STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215346	A. Building B. Wing	08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northwest Healthcare Center	4601 Pall Mall Road Baltimore, MD 21215

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 31982 Based on record review and interview it was determined the facility staff failed to notify a resident representative of a resident-to-resident assault. This was evident for 1 (#20) of 50 residents reviewed. The findings include: Complaint #MD00173898 was reviewed on 8/20/24 at 3:45 PM. The complainant indicated Resident #20 informed him/her that on 11/3/21 he/she and a staff person were attacked by another resident however the facility never notified him/her of the incident. Review of Resident #20's medical record at that time failed to reveal documentation related to an incident involving resident #20. In an interview on 8/22/24 at 1:43 PM the complainant identified the staff person involved in the incident as the Activities Director (AD). The AD was interviewed on 8/22/24 at 3:23 PM and indicated she recalled the incident. When asked to describe the events she stated He/She struck us, I got in front, between the two residents, (Resident #912) was hitting (Resident #20) and kicking out at (Resident #20), I tried to stop him/her, and he/she kicked me in the stomach. I told the (former) Administrator, but he didn't think it was serious, so I called the regional, he immediately called the Administrator. When asked if facility staff notified Resident #20's responsible party she indicated that she did not know how staff followed up regarding Resident #20. This concern was reviewed with the Administrator and Mobile Director of Nursing (MDON) on 8/26/24 at 2:55 PM.

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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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 31982 Based on record review and interview it was determined the facility staff failed to provide written discharge/transfer notice to the resident and their representative. This was evident for 2 (#22 and #915) of 50 resident's reviewed during the survey. The findings include: 1) Review of Resident #22's medical record on 8/19/24 at 11:41 AM revealed a Social Services note dated 4/4/24 17:38 by the Social Services Director (SSD) indicating Resident #22 was sent to the hospital for evaluation after he/she was assaulted by another resident on 4/4/24. The note indicated the resident's guardian was notified by the Unit Manager of the incident. There was no evidence that the resident and their representative were provided with a written discharge notice. Licensed Practical Nurse (LPN3) who is the Unit Manager was interviewed on 8/19/24 at 2:29 PM. She was asked how the facility provides a written discharge notification to the resident and their representative when transferring to the hospital. She stated, we don't normally provide it in writing we call them, call their person of contact at that time. The Social Services Director (SSD) was interviewed on 8/20/24 at 9:25 AM. When asked if she provided a written notification of discharge to the resident and representative, she indicated she did not. This concern was reviewed with the Administrator and Mobile Director of Nursing (MDON) on 8/26/24 at 2:55 PM. 18819 2) On 08/19/24 reviews of Resident #915's closed medical record revealed the resident was admitted to the facility in January of 2023 and was discharged to another facility in January 2024. Further review of Resident #915's closed medical record revealed social worker documentation that on 11/02/23 at 3:50 PM, the Social Work Director spoke with Resident #915's responsible party and informed them that the facility is planning to transfer Resident #915 to another facility that has a dementia unit. Further review of the medical record failed to reveal documentation that a 30-day involuntary notice of transfer had been issued to the resident or the responsible representative. 08/20/24 at 3:11 PM, in an interview with the facility Social Work Director, the Social Work Director stated that the facility did not issue Resident #915 nor the resident's responsible party a 30-day notice of involuntary discharge. On 08/26/24 at 4 PM the surveyor reviewed this concern with the Administrator regarding failure to provide the transfer notice.

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. 31982 Based on record review and interview it was determined the facility staff failed to ensure residents were prepared and oriented to ensure safe and orderly transfer from the facility.This was evident for 1 (#22) of 50 resident's reviewed during the survey. The findings include: Review of Resident #22's medical record on 8/19/24 at 11:41 AM revealed a Social Services note dated 4/4/24 17:38 by the Social Services Director (SSD) indicating Resident #22 was sent to the hospital for evaluation after he/she was assaulted by another resident on 4/4/24. There was no evidence that the facility provided and documented sufficient preparation and orientation of Resident #22 to ensure his/her safe and orderly transfer from the facility. Licensed Practical Nurse (LPN3) who is the Unit Manager was interviewed on 8/19/24 at 2:29 PM. When asked where nurses were expected to document that they prepared and oriented the resident for transfer, she was unable to explain and failed to find documentation indicating Resident #22 was prepared and oriented to the situation prior to transfer to the hospital after the incident on 4/4/24. This concern was reviewed with the Administrator and Mobile Director of Nursing (MDON) on 8/26/24 at 2:55 PM.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 42886 Based on record review and interview, it was determined that the facility failed to provide a comprehensive care plan for a resident (resident #902) with a history of substance use disorder. This was found to be true for 1 of 50 residents reviewed during a annual survey. The findings include: Care Plan - This term refers to document which is the written plan of how a long-term care facility will provide care. This plan is based on resident health assessments, preferences and goals. Surveyor review of records on 8/22/24 at 8:15 AM revealed the resident #902 was admitted with records revealing a history of substance use disorder. Continued review of records on 8/22/24 at 8:30 AM revealed the resident's care plan failed to have interventions to prevent or assist with difficulties that can arise with a resident with a history of substance use disorder until the resident was in the facilities for over two weeks. During a surveyor interview with the Executive Director on 8/22/24 at 10:15 AM, the Executive Director admitted that the facility failed to fully develop a care plan that included interventions for substance use disorder.

