STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215344	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Residences at Vantage Point	5400 Vantage Point Road Columbia, MD 21044

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. 47200 Based on observation and interview it was determined the facility failed to ensure privacy of protected health information was maintained for residents of the facility (#8, #16, #12, #122, #2, #3, #11, #14, #7, #1, #17). This was evident for 11 out of 21 residents during the facility's recertification/complaint survey. The findings include: On 12/11/24 at 3:13 PM surveyors observed an unlocked, unattended monitor screen in the resident hallway which displayed the photo images of 11 residents of the facility (#8, #16, #12, #122, #2, #3, #11, #14, #7, #1, and #17) with their medical record numbers listed next to their photo images. The monitor screen also displayed various tabs and applications. Geriatric Nursing Assistant (GNA) #12's name was observed on the screen. On 12/11/24 at 3:17 PM surveyors observed GNA #12 enter the resident hallway at which time surveyors shared their concerns and conducted an interview. GNA #12 observed the concern and stated the following during the interview: Okay, let me close it. On 12/11/24 at 3:18 PM surveyors requested a dual observation of the concern with the facility's Director of Nursing (DON) #8 and shared the concern. The DON observed the concern and acknowledged and confirmed understanding of the concern and was observed stating the following information to GNA #12: You can't leave it unlocked. At this time, the DON was observed locking the monitor screen for GNA #12. On 12/13/24 at 9:47 AM the surveyor shared all concerns with the facility's Executive Director who acknowledged and confirmed understanding of the concerns. On 12/13/24 at approximately 3:45 PM the concern was again shared during the facility's exit conference with surveyors.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215344	A. Building B. Wing	12/13/2024

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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 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. 47200 Based on interview and record review it was determined the facility failed to timely report an injury of unknown origin to the Office of Health Care Quality. This was evident for 2 (#MD00200761, and #MD00162737) out of 2 facility reported incidents reviewed for injuries of unknown origin for Resident #220 during the facility's recertification/complaint survey. The findings include: 1.) On 12/6/24 at 8:22AM the surveyor requested the complete investigation file for facility self-report #MD00200761 from the facility's Administrator. On 12/6/24 at 8:42AM the surveyor received the investigative file from the Administrator who confirmed this was the complete investigation file. Review of the facility's initial self-report revealed Resident #220's hip fracture was reported as an injury of unknown source to the Office of Health Care Quality on 12/19/23 at 10:30AM. Review of the follow-up self-report revealed the following information was documented: Resident had a fall on 11/28/23 from his/her wheelchair. On 12/10/24 at 9:58 AM the surveyor conducted a review of the medical record of Resident #220 which revealed the following was documented in a nursing progress note dated 11/28/23 at 2:01PM: At 11:30AM nurse was called to resident's room, observed resident laying face down in front of w/c (wheelchair), Resident slid out of w/c, sustained hematoma to left side of forehead size of a golf ball, ice applied, Root cause determine from constant agitation, always reaching and trying to grab things around him/her, Frequent yelling at all times on going behavior, Neuro check initiated WNL (within normal limits), on routine pain management . On 12/10/24 at 10:53 AM the surveyor conducted an interview with the facility Administrator who reported the following information to surveyors regarding the root cause analysis process for Resident #220: We think through what could be done for this resident, s/he can't communicate, does s/he need a new cushion, did s/he slide out of it because of the traction? At this time, the surveyor provided opportunity to the Administrator for all documentation and actions taken by the facility regarding Resident #220's 11/28/23 incident to be provided to the surveyor for review. (continued on next page)

