STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215084	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PATAPSCO HEALTH AND REHABILITATION	9109 LIBERTY ROAD RANDALLSTOWN, MD 21133

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** Based on medical record review, review of complaint MD 346, interviews with staff, resident and complainant it was determined the facility failed to thoroughly investigate an allegation of misappropriation of property and implement a plan to safeguard Resident #6's finances. This was evident for 1 of 3 residents reviewed for abuse during this complaint investigation. The findings include: Medical record review on 3/4/20 revealed Resident #6 was admitted to the facility for skilled nursing services with a history of Altered Mental Status, Unspecified Cognitive Communication Deficit, and Unspecified Dementia without Behavioral Disturbance. A Nursing Note dated 11/30/19 reported that at 12:15 PM the resident came to the nursing station with a friend and reported s/he lost his/her bank card. The nurse and the resident contacted the bank and learned the bank card was canceled per the resident's request and directed that the resident needed to physically go into the branch office to review his/her account. The medical record contained a Physician's Certification Related to Medical Condition, Decision-Making, and Treatment Limitations, dated 2/25/20, that indicated the resident lacked adequate decision-making capacity. Surveyor review of complaint MD 346 revealed a concern that Resident #6's bank card was lost or stolen, and unauthorized charges appeared on his/her account. According to bank records the resident had multiple reports of his/her card being stolen and unauthorized charges applied to the account. The complainant noted there were numerous questionable charges that included cash withdrawals. The resident did visit the bank to cancel the card and received instructions on how to dispute unauthorized charges. In interview with the surveyor on 3/3/20 at 12:16 PM the Director of Nursing (DON) stated s/he was aware of the resident's concerns that his/her bank card was missing. Upon further investigation it was discovered the resident had given his/her bank card pin number to a friend. The DON stated that since the resident cancelled the card there were no concerns. During an interview with the surveyor on 3/4/20 at 10:41 AM the complainant stated since this complaint was filed regarding suspicious activity on the resident's bank card in November 2019 there continued to be large withdrawals from the account. In February 2020 approximately $900 was withdrawn from ATM. On 2/3/20, $1000 + dollars was spent at a grocery store. The complainant noted there were withdrawals of approximately $900.00 on 3/2/20 and 3/3/20. In interview with the resident on 3/4/20 at 11:18 AM the surveyor asked if the resident was aware of money being withdrawn from his/her account. The resident stated s/he gave a friend permission to pay bills because s/he can't leave the clinic. The surveyor asked the resident if s/he knew how much money the friend was withdrawing from the account and the resident stated $1200, $200 but could not state exactly how the money was being spent. During an interview with Social Services Staff #1 and #2 on 3/4/20 at 12:50 PM the surveyor asked if they were aware that charges continued to appear on the resident's account and if they were able to ensure the resident was not being financially exploited. Social Services staff were not aware of the continued charges. Social Services Staff #1 stated she thought the resident still maintained a house or apartment. Refer to F745
F 0623 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** Based on medical record review and interview with staff it was determined the facility failed to have a system in place to ensure that the resident and/or resident's representative were notified in writing of the resident's transfer and the rationale for the transfer. This was evident for 2 of 4 residents (Resident #6 and Resident #5) reviewed for hospitalization during this complaint survey. The findings include: 1) Review of the medical record for Resident #6 on 3/4/20 revealed Resident #6 was hospitalized in February 2020. A Change in Condition note dated 2/15/20 at 7:04 AM reported the resident was sent to the hospital for treatment regarding a change in condition. Further medical record review failed to reveal written notification was given to the resident/responsible party regarding the reason for the transfer to the hospital. 2) Review of the medical record on 3/5/20 revealed Resident #5 was admitted to the facility for skilled nursing care. A Nursing Home to Hospital Transfer Form dated 12/16/19 reported the resident was transferred to the hospital for altered mental status. Further medical record review failed to reveal evidence that written notification was given to the resident/responsible party regarding the reason for the transfer to the hospital. During an interview with the surveyor on 3/4/20 at 1:39 PM the Director of Nursing acknowledged the lack of written notification to the residents/responsible parties regarding the reason the residents' were transferred to the hospital.
