| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **215033** | A. BUILDING _____ B. WING _____ | **07/13/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| **LEVINDALE HEBREW GER CTR & HSP** | **2434 W. BELVEDERE AVENUE BALTIMORE, MD 21215** |

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| F 0623<br><br>**Level of harm** - Potential for minimal harm<br><br>**Residents Affected** - Some | **Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on review of medical records and other pertinent documentation and interviews it was determined that the facility failed to ensure the written transfer notice included all of the required information including the right to appeal. This was found to be evident for 3 out of 3 residents (Resident #1, #4 and #7) reviewed for discharge and has the potential to affect any resident transferred to the hospital. The findings include: 1) On 7/9/2020 review of Resident #7's medical record revealed the resident had been transferred to the hospital on [DATE]. Review of the transfer form that corresponds to the transfer failed to include information regarding the resident's right to appeal. 2) On 7/9/2020 review of Resident #1's medical record revealed the resident had been discharged to the hospital on [DATE]. Review of the transfer form that corresponds to the transfer failed to include information regarding the resident's right to appeal. Further review the 3/26/2020 transfer form of Resident #1's failed to reveal the reason for the transfer as evidenced by emergency room being the only documentation found in the section titled Reason for transfer. 3) On 7/9/2020 review of Resident #4's medical record revealed the resident had been discharged to the hospital on [DATE]. Review of the transfer form that corresponds to the transfer failed to include information regarding the resident's right to appeal. On 7/10/2020 9:02 AM surveyor reviewed the concern regarding the failure to include required information in the transfer documentation with the Director of Nursing. The concern was again addressed with the Administrator and the DON at 3:00 PM on 7/13/2020. |
| F 0625<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **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.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on review of medical records and other pertinent documentation and interviews it was determined that the facility failed to have an effective system in place to ensure residents and their responsible representative received a written notice of the facility's bed hold policy; failed to follow their own policy and procedure in regard to discussing bed hold with resident/responsible representative and failed to ensure the bed hold policy that is provided during the admission process included all the required information found at 483.15 (e) (1). This was found to be evident for 3 out of 3 discharged residents (Resident #1, #4 and #7) reviewed during the investigation of a complaint. 483.15 (e) (1). 483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. The findings include: 1) On 7/9/2020 review of resident #7's medical record revealed the revealed the resident had been discharged to the hospital on [DATE]. Further review of the medical record failed to reveal documentation to indicate that the bed hold policy was provided to the resident or the responsible representative. 2) On 7/9/2020 review of Resident #1's medical record revealed the resident had been discharged to the hospital on [DATE]. Further review of the medical record failed to reveal documentation to indicate that the bed hold policy was provided to the resident or the responsible representative. 3) On 7/9/2020 review of Resident #4's medical record revealed the resident had been discharged to the hospital on [DATE]. Further review of the resident's medical record revealed [REDACTED]. The resident had medical assistance as the primary payor source. On 7/9/2020 at 2:00 PM the unit nurse manager (Staff #2) reported the bed hold policy is mailed (to the responsible representative) or if the resident is alert and oriented the policy is given to the resident. She went on to confirm that they document that the bed hold policy has been provided. Further review of Resident #4' medical record failed to reveal documentation that a bed hold policy had been provided to the resident or the responsible representative at the time of transfer to the hospital. Further review of the medical record revealed that on 2/7/2020 the unit clerk (Staff #1) wrote a note indicating a transfer notice and care plan had been mailed out to the resident's responsible party. Interview with the unit clerk (Staff #1) on 7/9/2020 at 2:40 PM confirmed that she did not send anything about the bed hold policy to the resident's responsible party and reported that the finance department follows-up with the family regarding the bed hold. Review of policy 6.2.10 for the procedure for Bed Hold (with a revision date of 8/1/2019) revealed Medicaid recipients are placed on an Administrative Bed Hold for 72 hours when they require acute care (hospitalization ). And