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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 - Few	On 12/10/24 at 11:50AM the surveyor conducted an interview with the facility's Administrator who reported to surveyors the following information regarding the 11/28/23 incident for Resident #220: S/he slid out of his/her wheelchair, s/he was in a room by her/himself, Staff do rounds every two hours typically, a lot of staff walk by, someone was walking by and from the note s/he was found there on the floor. When the surveyor inquired as to if there was an investigation performed and an investigation file for the incident, the Administrator replied: No, we don't keep investigation files for every single fall, we don't report every single fall to your office, it's only when they have injuries, it was part of the investigation because we said the fracture was related to the fall. At this time the surveyor inquired as to how staff ruled out abuse and neglect and how staff knew that Resident #220's hematoma was from a fall sliding from the wheelchair; to which they replied: because s/he was on the floor. At this time, the surveyor shared their concerns and noted that the 11/28/23 incident resulting in an injury of unknown origin with the resident having been documented as sustaining a hematoma to the left side of their forehead the size of a golf ball in which neuro checks were instituted, was not reported to the Office of Health Care Quality. Review by the surveyor on 12/10/24 at 11:53AM of the facility's incident report dated 11/28/23 documented the following was selected on the report: alleged fall, unattended. Other options present on the incident report were: abuse investigation for unknown injury, and abuse ruled out, in which neither of these options were observed selected. On 12/10/24 at 4:47 PM the surveyor reviewed the facility's initial self-report for injury of unknown source dated 12/19/23 at 10:30AM and noted the following information was present on the self-report for the hip fracture reported on 12/19/23: Date/time/Name of when staff became aware of the incident: 12/19/23 at 8:15AM, Director of Health Services. Review of the email submittal for the initial self report was observed to be dated 12/19/23 at 10:28AM. Further review of the final report radiology results which notified the facility of the hip fracture was observed to be dated 12/19/23 at 1:56AM. 2.) On 12/6/24 at 8:22 AM the surveyor requested the complete investigation file for facility self-report #MD00162737 from the facility's Administrator. On 12/6/24 at 8:42 AM the surveyor received the investigative file from the Administrator who confirmed this was the complete investigation file. Review by the surveyor of the facility's self-report of an injury of unknown origin revealed the following information was reported to the Office of Health Care Quality dated 1/19/21 at 4:15PM: Resident complained of left hand pain, Order for x-ray was completed, X-ray was performed and found acute anterior humeral head dislocation, Resident was taken to the hospital where s/he had a successful closed reduction of dislocation. The following date and time of the incident was observed documented on the facility's initial self-report form: 1/18/2021 6:40PM. Review of the resident's final radiology report to the facility of the dislocation revealed a date of 1/18/21 at 6:40PM. Review of email documentation by the surveyor revealed the self-report was documented as sent to the Office of Health Care Quality on 1/19/21 at 5:37PM with the following information in the subject line: Self report 1/18/2021. (continued on next page)

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	215344	A. Building B. Wing	12/13/2024

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/9/24 at 12:36 PM the surveyor reviewed the medical record for Resident #220 which revealed the following documentation by Licensed Practical Nurse #22 dated 1/18/21 at 22:40PM: Results for x-rays ordered earlier this shift received, Left shoulder x-ray shows acute anterior humeral head dislocation. The surveyor noted that the Resident #220's serious injury was not reported to the Office of Health Care Quality until approximately 22 hours and 57 minutes after notification to the facility of the resident's x-ray results which revealed the acute anterior humeral head dislocation. Review of Certified Registered Nurse Practitioner's visit summary dated 1/18/21 documented the resident was being seen at the request of nursing for inability to use his/her left arm and left arm pain.

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	215344	A. Building B. Wing	12/13/2024

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 47200 Based on record review and interview it was determined the facility failed to ensure a thorough investigation was performed for an injury of unknown origin. This was evident during the surveyor's review of facility reported incident #MD00200761 reviewed by the surveyor during the facility's recertification/complaint survey. The findings include: On 12/6/24 at 8:22AM the surveyor requested the complete investigation file for facility self-report #MD00200761 from the facility's Administrator. On 12/6/24 at 8:42AM the surveyor received the investigative file from the Administrator who confirmed this was the complete investigation file. Review of the facility's initial self-report revealed Resident #220's hip fracture was reported as an injury of unknown source to the Office of Health Care Quality on 12/19/23 at 10:30AM. Review of the follow up self-report revealed the following information was documented: Resident had a fall on 11/28/23 from his/her wheelchair. On 12/10/24 at 9:58AM the surveyor conducted a review of the medical record of Resident #220 which revealed the following was documented in a nursing progress note dated 11/28/23 at 2:01PM: At 11:30AM nurse was called to resident's room, observed resident laying face down in front of w/c (wheelchair), Resident slid out of w/c, sustained hematoma to left side of forehead size of a golf ball, ice applied, Root cause determine from constant agitation, always reaching and trying to grab things around him/her, Frequent yelling at all times on going behavior, Neuro check initiated WNL (within normal limits), on routine pain management . On 12/10/24 at 10:53AM the surveyor conducted an interview with the facility Administrator who reported the following information to surveyors regarding the root cause analysis process for Resident #220: We think through what could be done for this resident, s/he can't communicate, does s/he need a new cushion, did s/he slide out of it because of the traction? At this time, the surveyor provided opportunity to the Administrator for all documentation and actions taken by the facility regarding Resident #220's 11/28/23 incident to be provided to the surveyor for review. During the interview, the Administrator reported to the surveyor that the risk meeting documentation that had been provided to the surveyor was the risk meeting minutes and there was no other documentation for the risk meetings. (continued on next page)