F 0625 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview it was determined the facility failed to notify the resident or resident representative in writing of the current bed-hold policy, reflective of the current regulations, upon transfer to an acute care facility. This was evident for 2 of 4 residents (Resident #6 and Resident #5) reviewed for discharges during this complaint survey. The findings include: 1) Review of the medical record for Resident #6 on 3/4/20 revealed that on 2/15/20 the resident was transferred to an acute care facility for further evaluation and treatment for [REDACTED]. A bed hold is when a nursing home holds a bed for the resident when they go into the hospital. Starting July 1, 2012, MD Medicaid is no longer paying for nursing homes to hold a bed if a resident is hospitalized . All nursing homes must have a written bed-hold policy. They must give it to residents when they are admitted , before any transfer to the hospital, and when residents transfer. (Bed-Hold Fact Sheet - MD Department of Aging) During an interview with the surveyor on 3/4/20 at 1:39 PM, the Director of Nursing stated they are using the policies implemented by the corporation that previously owned the facility. This policy noted the bed would be held for 15 days. 2) Review of the medical record for Resident #5 on 3/5/20 revealed that on 12/16/19 the resident was transferred to an acute care facility for further evaluation and treatment for [REDACTED]. A bed hold is when a nursing home holds a bed for the resident when they go into the hospital. Starting July 1, 2012, MD Medicaid is no longer paying for nursing homes to hold a bed if a resident is hospitalized . All nursing homes must have a written bed-hold policy. They must give it to residents when they are admitted , before any transfer to the hospital, and when residents transfer. (Bed Hold Fact Sheet - MD Department of Aging) During an interview with the surveyor on 3/4/20 at 1:39 PM the Director of Nursing stated they are using the policies implemented by the corporation that previously owned the facility.
F 0637 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assess the resident when there is a significant change in condition** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, it was determined facility staff failed to conduct a comprehensive

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 0637 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) assessment when a significant decline occurred in a resident's condition. This was evident for 1 of 3 residents (Resident #3) reviewed for a change in condition during this complaint survey. The findings include: The Minimum Data Set (MDS) is a comprehensive assessment of the resident completed by the facility staff. The MDS is a multi-disciplinarian tool that allows many facets of the resident's care (cognition, behavior, mobility, activities of daily living, accidents, activities, weight, pain and medications to name a few) to be addressed. The MDS assessment directs the facility staff on issues that may need to be addressed. Medical record review on 2/28/20 revealed Resident #3 was a long-term care resident with [DIAGNOSES REDACTED]. Resident #3 had a right above the knee amputation in May 2019 and a left above the knee amputation in (NAME)2019. Review of the discharge MDS assessment dated [DATE] revealed facility staff coded the resident in Section G Functional Status G0110 A Bed Mobility, E-Locomotion on the Unit, F-Locomotion Off the Unit and as a 1/2 (required the supervision of 1 staff). The resident was coded in section B Transfers as a 1/1 (supervision with set-up help only) and G-Dressing as a 0/1 (independent with set-up help only). Review of the quarterly MDS assessment dated [DATE] revealed facility staff coded the resident in Section G Functional Status G0110 A Bed Mobility and B Transfers as 3/3 (required the extensive assistance of 2 staff). Facility staff coded the resident in E-Locomotion on the Unit, F-Locomotion Off the Unit and G-Dressing as 3/2 (required the extensive assistance of 1 staff). The failure to capture the significant change for the resident was discussed with MDS Coordinators #1 and #2 and the Director of Nursing on 3/3/20 at 2:59 PM. MDS Coordinator #2 stated there were [MEDICATION NAME] (temporary MDS staff) completing the resident MDS assessments during the period between May 2019 and September 2019 and acknowledged it was an oversight that an assessment was not completed after the significant change.