that the resident/responsible representative would be contacted by facility staff regarding the facility's hold policy after 72 hours, if the resident had not returned. If the resident/responsible representative indicated they want to pay for the bed hold they are then sent a Bed Hold agreement to sign. Further review of this policy failed to reveal a procedure for ensuring a copy of the Bed Hold policy was provided to a resident or responsible representative when the resident was transferred to the hospital. On 7/9/2020 at 2:30 PM surveyor reviewed the concern with the Director of Nursing (DON) that review of three out of three residents that had been transferred to the hospital failed to reveal documentation that the bed hold policy had been provided at the time of transfer. The DON reported that finance usually has that conversation with them (resident/responsible representative). On 7/13/2020 at 11:30 AM interview with the Director of Patient Accounting revealed that if a resident has medical assistance a collection coordinator will contact the resident or responsible representative to discuss the Bed Hold. She confirmed that these contacts are documented. Review of documentation completed by the billing department staff failed to reveal documentation to indicate facility staff attempted to contact the Resident #4 or the responsible representative 72 hours after the transfer to the hospital. There was a note, dated 2/19/2020, which revealed the responsible representative called wanting to know why they were not holding a bed for the resident and was told that (the resident) was listed as own guarantor so (staff) did not contact (responsible representative) about holding the bed. Further review of the billing department documentation failed to reveal documentation of attempts to contact Resident #4 or the responsible representative regarding the Bed Hold policy. On 7/13/2020 at 12:15 PM the Administrator confirmed that at time of discharge the (responsible representative) was the financial decision maker for Resident #4, as indicated by the surrogate decision maker notation on the face sheet. Surveyor reviewed the concern that there was no documentation that any attempt was made to contact either the resident or the responsible representative about the bed hold 72 hours after discharge to the hospital as indicated in the policy and as reported by staff. Review of documentation of the Bed Hold information provided to residents at time of admission failed to reveal information regarding permitting resident to return to the facility to their previous room if |

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 0625<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | (continued... from page 1)<br>available or immediately upon the first availability of a bed in a semi-private room as indicated in regulation 483.15(e)(1) Permitting Residents to return to facility. |
| F 0656<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review and staff interview it was determined that facility staff failed to develop and implement comprehensive care plans for residents who had been diagnosed with [REDACTED].#6, #14, and #5) reviewed for care plans. The findings include: 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. 1) A medical record review for Resident #6 on 7/9/20 at 10:54 AM, revealed a physician's orders [REDACTED]. The document listed the following [DIAGNOSES REDACTED]. Review of a laboratory result for 7/3/20, the resident tested positive for COVID-19. Review of Resident #6's care plan revealed that facility staff failed to develop and implement a care plan to address the needs for this resident. The [DIAGNOSES REDACTED]. 2) During a medical record review for Resident #14 on 7/9/20 at 11:00 AM, revealed documentation in the discharge summary from the local hospital that the resident had a medical history of [REDACTED]. During this hospital stay, the resident was tested for COVID-19 on 6/25/20, due to a fever, and was found to be positive. Further review of the history and physical revealed the resident was discharged to the facility on [DATE]. Review of Resident #14's care plan revealed that the facility failed to develop and implement a care plan to address the needs of this resident related to the COVID-19 infection. The [DIAGNOSES REDACTED]. 3) On 7/10/20 at 11:20 AM, a medical record review for Resident #5 revealed a history and physical dated 1/21/20, that documented the resident had the following Diagnoses: [REDACTED]. Review of a laboratory test dated 6/29/20 revealed the resident tested positive for COVID-19. Review of the resident's care plan revealed that facility staff failed to develop and implement a care plan to address the needs of this resident in relation to complications of COVID-19 infection related to the other [DIAGNOSES REDACTED]. During an interview with Registered Nurse (RN) #5 on 7/10/20 at 12:30 PM, she reported that she developed care plans based on the daily nursing assessments of the residents. She stated as a new problem develops she was expected to add it to the care plan. She reported that there was an expectation for staff to develop care plans for COVID-19 infection. An interview with the RN Nurse Manager #4 on 7/10/20 at 12:41 PM, revealed her expectation was that the nurses caring for the residents was responsible to develop and implement care plans for the residents. She reported that she had an in-services regarding COVID-19 care plans and provided a template for the nurses. She stated that care plans were monitored by the charge nurses and herself to ensure that they were completed. However, she was unaware that the positive residents on her unit had not had a care plan completed for COVID-19. On 7/10/20 at 2:03 PM, the concerns were discussed with the Nursing Home Administrator, DON, and Quality Assurance Director. |
