. Building B. Wing	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waldorf Center	4140 Old Washington Highway Waldorf, MD 20602

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31145 Based on record review, observation of resident rooms, equipment, and interviews, it was determined the facility staff failed to 1.) provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior, this was evident on 2 of 3 nursing units observed along with the dining room; and 2.) failed to exercise reasonable care for protecting one supplemental resident's (Resident (R)169) personal property from loss or theft. The findings include: 1.) On [DATE] at 10:58 AM observation was made of room [ROOM NUMBER]. The left wall by the door entrance had a large, spackled area that was not painted over that was at least 2 ,d+[DATE] ft. by 3 ft. The laminate was peeling off the 4 dresser drawers. The handrail in the bathroom had brown material and brown drip marks near the front of the handrail by the door approximately 5 inches long. On [DATE] at 11:06 AM observation was made of room [ROOM NUMBER]. The privacy curtain was stained with brown and black material. The floor was dirty with debris and a soiled plastic glove was on the floor by the end of the bed. At that time Certified Medicine Aide (CMA) #3 walked in the room and was asked what she does when she sees something in disrepair. CMA #3 stated she will put it in the TELS system (electronic system) and then ask the Geriatric Nursing Assistants) GNAs if they have any repair orders. CMA #3 was shown the areas of concern. On [DATE] at 12:40 PM observation was made in the dining room of Resident #12 sitting in a wheelchair. The right wheelchair armrest was missing the underneath padding. The left wheelchair armrest vinyl covering was torn along the outer and inner edge, exposing the underneath padding. Resident #53 was also observed in the dining room sitting in a wheelchair. The right and left vinyl on the armrests of the wheelchair were cracked throughout the armrest. Resident #5 was observed sitting in a wheelchair. The vinyl on the right armrest was torn at the front with foam exposed and the vinyl was also cracked throughout the armrest. On [DATE] at 12:42 PM Staff #12, Maintenance Director was interviewed in the dining room as he was shown the wheelchair armrests. Staff #12 stated that he audits wheelchairs every 2 months and had replacement armrests that he could put on the chairs. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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	215273	A. Building B. Wing	08/20/2024

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 2:28 PM observation was made in room [ROOM NUMBER] of the nightstand. The top drawer in the right-hand corner was missing laminate. The bottom cabinet drawer below the handle was missing laminate approximately 4 inches by 4 inches. On [DATE] at 2:35 PM the Nursing Home Administrator (NHA) was informed of the furniture observations which included the wheelchairs. The NHA stated, when I got here in July, I did a furniture audit, and the order was approved yesterday. Maybe it was pushed along because the surveyors are in the building. I also hired a painter for the rooms. The surveyor also requested the most recent invoices for the wheelchair armrests. The NHA could not provide the invoices. 36917 2.) Review of a Grievance/Concern Form, provided by the facility and dated [DATE], from R169's Family Member (F3). The grievance reported R169's gold ring was missing from his/her personal items since his/her death in the facility on [DATE]. Review of the undated Admission Record, located in R169's electronic medical record (EMR) under the Profile tab, indicated R169 was admitted to the facility on [DATE] with diagnosis to include but not limited COVID-19 and sepsis. Review of the EMR MDS (Minimum Data Set) tab, MDS tracking item set dated [DATE], indicated R169 died in the facility on [DATE] from complications related to her admitting diagnosis of COVID-19 and sepsis. Review of the facility provided investigation of the reported incident documented the facility was in possession of R169's gold ring on [DATE] as received from the funeral home staff receiving R169 from the facility. Nurse Manager (NM) 2 put the ring up for safe keeping until R169's family could pick up the ring along with R169's other personal items. On [DATE], the ring was placed in a zip top back and held in the medicine cart by Licensed Practical Nurse (LPN) 6 for the family member to pick up. The family member did not come to pick up the ring as planned so LPN6 notified the oncoming nurse LPN5 at 3:00 PM that the ring was in the medication cart for the family member to pick up. LPN5 acknowledged receipt of the ring in the medication cart for the evening shift. LPN5 was instructed to pass along the ring and information to the night nurse Registered Nurse (RN) 1. The investigation documented that during an interview, RN1 stated she had no knowledge of the ring, and the ring was unable to be located on Sunday morning, [DATE], when F3 came to pick up the ring. RN1 recalled NM1 went to retrieve the ring from the medication cart but she could not find it and determined the ring to be lost or stolen. Review of the facility documentation indicated the family was notified the ring was missing and multiple attempts had been made to find it. The local law enforcement was notified, and the incident was reported to the State Agency (SA) and the Long-Term Care (LTC) Ombudsman. Staff interviews were conducted by NM1, and staff members were re-educated on policy regarding residents' personal property. The investigation was conducted by the Unit Manager (UM). Documentation provided by the UM indicated LPN5 was the last staff member to see and have possession of the ring in the medication cart. The facility was not able to determine LPN5 took the ring, however he was terminated from employment for gross misconduct concerning personal effects of a deceased residents' property after failing to inform the oncoming nurse of the ring's location. (continued on next page)