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff and resident interview, it was determined facility staff failed to implement the care plan specifying the method of transfer for a functionally impaired resident who fell during a transfer and suffered a [MEDICAL CONDITION]. This was evident for 1 of 3 residents (Resident #3) reviewed for falls during this complaint survey. The findings included: Medical record review on 2/28/20 revealed Resident #3 was a long-term care resident with [DIAGNOSES REDACTED]. The medical record contained a care plan initiated on 2/19/19 that addressed the risk for falls related to impaired mobility. The care plan was modified on 8/28/19 to reflect the risk for falls due to bilateral (both sides) above the knee amputations. An intervention initiated on 5/27/19 instructed staff to assist resident getting into and out of bed with 2 staff and a mechanical lift. Review of the facility self-report incident dated 1/29/20 revealed Resident #3 fell while attempting to self-transfer using a wooden sliding board. A Change in Condition Note dated 1/28/20 reported the resident had a fall at night. The physician was contacted and ordered a pelvic x-ray. A General Note labeled Late Entry dated 1/28/20 at 3:47 AM noted the evening shift nurse reported the resident fell . A General Note labeled Late Entry dated 1/29/20 at 4:41 AM noted an X-ray report was received and showed a [MEDICAL CONDITION] femoral neck. The doctor was contacted and instructed staff to transfer the resident to the hospital for evaluation and treatment. A femoral neck fracture is one type of [MEDICAL CONDITION]. When a femoral neck fracture occurs, the injury is just below the ball of the ball-and-socket hip joint. Hospital Discharge instructions dated 1/29/20 confirmed the resident had a right femoral neck fracture. Review of a written witness statement dated 1/29/20 revealed Staff #1 noted several weeks before the incident the resident was using the sliding board in the presence of a nursing assistant. Another statement (not dated) by GNA #1 noted the resident was using the Hoyer lift but recently used the sliding board. In interview with Occupational Therapist (OT) #1 on 3/2/20 at 11:25 AM the surveyor asked why the sliding board was in the resident's room if s/he was not cleared to use it. OT #1 stated facility staff realized the danger of leaving items like that in the resident's room after this incident, noting this was the resident's personal sliding board. OT #1 further stated it had been established that the resident should only be transferred using a Hoyer (mechanical) lift. During an interview with the surveyor on 3/3/20 at 10:11 AM, the Assistant Director of Nursing #1 stated s/he was not aware the resident had a sliding board before the fall incident. In interview with the surveyor on 3/3/20 at 10:25 AM the resident stated s/he was in the wheelchair on the sliding board and attempted to transfer to the bed and fell . The resident stated there were no staff present when s/he attempted the transfer. In interview with the surveyor on 3/3/20 at 10:35 AM Staff #1 confirmed her/his observation of the resident using the sliding board before the fall incident that occurred on 1/28/20. The facility failed to clarify the method of transfer determined to be safe for Resident #3 and ensure staff consistently implemented the use of a mechanical lift with the assistance of 2 staff.
F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review it was determined the facility staff failed to: 1) show evidence of ongoing monitoring of an abscess on Resident #1's face and head until further medical intervention and treatment was required; 2) ensure Resident #3 maintained scheduled appointments or document a rationale for missed appointments; and 3) clarify physician's orders [REDACTED]. This was evident for 3 of 4 residents reviewed for quality of care during this complaint survey. The findings include: 1) The facility failed to evidence a plan for the ongoing monitoring of an abscess to Resident #1's head. An abscess is a pocket of pus (infected fluid). Medical record review on 3/2/20 revealed Resident #1 was admitted to the facility for skilled nursing care with [DIAGNOSES REDACTED]. Review of complaint MD 453 revealed a concern that there was a delay in treatment of [REDACTED].