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	215344	A. Building B. Wing	12/13/2024

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/10/24 at 11:50AM the surveyor conducted another interview with the facility's Administrator who reported to surveyors the following information regarding the 11/28/23 incident for Resident #220: S/he slid out of his/her wheelchair, s/he was in a room by her/himself, Staff do rounds every two hours typically, a lot of staff walk by, someone was walking by and from the note s/he was found there on the floor. When the surveyor inquired as to if there was an investigation performed and an investigation file for the 11/28/23 incident, the Administrator replied: No, we don't keep investigation files for every single fall, we don't report every single fall to your office, it's only when they have injuries, it was part of the (12/19/23) investigation because we said the (12/19/23) fracture was related to the (11/28/23) fall. At this time the surveyor inquired as to how staff ruled out abuse and neglect and how staff knew that Resident #220's hematoma was from a fall sliding from the wheelchair; to which they replied: because s/he was on the floor. At this time, the surveyor shared their concerns and noted that the 11/28/23 incident resulting in an injury of unknown origin with the resident having been documented as sustaining a hematoma to the left side of their forehead the size of a golf ball in which neuro checks were instituted, was not reported to the Office of Health Care Quality. There was no investigation file that could be provided to the surveyor for the 11/28/23 incident. Review by the surveyor on 12/10/24 at 11:53AM of the facility's incident report dated 11/28/23 documented the following was selected on the report: alleged fall, unattended. Other options present on the incident report were: abuse investigation for unknown injury, and abuse ruled out, in which neither of these options were observed selected. On 12/10/24 at 12:53PM the surveyor reviewed the root cause analysis for the 11/28/23 incident which was risk meeting documentation that consisted of the following: On 11/28/23 before lunch resident was found on the floor in front of his/her bed, Resident slid off his/her wheelchair, Offer to lay down after breakfast, New cushion in place by rehab team. The surveyor noted that there was no documentation of a thorough investigation to support how the interdisciplinary team came to those conclusions.

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	215344	A. Building B. Wing	12/13/2024

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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. 37585 Based on interview with residents, review of resident medical records, and interview with facility staff, it was determined that the facility failed to hold care plan meetings at least quarterly. This was evident for 1 (Resident #17) of 1 resident reviewed for care planning during the recertification/complaint survey. The findings include: On 12/03/24 at 03:02 PM, Resident #17 was interviewed. During the interview, the resident indicated that s/he did not recall ever being invited to a care plan meeting but would like to attend one. On 12/12/24 at 10:34 AM, Resident #17's medical record was reviewed. The review revealed that the resident was admitted to the facility in June, 2024. The review failed to reveal evidence that a care plan meeting was held after the initial care plan meeting in June. On 12/12/24 at 11:16 AM, the Health Center Social Worker (SW) #9 was interviewed. During the interview, SW #9 indicated that residents should receive a care plan meeting on admission and quarterly. She stated that she creates a sign-in sheet for the meeting, a letter inviting the resident's responsible party (or the resident themselves) to the meeting, and documents a summary of the meeting. All of these documents should be stored in the electronic health record. When asked for evidence of Resident #17's most recent quarterly care plan meeting, SW #9 could only find a letter inviting family to the initial care plan meeting in June. After looking in the resident's paper medical record, current and previous electronic medical record, and in her personal computer files, she found no evidence that a care plan meeting occurred since June for Resident #17. She stated, [the resident] should have had one in September. I missed that.

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	215344	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Residences at Vantage Point	5400 Vantage Point Road Columbia, MD 21044