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	215273	A. Building B. Wing	08/20/2024

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 4:45 PM, the Administrator confirmed the outcome and documented conclusion of the investigation. The facility did not provide a policy related to protecting residents' property.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 34484 Based on documentation review and interview it was determined the facility failed to report allegations of abuse, neglect, or an injury of unknown origin within 2 hours of the allegation to the regulatory agency, the Office of Health Care Quality (OHCQ) (Resident #15, #55). This was evident for 2 of 17 residents reviewed for allegations of abuse, neglect or an injury of unknown origin during an annual survey. The findings include: 1. On 8/14/24 review of facility reported incident MD00179419 revealed Staff #8 reported she witnessed Staff #7 hit Resident #15's hand on 5/19/22. Review of the Comprehensive and Extended Care Facilities Self-Report Form revealed the facility submitted the initial report to OHCQ on 5/26/22 with a date and time of the incident of 5/19/22 at 4:00 PM, 7 days after the alleged incident. Interview with the Director of Nursing and Administrator on 8/14/24 at 4:00 PM confirmed the facility failed to report an allegation of abuse to OHCQ timely. 31145 2) On 8/20/24 at 9:00 AM facility reported incident MD00208736 was reviewed and revealed Resident #55 alleged that Licensed Practical Nurse (LPN) #13 waved her finger in Resident #55's face. Resident #55 reported the allegation to a surveyor, who in turn reported it to the Nursing Home Administrator (NHA) on 8/13/24 at 4:30 PM. Review of the facility's investigation revealed documentation that it was not reported to OHCQ until 8/14/24 at 1:15 PM, which was not within 2 hours of the alleged abuse. On 8/20/24 at 10:30 AM an interview was conducted with the NHA. The NHA was asked why the report was not submitted within 2 hrs of her being informed of the allegation. The NHA stated she got distracted because there were things going on with surveyors in the building. At that time the regulation was reviewed with the NHA who stated she understood.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 34484 Based on documentation review and interview, it was determined the facility failed to thoroughly investigate an allegation of abuse for a resident (Resident #15). This was evident for 1 of 17 residents reviewed during an annual survey. The findings include: On 8/14/24 review of facility reported incident MD00179419 revealed Staff #8 reported she witnessed on 5/19/22 Staff #7 hit Resident #15's hand. Review of the facility investigation provided by the facility on 8/14/24 revealed it was incomplete. It did not contain the name of Staff #8 or a statement from Staff #8. It did not contain any other statements from staff that worked the day of the alleged incident other than Staff #7. Further review of the facility investigation also revealed the facility failed to obtain any statements from residents that also were receiving care from Staff #7 to see if there were any other concerns of abuse. Interview with the Administrator and Director of Nursing on 8/14/24 at 4:00 PM confirmed the facility staff failed to complete a thorough investigation of alleged abuse of Resident #15 on 5/19/22.