#1's head. A General Note dated 7/15/19 at 2:22 PM reported that upon return from a wound consult, staff noted Resident #1 had a prominent bump on the right side of his/her head. It was noted the resident complained of pain and the physician ordered that the resident be given Tylenol and to send the resident to the hospital for a CAT scan. It was further noted that the resident refused to go to the hospital. A Change in Condition Note dated 7/15/19 at 5:12 PM reported the resident had an abscess on the right side of the head. A Nursing Note dated 7/17/19 at 10:12 AM noted the abscess to the right side of the resident's head and face persists. A Nursing Note dated 7/18/19 at 2:12 AM reported Resident #1 complained of pain with three raised areas on the right side of his/her face and forehead. A Skin Check dated 7/26/19 did not note the abscessed areas. A physician's orders [REDACTED]. A General Note dated 7/27/19 at 12:48 PM reported the resident returned from the hospital where the abscess was drained and with a new order for a 10-day course of antibiotics. A care plan initiated on 7/28/19 addressed an actual infection due to abscesses of the right forehead and jaw. Interventions instructed staff to monitor the areas daily for signs and symptoms of reoccurrence, provide ordered treatments, evaluate for the presence of pain, and monitor vital signs as indicated. The findings were discussed with the Director of Nursing and Administrator on 3/5/20 at approximately 2:45 PM. 2) The facility failed to ensure Resident #3 attended scheduled medically necessary appointments or document a rationale for the missed appointments. Medical record review on 2/28/20 revealed Resident #3 had a history of [REDACTED]. Surveyor review of complaint MD 172 revealed a concern that Resident #3 missed several appointments with a vascular surgeon. A Nurse Practitioner's Note dated 6/17/19 reported the resident was being sent to the hospital for evaluation and treatment of [REDACTED]. A General Note dated 7/8/19 at 8:11 PM reported the resident had complications due to surgery. A Nursing Note dated 7/17/19 reported the resident returned to the facility following the amputation of left toes. The resident missed subsequent vascular appointments on 7/30/19 and 8/6/19. The appointment was rescheduled for 8/27/19. Documentation did not indicate why the appointments were missed. A physician's note dated 8/19/19 reported the resident's left foot was gangrenous and the resident was to be transferred to the emergency room . Review of an ambulance transport form noted a date of transport for 8/6/19. The form noted Medicaid would not pay for the transport because the resident's Medicaid insurance was not active. During an interview with the surveyor on 2/28/20 at 10:30 AM Resident #3 stated s/he missed 3 appointments (vascular) prior to losing his/her legs. The resident stated s/he did not know why the appointments were missed. During an interview with the surveyor on 2/28/20 at 2:28 PM Staff #2 stated the resident's appointment with the vascular surgeon was ignored. Staff #2 stated when s/he voiced concerns to the unit secretary, s/he stated the Administrator had advised her/him to hold off on scheduling. Staff #2 stated s/he was not advised of the missed appointments. In interview with the surveyor on 3/3/20 at 10:35 AM Staff #1 stated s/he scheduled appointments for the resident for 7/30/19 and 8/6/19. Staff #1 stated

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) the Administrator told her/him to reschedule the appointments to give the resident's insurance a chance to kick in. Staff #1 stated s/he wrote hold off at the top of the form because that's what the previous Administrator instructed her/him to do. 3) The facility failed to clarify physician's orders [REDACTED]. Medical record review on 3/5/20 revealed Resident #5 was admitted to the facility for skilled nursing care including care of an abdominal catheter. Review of complaint MD 093 revealed a concern that staff were not caring for Resident #5's abdominal drain as directed by the resident's consulting physician. Further record review revealed facility staff received orders from the hospital on [DATE] to drain the catheter only with the supplied drainage kits, drain for symptomatic relief, frequency of drainage would be determined by the resident's referring physician and do not drain more than 2 liters of fluid at a time. Review of the Medication Administration Record [REDACTED]. Staff were also instructed not to drain more than 1-2 Liters daily. The order was signed off daily on every shift. It was unclear what aspects of the order were to be implemented as needed versus what should be done every shift. It was also unclear why there was a delay in implementing care procedures for the abdominal catheter. During an interview with the surveyor on 3/5/20 at 12:25 PM, ADON #1 stated s/he remembered calling the doctor for information on care of catheter. ADON #1 stated the resident's friend brought the dressing kit to the facility and eventually they received something in writing about caring for the catheter. The surveyor discussed concerns regarding the delay in obtaining the treatment order. In interview with ADON #1 on 3/5/20 at 1:17 PM, the surveyor discussed the lack of clarity regarding the order written for the care of the catheter. The order directed staff to monitor certain conditions and drain the catheter. The frequency of conducting the activities are both PRN (as needed) and daily, every shift.
