STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215133	A. BUILDING _____ B. WING _____	07/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CARROLL LUTHERAN VILLAGE	200 ST. LUKE'S CIRCLE WESTMINSTER, MD 21157

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)
F 0622 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on complaint, reviews of a closed medical record, and staff interview, it was determined that the facility failed to document the reason for an emergent discharge of a resident in the medical record. This was evident for 1 (Resident #3) of 4 residents reviewed during a complaint survey. The findings include: Review of complaint MD 129 revealed an allegation that the facility engaged in improper discharge practices. Review of Resident #3's closed medical record on 07/10/20 revealed that Resident #3 was transferred to the emergency room under emergency petition on 02/25/20. Review of the 02/25/20 emergency petition, which was completed by Resident #3's attending physician, indicated Resident #3 was displaying aggressive behaviors and was assaulting other residents in the facility repeatedly. In an interview on 07/10/20 at 10:35 AM, the facility administrator stated that Resident #3 received a transfer notice on 02/25/20 when s/he was sent to the emergency room . All residents that are sent to the hospital receive the same facility transfer documents. The facility administrator indicated that the goal of the facility-initiated transfer of Resident #3 to the emergency room was to get her/him stabilized and the best way to accomplish this was for Resident #3 to be admitted to an inpatient psychiatric facility. The facility administrator stated that on 02/27/20, the nursing home staff had a meeting with the hospital staff and were made aware by the hospital staff that Resident #3 was medically stable and was cleared for discharge back to the nursing home. At that time, the facility administrator told the hospital staff that Resident #3 would not be allowed to be discharged back to the nursing home. Reviews of Resident #3's closed medical record failed to reveal documentation regarding the discharge of Resident #3 from the facility nor any newly developed and implemented interventions to attempt to keep Resident #3 in the facility. Resident #3's closed medical record also failed to reveal documentation that the facility provided information to the receiving provider to ensure a safe and effective transition of care. In an interview on 07/13/20 at 2:17 PM, the hospital case manager stated that the nursing home informed the hospital on [DATE] that they would not take Resident #3 back. The hospital case manager stated that the emergency room staff wrote that Resident #3 could be discharged back to the nursing home on 02/27/20. The hospital case manager stated the emergency staff were documenting that Resident #3 was fine and was not displaying any behaviors. In an interview with the facility Director of Nurses (DON) on 07/16/20 at 4:45 PM, the DON stated that there were no changes to Resident #3 plan of care leading up to Resident #3 being emergency petitioned to the emergency roiagnom on [DATE]. The facility DON stated that only Resident #3's medications were updated in Resident #3's nursing care plans.
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.** Based on complaint, reviews of a closed medical record review and interview, it was determined that the facility failed to timely send a written notice of discharge to the resident, the resident's responsible party, and the Ombudsman. This failure did not allow the resident or the resident's representative the opportunity to make an appeal of the resident's discharge that occurred on 02/27/20. This failure also did not allow the Ombudsman the opportunity to provide the resident or the resident's responsible party the added protection from being inappropriately discharged . This was evident for 1 (Resident #3) of 4 residents reviewed during a complaint survey. The findings include: Review of complaint MD 129 revealed an allegation the facility engagied in improper discharge practices. Review of Resident #3's closed medical record on 07/10/20 revealed that Resident #3 was transferred to the emergency room under an emergency petition on 02/25/20 for aggressive behaviors and was repeatedly assaulting other residents in the facility. In an interview on 07/10/20 at 10:35 AM, the nursing home administrator stated that s/he informed the hospital staff on 02/27/20, that the nursing home would not allow Resident #3 to return to the facility. In an interview on 07/10/20 at 4:38 PM, Resident #3's responsible party stated that s/he did not receive the discharge notice, dated 03/02/20, from the nursing home administrator until 03/21/20. In an interview on 07/13/20 at 4:01 PM, the local Ombudsman stated that the facility did not send a hospital discharge notice regarding Resident #3 on or around 02/25/20. In an interview on 07/14/20 at 10:53 AM, the nursing home social worker stated that the facility had an agreement with the local Ombudsman's office to send a list of all the discharges at the end of the month. This would usually happen in a monthly email to the Ombudsman. The surveyor requested that the nursing home social worker send a copy of the monthly emails that the facility sent to the Ombudsman's office regarding all of the discharges for February, March, and April 2020. The facility social worker provided the February, March, and April lists of the monthly discharges to the surveyor on 07/14/20. Review of the lists indicated the Ombudsman was made aware of the facility February 2020 discharges on 04/27/20, the March 2020 discharges on 05/08/20, and the April 2020 discharges on 06/02/20.