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	215273	A. Building B. Wing	08/20/2024

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30347 Based on interview and record review, the facility failed to have quarterly care plan meetings for residents, and to invite the resident and/or the resident representative to participate in the development of the resident's care plan and This was evident for 3 of 44 residents (Resident (R) 51, #901 & # 923) reviewed for care planning. This failure placed the residents at risk of unmet care needs and a decrease in quality of life. Findings include: Once the facility staff completes an in-depth assessment (MDS) of the resident, the interdisciplinary team meet and develop care plans. Care plans provide direction for individualized care of the resident. A care plan flows from each resident's unique list of diagnoses and should be organized by the resident's specific needs. The care plan is a means of communicating and organizing the actions and assure the resident's needs are attended to. The care plan is to be reviewed and revised at each assessment time of the resident to ensure the interventions on the care plan is accurate and appropriate for the resident. Care plan meetings are held each quarter and as needed. 1.) Review of R51's undated Admission Record, located in the electronic medical record (EMR) Profile tab, revealed R51 was admitted to the facility on [DATE] with diagnoses including nontraumatic intracranial hemorrhage, chronic kidney disease, epilepsy. Review of R51's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/09/24, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 11 out of 15, which indicated R51 was moderately impaired in cognition. Further review of R51's record failed to reveal any record of a care plan conference being held. However, R51's baseline and comprehensive care plans were available for review. During an interview on 08/13/24 at 1:53 PM, Family Member (F) 2 stated, I do not remember being invited or attending any care plan meetings to discuss his/her [R51's] care. During an interview on 08/16/24 at 3:40 PM, the Social Services Coordinator (SSC) stated, Care plans were placed into QAPI [Quality Assurance and Performance Improvement] in July '24 after discovering care plan meetings were not being held. There are no records of [R51] having any care plan meetings during the last 12 months. Facility policies regarding care plans and care plan meetings were requested but not provided prior to survey exit. 34484 2.)a. Review of Resident #901's medical record on 8/16/24 revealed the Resident was admitted to the facility on [DATE]. (continued on next page)

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	215273	A. Building B. Wing	08/20/2024

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident #901's medical record revealed the facility staff had a care plan meeting on 12/21/23 but failed to have any other care plan meetings until the Resident's discharge on 6/9/24. Interview with the Director of Nursing on 8/19/24 at 9:13 AM confirmed the facility staff failed to have a quarterly care plan for Resident #901 in 2024. b. Review of Resident #923's medical record on 8/14/24 revealed the Resident was admitted to the facility on [DATE]. Further review of Resident #923's medical record revealed the facility staff had a care plan meeting on 9/17/21 but failed to have any other care plan meetings until the Resident's discharge on 6/7/22. Interview with the Director of Nursing on 8/15/24 at 11:58 AM confirmed the facility failed to have a quarterly care plan meeting in December 2021 and March 2022 for Resident #923.

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	215273	A. Building B. Wing	08/20/2024

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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. 31145 Based on medical record review and staff interview it was determined the facility failed to schedule a follow-up colonoscopy per physician's orders. This was evident for 1 (#906) of 40 residents reviewed for the complaint portion of the annual survey. The findings include: On 8/15/24 at 8:12 AM Resident #906's medical record was reviewed and revealed the resident was admitted to the facility in August 2022 with diagnoses that included gastrostomy status, GERD (gastrointestinal reflux disease), and peptic ulcer. A G-tube (gastrostomy) is a small, soft tube that is surgically inserted through the abdomen and into the stomach to provide direct access for feeding, hydration, or medicine. Review of Resident #906's paper medical record revealed a Report of consultation that was dated 4/19/23 which documented, poor colon prep. Solid stool throughout colon. No visualization. Repeat colonoscopy in 1 month. On the lower right-hand corner of the consultation paper was, schedule in 1 month with initials. On 8/15/24 at 9:04 AM Staff #6 was interviewed and stated she was responsible to coordinate transportation for the facility. Staff #6 stated that for long term care residents it is up to the unit manager to evaluate if a service is needed and the nurse on the unit or unit manager will make the appointment. On 8/15/24 at 1:00 PM an interview was conducted with the Director of Nursing (DON). The DON was shown the consultation paper and was informed that the surveyor could not find the results of the follow-up colonoscopy. The DON came back to the surveyor and stated the unit manager was not able to find any documentation about why the follow-up colonoscopy was not done. The DON stated she called the GI office and the last time the resident was seen was in December 2023 for G-tube removal. The DON confirmed that a follow-up colonoscopy was not done.

