

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215297	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/11/2024
NAME OF PROVIDER OR SUPPLIER  South River Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  144 Washington Road Edgewater, MD 21037	

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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a 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** 42828</b></p> <p>Based on observations and staff interview during facility environmental observations, it was determined that the facility staff (1.) failed to provide housekeeping and maintenance services necessary to maintain a safe homelike interior and (2.) failed to exercise reasonable care for the protection of the resident's property from the wandering residents. This was evident for 1 of 8 rooms and 1 (Resident #67) out of 3 residents observed during the annual survey.</p> <p>The findings include:</p> <p>1a. On 12/2/24 at 1 PM surveyors conducted an environmental tour which revealed:</p> <ul style="list-style-type: none"> <li>- room [ROOM NUMBER]: the baseboard on the wall adjacent to the resident's closet had visible damage-jagged edges where pieces of the baseboard were missing.</li> <li>- Circular shaped brown stains on two ceiling tiles in the shower room on the 200 unit One of the stained areas measured 6 inches in diameter and the other area measured 2 inches in diameter.</li> <li>- A structural wall to the left upon entrance into the shower room on the 200 unit with two capped copper pipes 1/2 inch in diameter, projected out of the wall. The copper pipes measured approximately 4 to 6 inches in length, sticking out of the wall.</li> </ul> <p>On 12/4/24 at 7:45 AM surveyors and the Director of Nursing (DON) conducted a tour of the shower room on the 200 unit and identified the stained ceiling tiles and 2 copper pipes projected out of the wall. The surveyor expressed concern about lack of resident safety with the copper pipes exposed and protruding out of the wall. The DON confirmed that there was daily resident use of that shower room and stated she will notify the Maintenance Director to address the identified concerns.</p> <p>49815</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1b. During the tour of the facility on 12/2/2024 at 8:15 AM to 10:45 AM the surveyor observed the following items in need of repair: the floor tile missing around sink area and baseboards marred and missing in Resident #29's room; the baseboard in bathroom not secured to the wall, marred walls and sink counter warped in Resident #34's room; sink counter top not secure to base and marred walls in bathroom in Resident #2's room; cracked lampshades and marred bathroom walls in Resident #21's and 32's room. In addition, the surveyor observed missing baseboard and floor tile in the Spa/Shower Room on Unit 200.</p> <p>In an interview with the Nursing Home Administrator (NHA) at 7:30 AM on 12/11/2024 the surveyor addressed the marred walls, unsecured and missing baseboards, missing floor tiles, and unsecured and warped sink counter tops in the resident rooms. The NHA stated that she was aware of the repairs that were needed for the walls, closets, sinks and counter tops, and the baseboards and floors.</p> <p>The Nursing Home Administrator (NHA) further stated that there was a plan in place for repairing these items and replacement of the sink counter tops and closets, but currently there was no flooring underneath the closets and that this would be a concern with replacement of the closets.</p> <p>45733</p> <p>2. Observation, on 12/2/24 at 01:04 PM, found that Resident #67 was upset about her cell phone charger which was broken 2 weeks ago and her notebook got taken by the resident who wandered into her room. Furthermore, this resident had other items missing and written information on a bulletin board got wiped out. The Resident was afraid and upset that her personal property was frequently taken or destroyed, especially when he/she was asleep. Resident #67 stated nursing staff were aware, but they could not stop the wandering residents.</p> <p>Resident #67 was admitted to the facility on [DATE] with encephalopathy with a substance abuse history, seizures disorder and contracture of the left hand. This resident was alert, oriented and can make he/she needs known.</p> <p>During the interview, on 12/10/24 at 10:20 AM, the Director of Nursing (DoN) and the [NAME] Clinical Director revealed that they were not aware that Resident #67's cell phone charger was recently destroyed. However, the DoN admitted that she was aware of the wandering residents roaming in the hallway who entered other residents' rooms to take and break personal properties.</p> <p>During Interview, on 12/10/24 at 10:36 AM, the DoN reported that the facility had replaced the Resident's cell phone charger.</p> <p>During the interview, on 12/11/24 at 9:15 AM, Resident #67 stated that he/she still did not feel safe and needed to secure personal belongings. During the further interview, the [NAME] Clinical Director was made aware that the above finding was a concern.</p>