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on reviews of a closed medical record and interview, it was determined the facility staff failed to provide a resident and the resident's responsible party enough preparation and orientation before transferring the resident to an acute care facility. This was found to be evident for 1 (Resident #3) of 4 residents reviewed during a complaint survey. The findings include: Review of Resident #3's closed medical record on 07/10/20 revealed that Resident #3 was transferred to the emergency room under an emergency petition on 02/25/20 at 6 PM for aggressive behaviors and was repeatedly assaulting other residents in the facility. In an interview on 07/10/20 at 4:38 PM, Resident #3's responsible party stated that s/he was led to believe that Resident #3 was going to be directly admitted to a psychiatric facility on 02/25/20. Resident #3's responsible party stated that s/he spoke with the memory care nurse manager regarding Resident #3's transfer to the psychiatric facility and mentioned that it was getting later in the day and asked why don't we wait until tomorrow morning to send Resident #3 to the psychiatric facility? Resident #3's responsible party stated that the memory care nurse manager said that Resident #3 had to leave the facility that evening. Resident #3's responsible party stated that Resident #3 did not have any aggressive behaviors the entire time that s/he was there on 02/25/20. In an interview on 07/13/20 at 10:12 AM, the memory care nurse manager stated that s/he and the facility social worker were trying to get Resident #3 directly admitted to the psychiatric facility during the day on 02/25/20, but could not get in touch with any staff at the psychiatric facility. The memory care nurse manager stated that the nursing home staff were having trouble placing

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

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.

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F 0624 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Resident #3 in the psychiatric facility. Reviews of the 02/25/20, 5:47 PM nursing discharge assessment on 07/10/20 revealed that Resident #3 was being discharged to the psychiatric facility and not the hospital emergency room for an evaluation. The staff failed to provide Resident #3 and Resident #3's responsible party enough preparation and orientation before transferring Resident #3 to the hospital on [DATE] under emergency petition.
F 0626 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on complaint, reviews of a closed medical record and staff interview, it was determined that the facility failed to allow a resident to return to the nursing home following a hospitalization . This was evident for 1 (Resident #3) of 4 residents reviewed during a complaint survey. The findings include: Review of Resident #3's closed medical record revealed that Resident #3 was originally admitted to the facility on [DATE] but was subsequently sent to a psychiatric facility due to aggressive behaviors in September 2019. Resident #3 was readmitted from the psychiatric facility on 11/12/19. Resident #3 [DIAGNOSES REDACTED]. On 01/30/20, Resident #3's physician documented Resident #3 was currently stable clinically, psychologically, and neurologically and that previous complaints of aggression and agitation were controlled. Resident was described as physically weak, but able to ambulate without a walker. Resident #3's closed medical record contained a care plan, initiated on 07/21/19, that addressed Resident #3's behavior problem of wandering aimlessly, touching other residents, and intruding on the privacy and activities of other residents. The goals of the nursing care plan were to maintain Resident #3's safety and to decrease the number of episodes of touching other residents' and their belongings. Nursing interventions included: the staff will assess for fall risk, distract Resident #3 from wandering into other residents' rooms or touching other residents belongings by offering diversions, structured activities, food, conversation, television, books. Also, to encourage participation in activities and exercise. Review of Resident #3's 02/20/20 psychiatric consultant's assessment revealed that Resident #3 was followed by the facility psychiatric service for medication management related to dementia, agitation, and altercations. The psychiatric consultant indicated that, on examination, Resident #3 was doing better, behavior was controlled better, and staff were able to redirect them. The psychiatric consultant documented on the 02/20/20 assessment that resident #3 was not a danger to self or others. In an interview on 07/10/20 at 11:13 AM, the psychiatric consultant stated that Resident #3 was not dangerous, but unpredictable, that Resident #3 could