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	215273	A. Building B. Wing	08/20/2024

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34484 Based on medical record review and interview, the facility staff failed to provide treatment/services to prevent/heal pressures ulcers (Resident #901). This is evident for 1 of 3 residents reviewed for pressure ulcers during an annual survey. The findings included: A pressure ulcer also known as pressure sore or decubitus ulcer is any lesion caused by unrelieved pressure that results in damage to the underlying tissue. Pressure ulcers are staged according the their severity from Stage I (area of persistent redness), Stage II (superficial loss of skin such as an abrasion, blister or shallow crater), Stage III (full thickness skin loss involving damage to subcutaneous tissue presenting as a deep crater), Stage IV (full thickness skin loss with extensive damage to muscle, bone or tendon) or Unstageable Pressure Ulcer (full thickness tissue loss in which the base of the ulcer is covered by slough and / or eschar in the wound bed). Review of Resident #901's medical record on 8/14/24 revealed the Resident was admitted to the facility on [DATE] with a Stage IV pressure ulcer to the sacrum. Review of the physician orders revealed the Resident had an order for wound treatment twice daily to the sacral wound on 12/18/23. Review of Resident #901's December 2023 Treatment Administration Record (TAR) revealed the facility staff failed to begin wound treatment until 12/25/23, 7 days after admission. Further review of Resident #901's medical record revealed he/she returned from a hospital stay on 4/4/24. Review of the physician orders revealed the Resident had an order for wound treatment daily to the sacral wound on 4/4/24. Review of Resident #901's April 2024 TAR revealed the facility staff failed to begin wound treatment until 4/11/24, 7 days after readmission. Further review of Resident #901's medical record revealed he/she returned from another hospital stay on 4/30/24. Review of the physician orders revealed the Resident had an order for wound treatment twice daily to the sacral wound on 4/30/24. Review of Resident #901's May 2024 TAR revealed the facility staff failed to begin wound treatment until 5/10/24, 10 days after readmission. Interview with the Director of Nursing on 8/19/24 at 10:45 AM confirmed the facility staff failed to provide wound treatment for Resident #901 per the physician orders from 12/18/23 until 12/25/23, from 4/4/24 until 4/11/24 and from 4/30/24 until 5/10/24.

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	215273	A. Building B. Wing	08/20/2024

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37296 Based on medical record review and interview it was determined the facility staff failed to ensure a resident received proper foot care and treatment. This was evident for 1 of 45 residents (Resident #904) selected for review during the complaint survey process. The findings include: On 8/19/24 at 12PM, investigating complaint MD00196654 revealed that Resident #904 was admitted to the facility on [DATE] with a diagnosis of amputation of left #2 toe. On 8/16/23 the physician ordered: Cleanse left 2nd toe surgical site with wound cleanser, pat dry. Cover with dry dressing daily. Every day shift. Further medical review revealed on 8/16, 8/18, 8/20, 8/23, and 8/26 that the 2nd toe surgical site was not cleaned and Cover with dry dressing daily as ordered by the physician. On 8/20/24 at 3:30PM an interview of the Director of Nursing revealed that there is no nursing progress notes or wound notes in the medical record to indicate that the wound care was done per physician orders.