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47200 Based on observations, interviews and facility record review it was determined the facility failed to ensure food handling practices were followed in accordance with professional standards for food service safety, ensure the dishwashing system met the required minimum temperatures and chemical concentration, ensure monitoring of dishwasher chemical concentration and food service equipment functioning, ensure thorough environmental cleaning of the kitchen, and ensure the monitoring of food temperatures and food storage. These deficient practices have the potential to affect all residents. The findings include: On 12/2/24 at 8:00AM during the surveyor's initial tour of the facility's kitchen the surveyor noted the following signage was present: Attention team! All food items must have the following: label, date, item covered. On 12/2/24 at 8:03AM during the surveyor's initial tour of the facility's kitchen the surveyor noted the following signage present on the facility's walk-in refrigerators/freezers: All product stored in this walk-in must be: covered, labeled, dated, any product over five (5) days old must be discarded. On 12/2/24 at 8:04AM the surveyor observed baking trays on a movable rack within the walk-in freezer containing the following items: an open, spilled bag of frozen corn mix on a baking tray, scattered pieces of ginger, a package containing two squares of brown meat-type product in which the label read: If frozen, best by 10JAN2023 which was noted to have lost the vacuum type seal, an unlabeled brown meat product loosely wrapped in saran wrap with uncovered areas exposed, unlabeled white meat product in a bag, an open unlabeled bag of cream puffs, an opened unlabeled bag of biscuit/cookie type dough, a package of brown meat with a label which read 10/7/24 and did not identify what the product was, assorted, spilled, uncovered pieces of foods/crumbs, a pan of prepared meat with a label which read 11/28 and did not identify what the product was, an open bag of turnover pastries with uncovered areas, an unlabeled bag of meat type product, a pan of prepared food with a label which read: 10/24 and no information identifying what the food was, a pan of what appeared to be chicken with a label which read: 11/28 with no identifying information as to what the food product was, an open and exposed package of pie crusts, 2 pans of frozen meat with no labeling, a package of open and spilled okra, and another pan of meat-type product with a label which read: 5/7 with no information indicating what the food was. Concerns were shared with [NAME] #5 who observed the concerns and reported they did not know when the foods should be thrown away, and was unable to identify what many of the food items were. On 12/2/24 at 8:10AM the surveyor observed 8 metal pans containing food products in the walk-in refrigerator with a label indicating a prep date of 12/1 with no information identifying the food products. One container of raw meat was observed stored next to a container of ready to eat salad. A bag of saran wrapped chopped cooked meat-type product was observed with a label dated 11/24, however there was no indication on the labeling of what the product was. Another bag of meat type product was observed dated 11/24 with no other identifying information completed on the labeling. Concerns were shared with [NAME] #5 who acknowledged and confirmed understanding of the concerns. (continued on next page)

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	215344	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Residences at Vantage Point	5400 Vantage Point Road Columbia, MD 21044

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 12/2/24 at 8:11AM the surveyor observed a pan of roast beef slices in the walk in refrigerator with a label which read: 10/30. [NAME] #5 confirmed with the surveyor that this should have been discarded. On 12/2/24 at 8:12AM the surveyor observed a container of labeled teriyaki sauce in the walk in refrigerator with a date of 11/24. [NAME] #5 confirmed with the surveyor that this should have been discarded. On 12/2/24 at 8:12AM the surveyor observed a meat-type mixture in a pan in the walk in refrigerator that had a label dated 11/21. The label did not identify what the food product was. [NAME] #5 confirmed with the surveyor that this should have been discarded and removed the item from the refrigerator. Observation by the surveyor on 12/2/24 at 8:13AM of the walk-in refrigerator near the kitchen's office revealed a saran wrapped tray which included cheese, strawberries, and grapes on it with a label dated 11/19. [NAME] matter/growth and brown areas was observed on strawberries. The circular thermometer located on the outside of the walk in refrigerator was observed to have masking tape on it, and was covered with frost on the inside. Observation of the temperature on the exterior thermometer of the walk in refrigerator read approximately -20 degrees, as compared to the surveyor's observation of the interior thermometer which read approximately 41 degrees. Foods within the walk-in refrigerator were noted to be refrigerated, not in frozen condition, indicating the exterior temperature gauge was not properly functioning. Concerns were shared with [NAME] #5 who observed the concerns, and removed the fruit and cheese tray. On 12/2/24 at 8:17AM the surveyor observed an unlabeled baking tray in the reach-in refrigerator which contained 6 slices of pie and one brownie dessert. Further observation of the reach-in refrigerator revealed a tray of cherry jello dated 11/14. On 12/2/24 at 8:21AM the surveyor observed the ice cream refrigerator chest and requested from [NAME] #5 to review the temperature log, at which time they reported to the surveyor that there was not a temperature log for it. On 12/2/24 at 8:22AM the surveyor observed the facility's conveyor dishwasher and noted that the circular wash and rinse temperature gauges appeared inoperable and had cracks present on both clear covers. The surveyor observed that the dishwashing machine was marked with signage indicating the following: Notice: This machine is currently in hot water sanitizing mode. Thick white matter was observed to be present on a plumbing piece which connected to the dishwasher chemical lines. On 12/2/24 at 8:24AM the surveyor observed a plastic container with broken edges and corners on it's lid located in the walk-in refrigerator which held chopped greens. A pan of cream based orange colored mixture was observed to have a label dated 11/27 with no other identifying information present. On 12/2/24 at 8:25AM an uncovered opening was observed to be present on a carton of mustard potato salad in the walk-in produce refrigerator which had no labeling present indicating a date or time of opening. (continued on next page)