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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** 42886 Based on record review and interview with staff it was determined that the facility staff failed to review and revise resident care plans after each assessment or as resident care needs became apparent or changed over time. This was evident for 3 (#911, #51 and #14) of 50 residents reviewed during the survey. The MDS (Minimum Data Set) is a complete assessment of the resident which provides the facility information necessary to develop a plan of care, provide the appropriate care and services to the resident, and to modify the care plan based on the resident's status. A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess and evaluate the effectiveness of the resident's care. The findings include: 1)Review of Resident #911's medical records on 8/19/24 at 1:30 PM revealed the facility administered Narcan, a medication that is used to reverse the effects of an opioid overdose, to the resident on 5/2/23. Review of the resident's care plan found no evidence of interventions for the prevention of substance use in the facility. During an interview with the Executive Director on 8/20/24 at 12:46 PM, the Executive Director admitted that the facility failed to place interventions for the prevention of substance use in the facility after the Narcan administration on 5/2/23. 31982 2)Resident #51's medical record was reviewed on 8/22/24 at 11:13 AM. The record revealed that the facility held a Care Plan meeting with the resident on 11/30/23 after his/her Quarterly MDS assessment dated [DATE]. Another Quarterly MDS assessment was dated 3/8/24 however, the next care plan meeting was not held until 6/4/24, 3 months after the MDS assessment and just prior to the next Quarterly MDS assessment dated [DATE]. The facility failed to ensure that the residents Plan of Care was reviewed and revised by the interdisciplinary team within 7 days after each assessment. The Administrator was asked to provide documentation for all care plan meetings held from 8/17/23 to 6/6/24. The documentation was provided however it did not include evident that a care plan meeting was held within 2 weeks after the Quarterly MDS assessment on 3/8/24 and 6/6/24. 3)A facility reported incident concerning a resident-to-resident assault was reviewed on 8/26/24. The report alleged Resident #14 struck Resident #910 with a walking cane on 6/15/23. The facility substantiated that the alleged assault took place. Resident #14's medical record revealed a Plan of Care initiated on 4/26/18 for behavior history. The resident's goal was (Resident #14) will have no episodes of behavioral problems through the next review date. The most recent revision of the plan of care was on 4/8/22. The Plan was not revised after Resident #14 assaulted another resident on 6/15/23. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor requested the Administrator provide Resident #14's behavior care plan evaluations and revisions including after the alleged assault. He returned on 8/26/24 at 2:20 PM and revealed that the documentation could not be found and confirmed that it was not done. The Administrator was made aware that the plan of care was not evaluated and revised to reflect and address Resident #14's aggressive behavior toward others. These concerns were reviewed with the Administrator and Mobile Director of Nursing (MDON) on 8/26/24 at 2:55 PM.