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	215273	A. Building B. Wing	08/20/2024

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 31145 Based on review of a complaint, medical record review, and staff interview, it was determined the facility failed to administer respiratory inhalers as ordered for a resident who required respiratory treatment. This was evident for 1 (Resident #909) of 31 residents reviewed for complaints. The findings include: On 8/19/24 at 9:51 AM a review of complaint MD00190541 alleged that the facility was not doing breathing treatments correctly for Resident #909 and that no one was assisting the resident who had a diagnosis of dementia. On 8/19/24 at 9:51 AM Resident #909's medical record was reviewed and revealed a Physicians History and Physical dated 3/20/23 which documented that Resident #909 was admitted from the hospital to the facility for treatment following respiratory failure secondary to COPD/Asthma exacerbation. Resident #909 was in intensive care, started on steroids, antibiotics, and nebulizer treatments. Review of March and April 2023 physician's orders revealed Resident #909 was to receive 2 inhalers: Budesonide Inhalation Suspension 0.5 MG/2ML (Budesonide (Inhalation)) 4 ml. inhale orally two times a day for SOB (shortness of breath) and Ipratropium-Albuterol Solution 0.5- 2.5 (3) MG/3ML 3 ml. inhale orally two times a day for SOB, Wheezing. Review of the March 2023 and April 2023 Medication Administration Record (MAR) revealed on 3/23/23 at 9 PM, 3/26/23 at 9 PM and 4/1/23 at 9:00 AM the spaces were blank which indicated the medication was not administered. Review of the care plan, Resident is at risk for respiratory complications related to Asthma, COPD with the intervention, Administer aerosol as ordered was not followed. On 8/14/24 at 1:35 PM an interview was conducted with the Director of Nursing (DON) regarding the inhalers. The DON was shown the MARs and the lack of signatures for the administration of the inhalers. On 8/14/24 at 2:06 PM the DON stated that the nurse that worked on those dates no longer worked at the facility and there was no documentation in the nurse's notes that the respiratory treatments were done.

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	215273	A. Building B. Wing	08/20/2024

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 37296 Based on a review of medical records, Controlled Medication Utilization Record sheets, Medication Administration Record (MAR), and interviews with staff, it was determined that the facility failed to consistently document the administration of an as-needed (PRN) pain medication on the electronic MAR and further monitor the resident's pain level and efficacy of the medication. This was evident during the complaint survey for Resident #903. The findings include: On 8/15/24 at 12 PM a review of Resident #903's clinical record revealed that the resident's primary physician on 11/13/23, ordered Dilaudid (Hydromorphone) Oral Tablet 2 MG, give 1 tablet by mouth every 6 hours as needed for Pain. This medication is used to help relieve moderate to severe pain. Dilaudid (Hydromorphone) belongs to a class of drugs known as opioid analgesics. A review of the December 2023, Control Medication Utilization Record revealed Dilaudid (Hydromorphone) on the following days and times was removed from the controlled lock box on 12/13 with no time noted, 12/15 @ 8:30PM, 12/16/at 8:30PM, 12/17 at 11:30 PM, 12/21 at 9:45AM, 12/22 at 10AM and 10PM, 1/1/2024 at 7PM, 1/5 at 12:30PM, and 1/10 at 8:50PM. Further review of the resident's clinical records revealed that the resident's December 2023 and January 2024 Medication Administration Record (MAR) revealed that the Dilaudid (Hydromorphone) medication on the stated date was not documented as given to the Resident and the resident's pain level and efficacy of the medication was not monitor. The facility staff failed to administered pain medication as ordered by the physician. Interview with the Administrator on 8/15/24 @ 2:30 PM confirmed the facility staff failed to ensure Resident #903's Dilaudid (Hydromorphone) was given as needed for pain.