| F 0684<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Provide appropriate treatment and care according to orders, resident's preferences and goals.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on medical record review and interview, the facility staff failed to administer medications as ordered by the physician. This was evident for 1 out of 3 residents (Resident #2) reviewed during a COVID-19 complaint survey. The findings include: Review of Resident #2's medical record on [DATE] revealed the resident was admitted to the facility on [DATE] and died at the facility on [DATE]. Review of the Resident's Medication Administration Record [REDACTED]. Review of March, April and [DATE] MARs revealed the following medications not administered as ordered: 1. Atorvastatin 40 mg give 1 tablet via gtube at bedtime for high density lipoprotein - ordered on [DATE]. Not given on ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE] and [DATE]. 2. Carvedilol tab 6.25 mg give 1 tablet one time a day for hypertension - ordered on [DATE]. Not given on ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE] and [DATE] 3. [MEDICATION NAME] 0.5 mg via gtube at bedtime for myocionus - ordered on [DATE]. Not given ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE] and [DATE]. 4. [MEDICATION NAME] pm opth ointment Instill 1 drop in both eyes at bedtime for dry eyes - ordered on [DATE]. Not given ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE] and [DATE]. 5. [MEDICATION NAME] tab 200 mg every 12 hours for [MEDICAL CONDITION] via GTube - ordered on [DATE] and reordered on [DATE]. Not given at 10:00 PM on ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE] and [DATE]. 6. Chlorhex gluc oral rinse 0.12 %- give 5 ml by mouth every 8 hours for mouth - ordered on [DATE]. Not given at 3:00 PM on ,[DATE] and [DATE] and at 11:00 PM on ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE] and [DATE]. 7. [MEDICATION NAME] moist mouth spray - 1 spray orally every 6 hours for dry mouth - ordered on [DATE]. Not given ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE] and [DATE]. 8. Refresh classic pf solution 1 drop in both eyes 2 times a day for dry eyes - ordered on [DATE]. Not given ,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE] and [DATE]. 9. Cranberry tablet 450 mg 1 tablet via gtube 2 times a day for uti [MEDICATION NAME] - ordered on [DATE]. Not given 6:00 PM on ,[DATE] and [DATE]. 10. [MEDICATION NAME] Capsule (Lactobacillus Rhamnosus) give 1 capsule via gtube 2 times a day for diarrhea ordered [DATE]. Not given at 6:00 PM on ,[DATE] and [DATE]. 11. Mulitvitamin liquid Give 5 ml via gtube 2 times a day for supplement ordered [DATE]. Not given at 5:00 PM on ,[DATE] and [DATE]. 12. [MEDICATION NAME] Acid 250mg/5ml - give 15ml 2 times a day for [MEDICAL CONDITION] - ordered on [DATE], reordered on [DATE]. Not given at 6:00 PM on [DATE], at 10:00 PM on ,[DATE] and [DATE]. 13. [MEDICATION NAME] Solution Reconstituted 1 GM-Cefriaxone Sodium-1 gram intravenously in the evening for pleural effusion/pneumonia for 5 days-ordered on [DATE]. Not given ,[DATE] and [DATE]. The resident only received 3 days instead of 5 as ordered. 14. [MEDICATION NAME] Sodium Solution 30mg/.3ml every 12 hours for elevated d-dimer for 14 day-ordered [DATE]. Not given [DATE] at 9:00 PM. Interview with the Director of Nursing on [DATE] at 8:50 AM confirmed the facility staff failed to administer all medications as ordered by the physician for a resident. |

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| F 0880<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation and staff interview it was determined that the facility staff failed to implement droplet precautions based on Centers for Disease Control (CDC) protocol on the observation unit. This was evident for 2 of 2 units in Hall 1. The findings include: During the initial tour of Hall 1 on 7/8/20 at 12:00 PM, revealed that there were two hallways designated for residents who were being observed for COVID-19 infection. The resident doors to the following rooms were observed open: room [ROOM NUMBER], #113, #114, and #117. On the other hallway doors for Rooms #120-133 were all open. Secondly, staff were observed exiting the resident's rooms removing their yellow gowns and carrying them down the hallway to a hamper. There was no receptacle to discard the gown in the