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45733</b></p> <p>Based on record review and interview, it was determined that the facility staff failed to provide a safe resident environment and protect residents from abuse from other residents. This was found to be evident for 2 (Resident #22 [1.] and #113 [2.]) out of 9 residents reviewed for abuse.</p> <p>The findings included:</p> <p>1. Record review, on 12/05/24 at 9:05 AM, found that staff GNA #30 witnessed Resident #103 on 4/14/23 at 4:30 PM that Resident #103 undressed while standing at Resident #22's bed side and had his/her hands in Resident #22's private area on. Immediately, GNA #30 called LPN staff #31 to assist and they removed Resident #103 out of Resident #22's room and started the one-to-one supervision. Additionally, they notified the local police about the abuse. No other residents were affected after the facility staff done the investigation. Resident #103 was arrested by the local police that night and had not returned to the facility since.</p> <p>During Interview, on 12/5/2024 at 09:55 AM, the Administrator stated that the incident was reported to the state within the required timeline and the facility had started the corrective action plans immediately and all staff had abuse training completed by 4/18/24. The surveyor informed the Administrator that the above finding was a non-compliance sexual abuse concern.</p> <p>Surveyor: DILLER, [NAME]</p> <p>2. During review of intake #MD00181842 on 12/10/2024 at 9:00 AM, the facility report stated Registered Nurse (RN) #29 and Geriatric Nursing Assistant (GNA) #28 heard a commotion coming from room [ROOM NUMBER]. Upon entering the room, they observed Resident #113 had wandered into the room and Resident #110 and Resident #113 had their arms intertwined. The facility staff then observed Resident #110 push Resident #113 and Resident #113 fell to the floor on his/her buttocks.</p> <p>The Executive Director (ED) was interviewed by surveyors on 12/10/2024 at 9:15 AM. The ED stated that Resident #113 was placed on 1:1 observation after the incident and acknowledged surveyor concern of resident-to-resident abuse.</p> <p>51589</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>44440</p> <p>Based on record review and interview, it was determined that the facility failed to provide necessary services to maintain good personal hygiene for dependent residents. This was found evident in 2 (Resident #449[1.] &amp; #68[2.]) out of 11 Residents reviewed for Activity of Daily Living (ADL) cares.</p> <p>The findings include:</p> <p>1. On 12/2/24 at 2:13 PM, the surveyor interviewed Resident #449. During the interview Resident #449 stated that he/she had concerns about ostomy (a surgical procedure that creates an opening in the abdominal wall to allow waste to exit the body) cares.</p> <p>On 12/5/24 at 11:08 AM, the surveyor reviewed Resident #449's medical record. The review revealed that Resident #449 had a care plan initiated on 11/18/24 that stated, Resident #449 has an alteration in bowel elimination related to need for ileostomy (an ostomy in which the opening is the end of the ileum, the lowest part of the small intestine). An intervention listed was, provide assistance with ostomy care as needed.</p> <p>On further review a Minimum Data Set (MDS) assessment, that was completed on 10/20/24, documented that Resident #449 was dependent (a helper needed to complete the activity for the resident) with toileting hygiene or managing the ostomy, to include wiping the opening.</p> <p>On 12/6/24 at 8:11 AM, the surveyor reviewed Resident #449's orders. The review revealed that on 12/5/24 orders were put in for ostomy cares.</p> <p>The surveyor next reviewed the Treatment Administration Record (TAR) for Resident #449. No cares were documented on the December TAR for ostomy care and only starting on 12/5/24 was there an area for cares to be documented.</p> <p>On 12/6/24 at 11:07 AM, the surveyor interviewed the Director of Nursing (DON). During the interview the DON confirmed that the ostomy care orders were only entered yesterday and not at the time of admission. She further stated that when orders are written they are entered into the TAR. The DON was unable to provide documentation that Resident #449 was assisted and provided ostomy cares according to his/her care plan.</p> <p>50385</p> <p>2. On 12/03/24 at 9:30 AM, an interview was conducted with Resident #68's representative. The representative stated that on 10/28/24 they visited the resident and upon observation the residents toenails were unkempt. They stated the nails were as long as my pinky finger. The representative stated that when they notified nursing and administration, the toenails were addressed.