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. 31982 Based on medical record review and interview with staff it was determined the facility staff failed to develop and implement an effective discharge planning process which addressed each resident's discharge goals and needs and involved the resident and the interdisciplinary team in development, implementation and ongoing evaluation. This was evident for 1 (#51) of 50 residents reviewed during the survey. Maryland's Medicaid waiver program, also known as the Home and Community-Based Services (HCBS) Waivers, provides vouchers to help Maryland residents pay for long-term care services. These services can help people live in their homes, with loved ones, in adult foster care, or in assisted living facilities instead of nursing homes. A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess and evaluate the effectiveness of the resident's care. The findings include: Resident #51's medical record was reviewed on 8/22/24 at 11:13 AM. The record revealed the resident was admitted to the facility in 9/2022. A progress note dated 1/20/23 14:21 by the Social Services Director (SSD) indicated she contacted the Waiver program for Resident #51 to enroll in the program, the waiver rep referred the resident to Money Follows the People program. The note indicated the SSD would get a call back the following Friday 1/27/23. There was no further documentation in the record related to the call back. A Social Services Progress note dated 3/27/23 indicated that a waiver interview was held, the application was completed and sent back to the waiver coordinator. A care plan note dated 11/30/23 16:17 by the SSD indicated Resident #51 is on the waiver program wait list and was given an update on the status of his application. However, there was no documentation in the resident's record of what the updated status was. No other updates were found in the record related to Resident #51's application status. Review of Resident #51's comprehensive Care Plan revealed that the facility failed to develop and implement a plan of care related to discharge planning. No documentation was found in Resident #51's record to indicate the facility staff implemented an ongoing discharge planning process including the resident's goal(s), the actions staff were taking to facilitate the resident in reaching his/her goal(s), evaluation of the effectiveness of the interventions and updated to reflect the progress toward reaching the resident's goals. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the SSD on 8/26/24 at 11:55 AM. She was made aware that the surveyor was unable to find a Plan of Care related to Resident #51's discharge planning. She stated We do a 48-hour care plan at admission, talk to them about discharge. We talk to them at quarterly care plan meetings. (48-hour care plans are completed within 48 hours of admission as an interim baseline plan for staff to follow until the Comprehensive Plan of Care is completed by the interdisciplinary treatment team.) The SSD added that she would add any changes in a note and indicated that she had 2 or 3 progress notes in Resident #51's medical record. When asked where she addressed residents ongoing discharge care planning needs, she replied, in the progress notes and I talk to them ongoing. She confirmed when asked, that she does not develop a Discharge Care Plan and stated no, we just document in the progress notes. This concern was reviewed with the Administrator and Mobile Director of Nursing (MDON) on 8/26/24 at 2:55 PM.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. 42886 Based on record review and interview, it was determined that the facility failed to place a provider discharge summary on a resident's (resident #911 and #913) medical record after discharge. This was evident for 2 of 50 residents reviewed in an annual survey. The findings include: 1) Review of resident #911's medical record on 8/20/24 at 1:30 PM revealed no evidence of a provider discharge summary after the resident discharged from the facility on 5/18/23. Interview with the Executive Director 8/20/24 at 2:00 PM revealed the resident discharged from the facility after the facility transferred the resident to a local hospital for psychiatric evaluation and he/she did not return to the facility after psychiatric treatment at the local hospital. The Executive Director also admitted that the facility failed to enter a provider discharge summary on the resident's medical record when the resident discharged . 2) Review of resident #913's medical record on 8/20/24 at 11:49 AM revealed no evidence of a provider discharge summary after the resident from the facility on 9/18/23. Interview with the Executive Director on 8/20/24 at 1:08 PM revealed the resident was discharged from the facility after the facility transferred the resident to a local hospital for psychiatric evaluation and he/she did to return to the facility after psychiatric treatment at the local hospital. The Executive Director also admitted that the facility failed to enter the provider discharge summary on the resident's medical record when the resident discharge.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 31982 Based on medical record review and interview it was determined the facility staff failed to maintain complete and accurate medical records by 1) failing to ensure X-Ray reports were filed in the medical record, 2) failing to document an assault by another resident in the resident's record. This was evident for 1 (#20) of 50 residents reviewed during the survey, and 3) failed to have a system in place to ensure investigative records were secured and free from being lost or misplaced. This was found to be evident for 1 facility investigation out of 30 facility reported incidents reviewed for investigative record documentation during an annual recertification survey. A medical record is the official documentation for a healthcare organization. As such, it must be maintained in a complete manner, readily accessible, systematically organized, and accurately documented. All entries to the record should be legible and accurate The findings include: 1) Resident #20's medical record was reviewed on 8/20/24 at 1:20 PM. The record revealed Physicians orders dated 6/5/23 and 6/27/23 for Repeat Lumbar X-Ray AP and Lateral with brace on, sitting upright. The X-Rays reports were not found in the resident's record. The Administrator was asked to provide the reports on 8/20/24 at 3:57 AM. On 8/21/24 at 9:48 AM The Unit Manager Licensed Practical Nurse (LPN3) provided copies of the reports and informed the surveyor that the X-Ray reports should have been uploaded into the Electronic Medical Record (EMR) but weren't. She indicated that she reached out to the radiology company to have the reports sent to the facility after the surveyor requested them and they were not in Resident #20's medical record until surveyor intervention. 2) Review of a complaint (#MD00173898) on 8/20/24 at 3:45 PM revealed an incident occurred on or about 11/3/21 in which Resident #20 and the Activity Director (AD) were assaulted by Resident #912. In an interviewed on 8/22/24 at 3:23 PM the AD indicated Resident #912 struck Resident #20 and herself and that Resident #912 was hitting and kicking out at Resident #20. No documentation was found in Resident #20's medical record regarding the event including but not limited to an assessment of Resident #20 and interventions the facility staff implemented in response to the incident. These concerns were reviewed with the Administrator and Mobile Director of Nursing (MDON) on 8/26/24 at 2:55 PM. 18819 3) During the annual recertification survey, that was conducted from 08/19/24 through 08/26/24, the nurse surveyor requested the facility produce the investigation for the facility reported incident MD00182124 on 08/19/24. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the facility Administrator on 08/22/24 at 9:52 AM, the Administrator stated that the staff cannot find the investigation into this reportable. The resident was out of the facility when the former Administrator reported this. This was during COVID19 Pandemic. On 08/26/24 at 4 PM, the nurse surveyor reviewed this concern with the facility Administrator regarding failure to secure investigative records.