resident's room. An interview with the RN Nurse Manager #4 on 7/9/20 at 12:00 PM, revealed that they had all new admissions on the unit. She stated that they were in droplet isolation. When asked why the room doors were not closed she stated that COVID-19 was not an airborne illness and therefore the doors did not need to be closed. On 7/9/20 at 9:15 AM, an interview with Infection Control Preventionist (ICP) for Medical System Staff #6 and (ICP) for facility Staff #7 revealed that staff were to be following Droplet Precautions for residents in the observation unit. During discussion of the door being shut, the ICP #6 and #7 indicated they were unaware that the door needed to be closed with droplet isolation. Review of CDC guidelines: Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Setting which stated, Newly admitted residents should be placed in a single room with the door closed. In addition, discussion with ICP #6 and #7 of the isolation set-up system where staff had to carry a dirty isolation gown to the end of hallway to discard the gown, ICP #6 and #7 stated staff were expected to remove the gown in the resident's room and place in a plastic bag to carry to the receptacles at the end of each hallway. ICP #6 and #7 were made aware that this had not been observed by the surveyors during their observations. Review of CDC guidelines for Use Personal Protective Equipment (PPE) When Caring for Patients with Confirmed or Suspected COVID-19 which clearly states in doffing (taking off gear) section, #2 that gown should be removed and discarded prior to exiting the patient's (resident's) room. Findings were reviewed with the Nursing Home Administrator, Director of Nursing, and Quality Assurance Director on 7/10/20 at 2:03 PM. |
| F 0885<br><br>**Level of harm -** Potential for minimal harm<br><br>**Residents Affected -** Many | |

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| F 0885<br><br>**Level of harm -** Potential for minimal harm<br><br>**Residents Affected -** Many | (continued... from page 2)<br>Based on interview and review of facility documentation it was determined that the facility failed to ensure residents, their representatives and families were informed by 5 PM the next calendar day following a newly identified COVID-19 infection. This was found to be evident for all residents, their representatives and families. The findings include: Review of the facility's process for reporting to residents, representatives and families began on 7/9/20. During interview with the Administrator on 7/9/20 at 11:00 AM, the Administrator was asked how the facility is informing residents, representatives and families of a newly identified COVID-19 infection. The Administrator stated on 4/22/20 the facility hand delivered a letter to all residents and mailed the same letter to resident representatives and families that included a newly created website to keep residents, representatives and families updated. The Administrator stated this website is updated weekly with the number of COVID-19 infections. The Administrator was asked if there were any other means to keep the residents, representatives and families updated with the latest COVID-19 infections in the facility and the Administrator stated no. Review of the facility's 4/22/20 letter provided to the surveyor on 7/9/20 revealed a newly created website entitled, www.lifebridgehealth.org/levindalefamilies. The letter did not include any phone number to call for those residents, representatives and families that do not have Internet access. Review of the facility website revealed it was updated with COVID-19 resident infection numbers for the week ending 4/28, 5/7, 5/14, 5/21, 5/28, 6/4, 6/11, 6/18, 6/25 and 7/3/20. The Administrator stated the facility updates the website on Fridays for the previous week's COVID-19 numbers through Thursday. Further review of the company website revealed there were no staff included in the COVID-19 numbers, just residents. On 7/9/20 at 11:48 AM, the surveyor reviewed the Maryland Secretary of Health issued a Directive and Order Regarding Nursing Home Matters Pursuant to Executive Order No. 20-04-24-01 stating: All facilities must provide informational updates on COVID-19 to residents, residents' representatives, and staff within 12 hours of the occurrence of a single confirmed infection of COVID-19, or when three or more residents or staff with new-onset respiratory symptoms that occur within 72 hours. After review of the order, the Administrator confirmed at that time he was doing updates incorrectly and not including staff. During interview with Resident #2's responsible party on 7/10/20 at 12:49 PM, he/she voiced concerns regarding timely notification of COVID-19 positive cases in the facility. He/she stated he/she was not aware of the facility's website and had only heard about the COVID-19 positive numbers from the local news. On 7/10/20 at 11:25 AM surveyor reviewed the concern with the Administrator regarding the failure to notify residents, representatives and families of a newly identified COVID-19 positive case in a timely manner as required. |