</p> <p>On 12/4/24 at 9:00 AM, a review of complaint #MD00211334 and the facilities investigation relating to FRI #MD00211725 was conducted. The facilities investigation documented that Resident #68's toenails were trimmed at time of complaint and podiatry was consulted.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/4/24 at 11:38 AM, a review of Resident #68's podiatry notes was conducted. The resident had last been seen by a podiatrist on 4/24/24. In the podiatry note on 4/24/24, the podiatrist noted, Debrided nail(s) to patient tolerance. Non-professional treatment is hazardous to the patient.</p> <p>On 12/4/24 at 1:21 PM, a review of Resident #68's Minimum Data Set (MDS). An MDS is a federally mandated assessment tool used in nursing homes to evaluate the health needs and functional capabilities of residents. Under the self-care portion (GG0130) of the MDS conducted on 10/31/24, it states that the resident is dependent, requiring the helper to do all the effort or the activity requiring 2 or more helpers to complete, for Putting on and taking off footwear and Personal hygiene.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>50385</p> <p>Based on record review and interview, it was determined that the facility failed to protect the resident from a preventable accidents. This was evident for 1 (Resident #104) of 3 residents reviewed for falls.</p> <p>The findings include:</p> <p>On 12/06/24 at 10:17 AM, a review of complaint #MD00200713 was conducted. The complaint indicates that on 12/10/23, Resident #104 fell off the bed while a Geriatric Nursing Assistant (GNA) was providing incontinent care. After the providers evaluation the provider recommended to monitor and manage the resident for pain. The resident and family decided to call 911 to get further evaluation.</p> <p>On 12/06/24 at 10:22 AM, a review of Resident #104's records was conducted. The records indicated that the resident was evaluated at hospital for possible injuries after a fall on 12/10/23. Per hospital discharge summary, there were no injuries or fractures identified after x-rays and evaluation.</p> <p>On 12/6/24 at 10:45 AM, Resident #104's Multiple Data Set (MDS) was reviewed. An MDS is a federally mandated assessment tool used in nursing homes to evaluate the health needs and functional capabilities of residents. Under the self-care portion (GG0130) of the MDS conducted on 9/29/23, stated that the resident is dependent, requiring the helper to do all the effort or the activity requiring 2 or more helpers to complete, for toileting hygiene.</p> <p>On 12/06/24 at 11:26 AM, an interview was conducted with the Director of Nursing (DON). The DON confirmed only 1 GNA was turning and providing incontinence care to the resident at the time of the incident on 12/10/23.</p> <p>On 12/10/24 at 10:34 AM, Resident #104's care plan was reviewed. Resident #104 has a care plan with a focus on turning and repositioning initiated on 12/5/2019. This care plan had an intervention to be repositioned with 2 people, lifter, slider.</p>

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45733</b></p> <p>Based on interview, record review and observation, it was determined that the facility staff failed to ensure that pain management of an intrathecal baclofen pump was provided to residents who require such services, consistent with professional standards of practice and monitoring appropriately for effectiveness and/or adverse consequences. This was found to be evident for 1 resident (#22) out of 1 for pain management review.</p> <p>The findings included:</p> <p>A baclofen pump is a surgically implanted device that delivers baclofen, a muscle relaxant medication, directly into the spinal canal to treat spasticity and other conditions. The pump's battery typically lasts around six to seven years. When the battery dies, the pump needs to be replaced with a surgical procedure. The pump needs to be refilled regularly, usually every four to six months. A needle is inserted through the skin into the refill port to add baclofen. Complications can occur, including catheter disconnections, migration, kinks, obstruction, and pump dysfunction. running out of baclofen causing symptomatic withdrawal symptoms, pump mechanical failure, pump battery end of life and the need for pump replacement.</p> <p>Observation, on 12/04/24 at 09:22 AM, found that Resident # 22 was asleep and all extremities were flat and rigid. The upper extremities were mildly contracted, and the head was tilted to the left side.