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	215344	A. Building B. Wing	12/13/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 12/2/24 at 8:26AM the surveyor observed mixed cut fruit in an unlabeled plastic container with broken corners of the lid where the fruit was observed to be uncovered. On 12/2/24 at 8:27AM the surveyor requested to [NAME] #5 to review food internal cooking temperature logs, to which they responded: I haven't seen it, we have to get temp logs and start recording temperatures. [NAME] #5 further reported to the surveyor that the facility does not keep any documentation of food temperatures taken during the cooking process. [NAME] #5 referred the surveyor to the skilled nursing unit where temperature logs were kept when taken on the steam table. On 12/2/24 at 8:30AM the surveyor observed the contents of a smaller refrigerator located near the food preparation and cooking areas. A plastic pan with a label dated 8/6 was observed within the refrigerator containing several individually packaged portion size packages of thawed pureed chicken, and condiment containers of cranberry orange sauce. 6 out of 13 cranberry orange sauce condiments were observed by the surveyor to have a green, fuzzy material present on them. An additional container of mint jelly was observed to be dated 11/14. An opened, saran wrapped package of pita bread was observed to be labeled 9/29. A saran wrapped container of red sauce was present with a label present with no identifying information of what the sauce was. [NAME] #5 reported this was strawberry glaze. A pan labeled with a date of 11/12 was observed containing individual cups of cole slaw. An unlabeled disposable soup container with mashed potatoes in it was observed within the fridge. A dual observation of the concerns was conducted with [NAME] #5 who acknowledged and confirmed understanding of the concerns. On 12/2/24 at 8:37AM the surveyor observed a metal pan of cookies with a label which read: 11/26. Upon further observation of the container, the surveyor observed flies through the saran wrap, flying around within it. The surveyor conducted a dual observation of the concern with [NAME] #5 who acknowledged observation of the flies, and confirmed understanding of the concern. The surveyor observed them pick up the pan and move it to a food preparation table. When the surveyor further inquired as to what [NAME] #5 would do with the pan, they stated to the surveyor that they were leaving the flies in the container in order to show their supervisor the concern and would be discarding the cookies, and ensured they would not be served. On 12/2/24 at 9:17AM the surveyor conducted an interview with Dietary Aide #13 who stated the following information regarding food temperatures in the skilled nursing unit food serving area: I microwave it if it's not up to temperature, then we see and check again. On 12/2/24 at 9:20AM the surveyor observed the skilled nursing unit food serving area and requested to review the food temperature logs. The surveyor reviewed the logs and observed there was no documentation of any food temperatures taken for the dinner meal on 12/1/24. The following items were recorded for the dinner meal without any temperatures documented: crab cake, vegetable lasagna, salmon, fish chowder, mashed potato, sweet potato, peas, corn, and spinach. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215344	A. Building B. Wing	12/13/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 12/2/24 at 9:24AM the surveyor conducted an interview with Dining Services Director (DSD) #2 who confirmed with the surveyor that there was no internal food temperature log. When the surveyor inquired as to if a temperature log should be in place for this, they stated: Sure it should be. The surveyor conducted a dual observation of the food temperature log for the 12/1/24 dinner meal with DSD #2 and shared the concern with DSD #2, who acknowledged the concern. The surveyor shared all concerns with DSD #2 who stated the following to the surveyor: Oh yeah, so do I, We threw a bunch of stuff out. DSD #2 confirmed they were able to visualize concerns the surveyor had, and acknowledged and confirmed understanding of the concerns. The surveyor made a request to DSD #2 for a copy of the 12/1/24 dinner temperature log. On 12/2/24 at 9:25AM the surveyor conducted an interview with Certified Dietary Manager (CDM) #3 who reported the following information to the surveyor: Temperatures should be taken at the start and at the end; the raw and finished product. CDM #3 confirmed with the surveyor that cooking of the food occurs in the facility's kitchen and when the food goes upstairs, we temp it before it goes in the steam table. On 12/5/24 at 11:12AM the surveyor observed the reach-in refrigerator temperature log was completed and filled out prior to lunchtime for the lunch and closing time temperatures for 12/5/24, and the open, lunchtime, and closing temperatures recorded, were documented as 51F for all three temperatures. The surveyor noted that 51F did not meet the minimum requirement of 41F or below for refrigerator temperatures, and the reach-in refrigerator was holding items which included: milk, sour cream, butter, caesar salad and other salads, pumpkin, and fruit. Observation of the food in the reach-in refrigerator revealed that labels present on foods now included identifying information of what the foods were. The surveyor shared concerns with CDM #3, and inquired as to if the elevated reach-in refrigerator temperatures on the log had been brought to their attention. CDM #3 confirmed they were not aware of any elevated temperatures and reported to the surveyor that no staff had notified them of any issues with the temperature of the refrigerator. On 12/5/24 at 11:23AM the surveyor was approached by CDM #3 who reported to the surveyor that gaskets had been replaced on the reach-in refrigerator in the summertime, and they had a vendor coming to check on it again, because when you shut the door, the other one opens, and we are constantly, shut, shut, shutting it. On 12/5/24 at 11:25AM CDM #3 showed the surveyor the issue occurring with the double doors to the reach-in refrigerator. The surveyor observed that when the door on the left shut, the door on the right popped open and was no longer closed. On 12/5/24 at 11:27AM surveyors observed thick grey matter on approximately 7 cords located on/above the food prep area near the cooking area. On 12/5/24 at 11:30AM the surveyor conducted a dual observation of the thick grey matter and shared concerns with CDM #3 who observed the concern and stated the following: We'll get it taken care of. CDM #3 acknowledged and confirmed understanding of the concerns. On 12/5/24 at 11:31AM CDM #3 was observed directing Dishwashing Staff #7 to cover the food area and and clean the dust. (continued on next page)