be nice for a few weeks then Resident #3's behaviors can escalate. The psychiatric consultant stated that s/he was not called to assess Resident #3 on 02/25/20 before being sent to the emergency room , but also stated that s/he was aware the facility did not allow Resident #3 to return to the nursing home after the hospitalization . Review of complaint MD 129 revealed an allegation the facility was engaging in improper discharge practices. Review of Resident #3's closed medical record on 07/10/20 revealed that Resident #3 was transferred to the hospital emergency room under an emergency petition on 02/25/20. Review of the 02/25/20 emergency petition, which was completed by Resident #3's attending physician, indicated that Resident #3 had aggressive behaviors and wasrepeatedly assaulting other residents in the facility repeatedly. In an interview on 07/10/20 at 10:35 AM, the facility administrator stated that Resident #3 received a transfer notice on 02/25/20 when s/he was sent to the emergency room . All residents that are sent to the hospital receive the same facility transfer documents. The facility administrator indicated that the goal of the facility-initiated transfer of Resident #3 to the emergency room was to get her/him stabilized and that the best way to accomplish this was for Resident #3 to be admitted to an inpatient psychiatric facility. The facility administrator stated that, on 02/27/20, the nursing home staff had a meeting with the hospital staff and were made aware by the hospital staff that Resident #3 was medically stable and was cleared for discharge back to the nursing home. At this time, the facility administrator told the hospital staff that Resident #3 would not be allowed to be discharged back to the facility. Reviews of Resident #3's closed medical record failed to reveal documentation regarding the discharge of Resident #3 from the facility nor any newly developed and implemented interventions to attempt to keep Resident #3 in the facility. Resident #3's closed medical record also failed to reveal documentation the facility provided information to the receiving provider to ensure a safe and effective transition of care. In an interview on 07/13/20 at 2:17 PM, the hospital case manager stated that the nursing home informed the hospital on [DATE] that they would not take Resident #3 back. The hospital case manager stated that the emergency room staff wrote that Resident #3 could be discharged back to the nursing home on 02/27/20. The hospital case manager stated the emergency staff were documenting that Resident #3 was fine amd not displaying aggressive behaviors. In an interview with the facility Director of Nurses (DON) on 07/16/20 at 4:45 PM, the DON stated that there were no changes to Resident #3 plan of care leading up to Resident #3 being emergency petitioned to the emergency roiagnom on [DATE]. The facility DON stated that only Resident #3's medications were updated in Resident #3's nursing care plans. In an interview on 07/14/20 at 9:30 PM, Resident #3's responsible party stated that s/he did not receive a copy of the facility discharge documents until 03/21/20. By then, Resident #3 was already in another long-term care facility. Resident #3's responsible party also stated that s/he was not aware there was an Ombudsman that could have helped advocate for Resident #3 during the discharge process. The facility failed to accurately evaluate Resident #3, rather the facility used Resident #3's escalated behaviors, that occurred just prior to Resident #3 being sent by emergency petition to the hospital, as the basis for discharging Resident #3 from the facility. Cross reference F 622
F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on reviews of a closed medical record, it was determined that the facility staff failed to follow a physician's order and administer medications as instructed. This was evident for 1 (Residents #3) of 4 residents reviewed during a complaint survey. The findings include: Review of Resident #3's closed medical record on 07/10/20 revealed that Resident #3 was admitted to the facility on [DATE]. Resident #3 [DIAGNOSES REDACTED]. Resident #3 received the medication [MEDICATION NAME] for mood stability, [MEDICATION NAME] as a supplement, Quetiapine [MEDICATION NAME] for behavioral disturbance and [MEDICATION NAME] for a cardiac arrhythmia. Reviews of Resident #3's February 2020 Medication Administration Record [REDACTED]. [MEDICATION NAME] - February 18, 23, 2020 at 12 PM. [MEDICATION NAME] - February 18, 23, 2020 at 1 PM. [MEDICATION NAME] - February 18, 23, 2020 at 1 PM. Further reviews of Resident #3's medical record failed to reveal any nursing documentation as to why the medications were not administered. These findings were brought to the attention of the facility Assistant Director of Nursing on 07/10/20 at 1 PM.