</p> <p>Record review, on 12/04/24 at 10:12 AM, revealed that Resident #22 was admitted to the facility on [DATE] with the diagnoses of a motor vehicle accident in 2013 leading to traumatic brain injury status post hemicraniectomy and flap replacement, quadriplegia with severe spasticity, an intrathecal baclofen pump insertion March 2015 and seizures disorder. The current pain management order prescribed Baclofen 10mg give 1 tablet via G-tube three times a day for spasms. A follow-up scheduled at the community Hospital on 9/20/24 for intrathecal baclofen pump refill but no information sent back included for the pump's dosage regimen nor the battery status.</p> <p>During observation, on 12/04/24 at 11:09 AM, Nurse Manager staff #14 at bedside to locate the baclofen pump site and it was located at the resident's right lower quadrant of the abdomen under the skin, however, no nursing documentation for assessing nor monitoring the pump's function, effectiveness and complications.</p> <p>During the interview, on 12/6/24 at 09:20AM, Nurse Manager staff #14 confirmed that the resident's baclofen pump's regimen was not combined with the oral pain management order. In addition, the nursing staff had never had training on the intrathecal baclofen pump care to be able to provide the standard of care and monitoring for effectiveness or adverse consequences.</p> <p>Interview, on 12/06/24 at 09:45 AM, the Administrator and the [NAME] Clinical Director stated that they only had the next baclofen pump refill dates and understood this was a concern because of lacking a standard of care for the intrathecal baclofen pump: baclofen combined dosage orders, current pump dosage sitting, battery status and assessing effectiveness /monitoring for complications.</p>		

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<p>F 0711</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44440</b></p> <p>Based on record review and interviews it was determined that the facility failed to have the medical provider thoroughly review and accurately document a resident's updated plan of care after a visit. This was found evident of 1 (Resident #106) out of 32 reviewed during the survey.</p> <p>The findings include:</p> <p>On 12/11/24 at 6:31 AM, the surveyor reviewed Resident #106's medical record. The review revealed that Resident #106 was admitted to the facility in late March of 2024 and was sent to the hospital in early April 2024 related to mental status changes, hypotension (low blood pressure), tachycardia (high heart rate) and increased creatinine and white blood cell count. Resident #106 returned to the facility with a Percutaneous Endoscopic Gastrostomy (PEG) tube or feeding tube related to his/her dysphagia (difficulty swallowing). After two days back at the facility Resident #106 then returned to the hospital due to a dislodged PEG tube and came back to the facility on [DATE] with a new tube placed.</p> <p>Next the surveyor reviewed Resident #106's orders. The review revealed Resident #106 was ordered a low sodium, controlled carbohydrate diet with dysphasia mechanical texture as well as liquids to be honey thick on his/her original admission. On 4/4/24 the order changed and was written for Resident #106 to be NPO meaning Nothing By Mouth related to emesis. The order indicated the resident could take medications with sips of liquid. When Resident #106 returned to the facility after having a PEG tube placed his/her diet order was written as NPO for nutrition. There was no comment that it was okay to take medications with sips. After Resident #106 returned to the facility after needing his/her PEG tube replaced an order was written to flush the feeding tube with at least 5 ml of liquid after administration of each medication via tube feed. Again, the diet was ordered as NPO.</p> <p>On review of Resident #106's May 2024 Medication Administration Record (MAR) the surveyor noted that when Resident #106 returned to the facility after having his/her PEG tube replaced on 5/1/24, aspirin low dose, cholecalciferol, famotidine, magnesium extra strength, and tamsulosin were written to be given in the morning starting 5/2/24 by oral route. These medications were documented as given by oral route on 5/2/24 but discontinued on 5/2/24 at 11:50 AM and switched to be given via PEG tube starting 5/3/24. Lactulose solution, metformin hydrochloride, and pantoprazole sodium were ordered to be given twice a day and the morning dose was written and documented as given via oral route but on 5/2/24 at 11:50 AM, they were discontinued and re-written to be given via PEG route. That afternoon the doses of these medications were given via PEG tube. Atorvastatin calcium, melatonin and, olanzapine were all ordered to be given oral route starting on 5/2/24, however, they were all scheduled to be given in the afternoon and on 5/2/24 at 11:50 they were switched to PEG route and given on 5/2/24 in the afternoon via PEG route. Lisinopril was the only medication written and continued to be written to be documented as given via oral out. The medication was started on 5/3/24 and documented as given the oral route until 5/6/24.</p> <p>Additionally, levofloxacin (a medication given to treat a bacterial infection) was ordered and documented as given via oral route on 5/2/24. This order was changed to PEG tube route on 5/2/24 at 11:50 AM but then discontinued altogether on 5/2/24 at 11:53 AM.</p> <p>(continued on next page)</p>		