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	215344	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Residences at Vantage Point	5400 Vantage Point Road Columbia, MD 21044

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 12/5/24 at 11:35AM the surveyor observed the reach-in refrigerator temperature log now had white out present on it, and an opening temperature of 37 degrees was now written over the white out. On 12/5/24 at 11:52AM the surveyor observed that dishes were in a metal pan on the steam table with a cloth over them for warming of the plates. When the surveyor inquired as to why the plate warming system present was not being used, Health Center Supervisor #14 stated the following to the surveyor: We have always done it this way, it has been broke for a long time. CDM #3 was observed flipping the switch to the plate warming system which revealed there was no indicator light turning on, and the system did not begin to heat. On 12/5/24 at 1:12PM the surveyor shared concerns with the facility's Administrator, who acknowledged and confirmed understanding of the concerns. On 12/6/24 at 8:21AM the surveyor requested from the facility Administrator to be provided with all policies and procedures relating to the kitchen. On 12/6/24 at 10:10AM the surveyor observed the items previously identified on 12/2/24 at 8:05AM continued to be present in the freezer. The surveyor additionally observed several trays of pies were present in the freezer which were partially uncovered. On 12/6/24 at 10:17AM the surveyor observed the dishwasher monitor to be red in color with a triangle and exclamation point symbol present on it. The temperature for the wash was observed to be reading 94.1F, and the temperature for the rinse was observed to be reading 116.2F on the monitor. Continued observation by the surveyor of dishes being put through the dishwashing system on 12/6/24 at 10:18AM revealed a wash temperature of 94.1F and a rinse temperature of 127.6F on the monitor. The following was observed on the monitor: Low rinse temperature. Continued observation of the circular temperature gauges for rinse and wash revealed the needles were barely moving throughout the dishwashing process, indicating they were not properly functioning. On 12/6/24 at 10:19AM the surveyor observed the dishwasher was connected to a container of liquid chemical, indicating that the dishwasher was being utilized in chemical sanitizing mode for sanitization. Review of the manufacturer plackard located on the machine indicated the following requirements for chemical sanitizing: minimum wash tank temperature 140F, minimum final rinse temperature 120F, minimum chlorine required 50ppm. The surveyor noted that signage present on the machine indicated the machine was in hot water sanitizing mode although the machine was currently operating in chemical sanitizing mode. On 12/6/24 at 10:26AM the surveyor reviewed dishwasher temperature logs which revealed consistent documentation that the minimum required temperatures were not reached. Review of the facility's food receiving and storage policy revealed the following information in the policy: Food services, or other designated staff, will maintain clean food storage areas at all times, All foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date), Such foods will be rotated using a first in first out system, Uncooked and raw animal products and fish will be stored separately in drip proof containers and below fruits vegetables and other ready-to-eat foods. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 12/6/24 at 10:30AM the surveyor conducted an interview with CDM #3 who stated to the surveyor that the dishwasher's booster heater (a type of water heater which heats water to the proper temperature for sanitizing dishes in a dishwasher) had failed earlier in the year and the UltraSan chemical was now being used. On 12/6/24 at 11:27AM the surveyor conducted an interview with DSD #2 who reported to the surveyor that the liquid chemical for dish washing was ppm (parts per million) tested (for adequate levels of chemical concentration needed for effective sanitization) every other week by their vendor. When the surveyor inquired as to what range the chemical concentration should result at, they reported that they did not know. On 12/6/24 at 11:42AM the surveyor conducted an interview with contact information provided by the facility for vendor technician #15 who reviewed the facility's vendor records and reported to the surveyor that 11/11/24 was the last time the vendor's assigned technician had visited the facility, and there was no documentation of the ppm test result in their report for that visit. Vendor technician #15 advised the surveyor that there were no future appointments presently scheduled with the facility, and that in addition to technicians checking the ppm at service calls, facility staff are recommended to be checking the ppm every day, every shift, and the circular temperature dials should be working in addition to the monitor. Vendor technician #15 confirmed with the surveyor that if the minimum water temperatures for the machine were not met for the wash cycle, the machine is