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	215273	A. Building B. Wing	08/20/2024

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31145 Based on observation, staff interview, and documentation review it was determined that facility staff failed to keep medication and treatment carts locked when unattended. This was evident on 2 of 3 nursing units observed during random observations made during a complaint survey. The findings include: On 8/14/24 at 6:50 AM observation was made on the B wing nursing unit of an unlocked and unattended medication cart sitting in the hallway outside of the clean utility room. A second observation was made of the same medication cart on 8/14/24 at 7:03 AM. The medication cart remained unlocked and unattended. The surveyor was able to open all drawers of the medication cart. A second medication cart in the same hallway, outside of room [ROOM NUMBER] was also unlocked and unattended. The surveyor was able to open all drawers which contained resident medications. On 8/14/24 at 7:04 AM Licensed Practical Nurse (LPN) #1 was informed. LPN #1 stated, Oh, I didn't know that. On 8/14/24 at 7:06 AM observation was made on the opposite hallway on the B wing nursing unit of an unlocked and unattended treatment cart. The surveyor was able to open all drawers of the treatment cart which contained medicated ointments and various treatment modalities. At 7:07 AM Registered Nurse (RN) #2 was informed of all of the unlocked carts. On 8/16/24 at 6:58 AM observation was made on the A wing nursing unit of an unlocked and unattended treatment cart sitting in the hallway outside of room [ROOM NUMBER]. The surveyor was able to open the top drawer which contained a pair of scissors. The other drawers were able to be opened and contained bandages, prescription ointments and creams and other various medicated dressings. At that time LPN #9 [NAME] was informed and stated, oh, ok. Review of the Medication Storage Policy that was given to the surveyor from the Director of Nursing (DON) on 8/14/24 at 8:20 AM documented the second line of the policy which stated, The medication supply shall be accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Procedure Number 3 documented in addition to the above sentence, Medication rooms, cabinets and medication supplies should remain locked when not in use or attended to by persons with authorized access. On 8/14/24 at 8:20 AM the DON was informed of the observations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215273	A. Building B. Wing	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waldorf Center	4140 Old Washington Highway Waldorf, MD 20602

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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 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. 37296 Based on medical record review and interview, the facility staff failed to follow up with outside resources for the care of resident (Resident #903). This was evident for 1 of 45 residents reviewed during a complaint survey. The findings include: The facility staff failed to follow up with outside facility for oral surgery post-operative instructions for Resident #904. Review of Resident #904's medical record on 8/9/2024 revealed the Resident was transported to the oral surgeon on 1/9/24, by a friend. Resident #904 had 3 teeth extracted and was given written post-operative instructions. Further, medical record review revealed no oral surgery post-operative instructions was noted in the medical record. Interview with the Administrator on 8/15/24 at 1 PM confirmed the facility staff failed to follow up with the Resident's Oral Surgeon at an outside facility for post-operative instructions.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215273	A. Building B. Wing	08/20/2024

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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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 31145 Based on interviews and observation, it was determined the facility failed to have an effective pest control program as evidenced by numerous gnats seen throughout the facility. This was evident on 1of 3 nursing units and public areas observed during a complaint survey. The findings include: On 8/15/24 at 11:06 AM an interview was conducted with Resident #74. Resident #74 sat on the side of the bed and complained about the gnats in his/her wheelchair. Observation was made of a folded blanket on the seat of the wheelchair with a minimum of 10 gnats flying around the seat. At that time Certified Medicine Aide (CMA) #3 walked in the room and was shown the gnats. When asked if this was normal, CMA #3 stated that the gnat problem was throughout the building and that the facility just got a new pest control company last week. On 8/15/24 at 12:42 PM observation was made in the dining room of Resident #41 sitting at a table with a lunch tray. There were gnats flying on the resident's fruit cocktail and BBQ sandwich. During the survey there were also several gnats observed in the Nursing Home Administrator's (NHA) office where the surveyors were located for 6 days. On 8/15/24 at 2:35 PM the NHA was asked for pest control logs. The NHA stated that she was going to be honest with the surveyor and that they had not had a pest control contract prior, but just got one over the past month. At that time the NHA was informed about the gnats in Resident #74's room, the dining room, and her office.