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<p>F 0711</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/11/24 at 6:39 AM, the surveyor reviewed Resident #106's progress notes. On 5/3/24 both Nurse Practitioner (NP) Staff #25 and Physician Staff #26 wrote progress notes. Both Staff #25 and #26 reviewed Resident #106's medication list. Both providers documented that Resident #106 was receiving his/her medications via oral route even after all medications except the lisinopril were changed to PEG tube route. Staff #25 documented in this note, This clinician spent 50 minutes reviewing records, assessing patient, counseling and educating patient, family, and/or caregiver, developing POC [Plan of Care] and making appropriate orders and recommendations, as well as documenting in the medical record. Staff #26 documented, Discussed with the team. All orders reviewed. Continue current management. For pneumonia, [he/she] is [no] levofloxacin, second course, finishing course. This was documented even after the medication was discontinued the day before.</p> <p>Again a note written on 5/6/24 by Staff #26, related to a discharge summary, documented that Resident #106 received his/her medications via oral route.</p> <p>On 12/11/24 at 9:39 AM, the surveyor conducted an interview with the Director of Nursing (DON). During the interview the DON stated she was unsure if the medication administration was by mouth and further stated that if a Resident has orders that need to be clarified the nurse should notify the provider and the provider should review and clarify the orders.</p> <p>On 12/11/24 at 1:11 PM, the surveyor conducted a phone interview with the facility's Medical Director (MD). During the interview the MD confirmed the providers should review orders on each visit. She further stated she would always go by the order and not the note. The MD confirmed that not changing the lisinopril to the PEG tube route may have been an oversight.</p> <p>On 12/11/24 at 1:39 PM, the surveyor conducted a follow-up interview with the DON. During the interview the surveyor reviewed the concern that the providers notes were not updated according to Resident #106's accurate plan of care.</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42828</b></p> <p>Based on observations, review of facility pest control records and interviews of facility staff, it was determined the facility failed to ensure an effective pest control program as flying gnats were observed throughout the building. This was found to be evident during the survey.</p> <p>The findings include:</p> <p>On 12/02/24 at 9 AM, during a tour of the 200 unit, surveyors observed gnats in room [ROOM NUMBER]'s toilet room.</p> <p>On 12/02/24 at 12 noon, surveyors were standing near the entrance of room [ROOM NUMBER] and observed gnats flying near their faces.</p> <p>On 12/03/24 at 9 AM surveyors interviewed, the Food Service Director, Staff #6, who confirmed that the kitchen had gnats by the floor drains and the juice machine. In addition, Staff #6 stated that the maintenance department was contacted at that time to address the issue.</p> <p>On 12/03/24 at 11:30 AM surveyors conducted a review of all maintenance records for room [ROOM NUMBER] which did not reveal any pest control visits or maintenance interventions for gnats.</p> <p>Further review of the facility's Pest Control Binder revealed numerous reports of gnats in resident care areas, however, it did not have any resolutions documented to address the multiple reports from 2017 through 2022 about gnats in the building.</p> <p>On 12/03/24 at 10 AM surveyors were standing at the nurses' station and observed multiple gnats flying around the area.</p> <p>On 12/03/24 at 12:40 PM Surveyors interviewed the Maintenance Director, Staff # 4, who confirmed there were reports of gnats in the building ( including the kitchen and in resident areas) and he treated the areas with a device and called in their pest control company to address the issue as well. However, Staff #4 did not provide surveyors with the necessary documentation to show where and how this issue of gnats in the facility was treated or prevented.</p> <p>On 12/03/24 1:30 PM surveyors conducted an interview with the Director of Nursing (DON) and the Maintenance Director present. The surveyor expressed concerns about multiple observations of gnats in the facility by the survey team and a lack of documentation to support the facility's attempt to prevent or treat resident care areas from gnats.</p>