not able to effectively clean grease and heavy soil prior to the rinse cycle which then utilized the chemical sanitizer. On 12/6/24 at 1:25PM multiple surveyors observed the dish washing system in operation as dishes were being put through the machine. The wash temperature was observed at 100F for the wash, and 117F for the rinse on the monitor, which were both below the minimum temperatures located on the machine's plackard for chemical sanitization. On 12/6/24 at 1:34PM surveyors observed the circular temperature gauges on the dish washing machine while in operation and noted that the left sided gauge needle was barely moving and read 109F, and the right sided gauge needle was not moving and read 114F. When the surveyor inquired as to the condition of the circular gauges, DSD #2 stated: It's calibrated through (vendor) we have no way of checking that, honestly, I don't know. When surveyors inquired as to where the ppm testing log was kept, CDM #3 informed surveyors that there was no log. When surveyors inquired as to how the ppm testing of the chemical concentration was tested , DSD #2 stated the test strips were in their office. DSD #2 retrieved test strips from their office, and returned with Hydrion QT-40 test paper which was observed being put through the dish machine, and the test paper did not return at the end of the dishwashing process. Surveyors observed Chef #16 wrap another piece of the test paper around a fork, and send it through the machine, which returned with no color change having resulted. Chef #16 then obtained a different container of test strips that were labeled for chlorine testing and wrapped it around a fork and sent it through the dishwasher, which revealed a pale yellow test result which did not closely match any of the color indicator test results on the guide on the test strip bottle. On 12/6/24 at 2:03PM the surveyor conducted an interview by phone with Vendor Technician #15 who reported to the surveyor that a chlorine strip should be used for ppm testing and should have a result of 50-100ppm, indicating appropriate chemical concentration levels. Vendor Technician #15 further advised that the test strip should be testing the water that is present after dishes are put through the dish washing system. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 12/6/24 at 2:17PM the surveyor observed Chef #16 dipping a test strip into the water pan within the machine, and no color change was noted to the strip. When the surveyor asked the procedure to be performed according to the vendors recommendation, the test strip color was observed to change, and when compared to the test strip bottle color indicators, was resulting at 25ppm, which was below the recommended concentration level for chemical sanitization. The 25ppm test result was acknowledged and confirmed by DSD #2, Chef #16, and multiple surveyors. On 12/6/24 at 3:13PM the surveyor conducted an interview with the facility Administrator. When the surveyor inquired as to when they had assumed the role of Administrator they stated: I'm going to get back to you on that. When the surveyor inquired to the Administrator if they were aware of issues concerning the dishwasher, they stated: I heard about it today from DSD #2, the p level was barely off with the sanitization, the color was slightly off, just the booster was not working, that's why they have the sanitization, but that's it, I'm not sure, I would have to get back to you. The surveyor shared all concerns with the Administrator and informed them that 25ppm was 25ppm below the minimum of the range for the ppm chemical concentration for effective sanitization. The Administrator acknowledged and confirmed understanding of the surveyor's concerns. On 12/9/24 at 11:10AM the surveyor observed the skilled nursing unit nutrition refrigerator located in the dining room which revealed one thermometer was present, and was observed to be in broken condition. The area on the inside of the thermometer where the result is read was in a diagonal position and read 46F, which did not meet the minimum required temperature. The surveyor reviewed the temperature log for the refrigerator which had last been recorded as 40F at opening for 12/9/24. At this time, the surveyor noted the temperature log for 12/8/24 was incomplete with no closing temperature recorded on the refrigerator or freezer logs. On 12/9/24 at 11:11AM the surveyor observed the skilled nursing unit nutrition freezer located in the dining room which contained an unlabeled disposable beverage cup with white contents, and a damaged container of lactaid ice cream with the contents visible. Further observation of the skilled nursing unit refrigerator on 12/9/24 at 11:11AM revealed a plastic bin of thawed magic cups and a plastic bin of strawberry shakes with no labeling present. When the surveyor inquired to Dietary Aide #13 as to when the products would be discarded, they confirmed the products should be dated, and responded: I will date and time them from now on, and only put 5 or 6 in there at a time, I don't know when these trays were put into the refrigerator. On 12/9/24 at 11:15AM the surveyor requested and performed a dual observation