F 0745 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide medically-related social services to help each resident achieve the highest possible quality of life.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff and resident interview it was determined the facility failed to clarify a resident's decision-making capacity. This was evident for 1 of 3 residents (Resident #6) reviewed for discharge during this complaint survey. The findings included: Medical record review on 3/4/20 revealed Resident #6 was admitted to the facility for skilled nursing services with a history of Altered Mental Status, Unspecified Cognitive Communication Deficit, and Unspecified Dementia without Behavioral Disturbance. A capacity assessment dated [DATE] conducted by behavioral health services staff determined the resident was beginning to show a decline in cognitive function that may have been due to recent medical concerns. The clinician concluded that the resident had not declined to the point of needing a guardian of finances or person. The medical record contained a Physician's Certification Related to Medical Condition, Decision-Making, and Treatment Limitations, dated 2/25/20, that indicated the resident lacked adequate decision-making capacity. The medical record contained a MD Order for Life Sustaining Treatment (MOLST) form dated 11/1/19 that indicated the resident or the resident's health care agent chose the DNR (do not resuscitate) option. Further review of the medical record failed to reveal that a health care agent was designated for this resident. A MOLST form dated 2/25/20 indicated the resident's DNR status was the result of a discussion with and informed consent of the resident's guardian of person. The medical record did not contain any guardianship documents for the resident. Medical Order for Life Sustaining Treatment (MOLST) is a portable and enduring medical order form covering options for cardiopulmonary resuscitation and other life-sustaining treatments based on a patient's wishes about medical treatments. During an interview with Social Services Staff #1 and #2 on 3/4/20 at 12:50 PM the surveyor discussed concerns about the resident's DNR status per consent of a guardian as there were no guardianship papers in the medical record. Social Services Staff #1 acknowledged the lack of clarity but could not explain the inconsistencies. Refer to F607
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview it was determined the facility staff failed to maintain accurate medical records as evidenced by the facility's failure to: 1) document the details of a fall for Resident #3 sequentially and in a timely manner; and 2) document the condition of Resident #5 prior to the transfer of the resident to the hospital. This was evident for 2 of 3 residents reviewed for accuracy of medical records during this complaint investigation. The findings include: 1) Medical record review on 2/28/20 of Resident #3's record revealed a care plan evaluation note dated 1/28/20 at 10:59 AM, written by Assistant Director of Nursing (ADON) #1, that reported the resident had an actual unwitnessed fall on 1/27/20 and was sent out for evaluation. Review of a facility reported incident dated 1/29/20 revealed Resident #3 fell while attempting to self-transfer using a wooden sliding board. The report noted the incident occurred on 1/28/20 at 8:30 PM. A Change in Condition Note dated 1/28/20 reported the resident had a fall at night. The physician was contacted and ordered a pelvic x-ray. A General Note labeled Late Entry dated 1/28/20 at 3:47 AM noted the evening shift nurse reported the resident fell . A General Note labeled Late Entry dated 1/29/20 at 4:41 AM noted an X-ray report was received and showed a [MEDICAL CONDITION] femoral neck. The doctor was contacted and instructed staff to transfer the resident to the hospital for evaluation and treatment. A femoral neck fracture is one type of [MEDICAL CONDITION]. When a femoral neck fracture occurs, the injury is just below the ball of the ball-and-socket hip joint. Hospital Discharge instructions dated 1/29/20 confirmed the resident had a right femoral neck fracture. During an interview with the Assistant Director of Nursing ADON) #1 on 3/3/20 at 10:11 AM the surveyor asked ADON #1 to clarify the date that the resident fell . ADON #1 stated s/he may have made a mistake with the date. Documentation of the fall in the record did not include the time the incident occurred, how the resident was found or how s/he fell . 2) Review of the medical record on 3/5/20 revealed Resident #5 was admitted to the facility for skilled nursing care. A Nursing Home to Hospital Transfer Form dated 12/16/19 reported the resident was transferred to the hospital for altered mental status. Further medical record review failed to reveal documentation in the medical record of details of the resident's change in condition at the time of transfer.