of the concerns with the facility Administrator. Dietary Aide #13 reported to the Administrator that no dates were put on the plastic containers. On 12/19/24 at 11:20AM the surveyor observed the Administrator throw away the cup from the freezer and stated: that's gross. When the surveyor inquired as to what further action would be taken, the Administrator reported the magic cups would be thrown away and a thermometer was observed being removed from the freezer and placed into the refrigerator. When the surveyor inquired as to if any other action would be taken, they stated: We will review the food that is in there and wait until it recalibrates, and we will see how accurate that temperature gauge is with the new one. The surveyor noted that it could not be ensured that the refrigerator had maintained minimum required temperatures for the food items it contained. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 12/9/24 at 11:43AM multiple surveyors observed the thermometer within the skilled nursing unit refrigerator which read: 50F. On 12/9/24 at 11:45AM the surveyor was informed by Dietary Aide #13 that DSD #2 was ordering a new refrigerator. On 12/9/24 at 3:07PM the surveyor conducted an interview with the facility's Executive Director who reported the following to surveyors regarding kitchen concerns: I was made aware on Friday, no I have not been made aware of any issues, not since I have been here February of 2023. They confirmed with the suveyor that if equipment fails, they would be expect to be notified, but if equipment was malfunctioning, that information would be provided to the DSD. The Executive Director further reported the following to surveyors: Staff would only come to us if they weren't able to resolve the issue, the DSD and CDM are responsible for ensuring kitchen compliance. The surveyor inquired to the Executive Director as to what issues were found to be present with the facility dishwashing system, to which they replied: They did their testing of the strips and that was within normal limits, and the vendor came out again Friday, and same with the plumber, and I'm waiting for updates, they were looking at the booster, I would have to get back to you on that. On 12/10/24 at 9:45AM the surveyor conducted an interview with DSD #2 who reported the dishwasher booster had failed since 2021, We had planned to get the booster fixed, but for whatever reason they left us on a chemical sanitizer which was working for us, We knew it was running at 110, it fluctuates due to whatever is happening, it wasn't a steady under 110 continual, we were just notified last week the guys just told us last week the hot water wasn't as hot as it should be. Surveyor's continued review of the dishwasher temperature logs revealed the dishwasher was repeatedly not meeting minimum required temperatures and temperature re-checks were performed, with results that still did not meet minimum required temperatures during the re-checks. On 12/13/24 at 12:24PM the surveyor conducted an interview with the Operations Director #17 who acknowledged ongoing water temperature control issues and cold water flow occurring affecting the kitchen operations, and stated the facility's mixing valve issue was being looked at, and additionally stated: now we have the proper person to look at the booster and fix that.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 51213 Based on observation during medication administration it was determined that the facility failed to follow infection control practices consistent with accepted standards of practice. This was evident for 3 (Residents #5, #10 and #13) of 4 residents reviewed for medication administration during the recertification/complaint survey. The findings include: On 12/06/24 at 8:17AM, surveyors observed LPN #10 drop Resident #5's medication bottle on the floor in the hallway on Cedar Place. LPN #10 picked up the medication bottle for Resident #5 off the floor and placed the medication bottle back in Resident #5's medicine drawer in the medication cart without sanitizing the medicine bottle or their hands. On 12/06/24 at 8:35AM, surveyor observed LPN #10 give Resident #5 their medications and leave Resident #5's room without sanitizing their hands. LPN #10 then retrieved the Blood Pressure (BP) cuff from the hallway on Cedar Place and entered Resident #13's room and took Resident #13's blood pressure. On 12/06/24 at 9:19AM, LPN #10 went to get another computer because the computer on the medication cart no longer worked. LPN #10 returned and hooked up a different computer on the medication cart. LPN #10 did not sanitize their hands and picked up the water pitcher, poured water in a clear plastic cup and went into resident #10's room and gave Resident #10 their medications. On 12/06/24 at 10:12AM, on Cedar Place during medication administration, surveyor observed two syringes sitting in the top part of the sharps container attached to the side of the medication cart. The two syringes appeared to be used and were accessible due to staff not pulling the lever on the side of the sharps container to discard the syringes in the bottom of the sharps container where they cannot be retrieved.