STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215069	A. BUILDING _____ B. WING _____	03/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ORCHARD HILL REHABILITATION AND HEALTHCARE CENTER	111 WEST ROAD TOWSON, MD 21204

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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 -** Some	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on family interview, medical record review and staff interview it was determined the facility staff 1) failed to notify the physician when medications were unavailable from the pharmacy and the medication was not given and 2) failed to notify the physician of blood pressure readings outside of physician ordered parameters. This was evident for 2 (Resident #4, #6) of 6 residents reviewed for complaints during a complaint survey. The findings include: 1) On [DATE] at 9:58 AM an interview was conducted with Resident #4's family member who stated Resident #4 had issues with getting medications timely. Resident #4 has since transferred out of the facility. Resident #4's medical record was reviewed on [DATE] at 10:30 AM. The April 2019 Medication Administration Record [REDACTED]. On 4/25/19 at 21:24 (9:24 PM) the medication [MEDICATION NAME] Allergy Tablet was not available on hand. Resident #4's June 2019 Medication Administration Record [REDACTED]. Resident #4's July 2019 MAR indicated [REDACTED]. On 7/27/19 the MAR indicated [REDACTED]. Resident #4's October 2019 MAR indicated [REDACTED]. On 10/6/19 at 9:26 AM the MAR indicated [REDACTED]. On 10/16/19 at 20:59 (8:59 PM), [MEDICATION NAME] 75 MG Capsule, give 1 capsule orally two times a day for Pain, not done. On [DATE] a review of all nursing documentation for Resident #4 from 4/6/19 to 10/17/19 failed to produce documentation that the physician was notified when the medications were not available. An interview was conducted with Physician #8 on [DATE] at 3:02 PM. Physician #8 stated that she would expect to be notified when a medication was not available. An interview was conducted on [DATE] at 11:15 AM with RN #16 about the process for reordering resident medications. RN #16 describe the process that she uses and stated she would call the physician to let the physician know that the medication was not available and not given. 2) Review of Resident #6's medical record on [DATE] at 8:44 AM revealed a 1/2/2020 physician's orders [REDACTED]. The order stated to hold if systolic was less than 110 and diastolic was less than 60 and if pulse was less than 60. The top number refers to the amount of pressure in the arteries during the contraction of the heart muscle. This is called systolic pressure. The bottom number refers to the blood pressure when the heart muscle is between beats. This is called diastolic pressure. Review of Resident #6's January 2020 Medication Administration Record [REDACTED]. On [DATE] at 9 PM the blood pressure (b/p) was 101/64, on [DATE] at 9 PM the b/p was 98/62, on 1/7/2020 at 9 PM the b/p was 98/63, on [DATE] at 9 PM the b/p was 93/62, on 1/9/2020 at 9 PM the b/p was 98/61 and on [DATE]20 at 9 PM the b/p was 102/64. The blood pressure medication was given on these dates and there was no documentation found in the medical record that the physician was notified. An interview was conducted with Physician #8 on [DATE] at 3:02 PM. Physician #8 stated she would expect to be notified if the blood pressure was outside of parameters and she would have expected the blood pressure medication to be held. On [DATE] at 11:44 AM the Director of Nursing and Nursing Home Administrator were made aware of the concerns related to physician notification. The Director of Nursing stated on [DATE] at 12:58 PM that she expected the physician to be notified as they can use CVS to get medication delivered.
F 0583 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Keep residents' personal and medical records private and confidential.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, it was determined that facility staff failed to assure that resident medical records remained private and confidential as evidenced by resident information being left visible on the medication administration computer while the nurse entered the resident's room. This was evident for 1 of 4 random observations of medication carts during a complaint survey. The findings include: Observation was made on [DATE] from 2:27 PM to 2:34 PM of Resident #8's electronic medical record displayed on an opened computer screen that was sitting on top of a medication cart. The vital sign section of the medical record was displayed. The medication cart was sitting in the hallway between room [ROOM NUMBER] and #215. Licensed Practical Nurse (LPN) #6 walked up to the medication cart where the surveyor was standing and the surveyor informed LPN #6 of the finding. LPN #6 confirmed the finding and stated, I have never done that before. The observation was discussed with the Director of Nursing and Nursing Home Administrator on [DATE] at 11:39 AM.
F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Respond appropriately to all alleged violations.** Based on review of facility documentation, staff and resident interview and observation, it was determined the facility failed to thoroughly investigate an incident of alleged abuse. This was evident for 1 (Resident #5) of 1 facility reported incident reviewed. The findings include: Review of the facility reported incident MD 125 on [DATE] at 9:30 AM revealed that Resident #10 reported a nurse came in and took Resident #5's call bell and struck Resident #5 with it. Resident #10 stated it happened several months ago. It was documented that Resident #10 had reported it to the prior Director of Nursing (DON). The documentation revealed the facility conducted 4 staff interviews which consisted of 1 Licensed Practical Nurse, 1 Registered Nurse Supervisor and 2 Geriatric Nursing Assistants. In the investigation that was provided to the surveyor there were no other staff interviews, no resident interviews, and no nursing schedule reviews of the previous 2 months to capture everyone that worked on the unit 7 days per week. An interview of Resident #10 was conducted on [DATE] at 11:35 AM. Resident #10 was asked if he/she remembered when the incident happened, if it was during the day, evening, or night. Resident #10 stated, Night shift. The resident advised a police officer came and talked to him/her. An interview was attempted of Resident #5 on [DATE] at 11:40 AM, however the resident was non-verbal. An interview with the DON was conducted on [DATE] at 8:48 AM. The DON stated, I started working in October 2019 and the Assistant Director of Nursing (ADON) investigated/interviewed 4 staff. When asked why only 4 staff were interviewed, her answer was they are the only ones who worked on that unit. When asked if the facility interviewed other staff from the previous month or interviewed other residents in the facility, her answer was, no because the resident didn't remember when it happened exactly.
F 0641 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure each resident receives an accurate assessment.** **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 ensure Minimum Data Set (MDS) assessments were accurately coded. This was evident for 1 (Resident #6) of 6 residents reviewed during a complaint survey. The findings include: The MDS is part of the Resident Assessment Instrument that was Federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned based on those individualized needs, and that the care is provided as planned to meet the needs of each resident. a) Resident #6's medical record was reviewed on [DATE] at 8:44 AM. Review of the admission MDS assessment for Resident #6 with an assessment reference date (ARD) of [DATE], Section I0020, Active Diagnosis, Indicate the resident's primary medical condition category, coded 11 which indicated Other Orthopedic Conditions. I0020B ICD Code was coded M48.20 which was Kissing Spine. Review of the hospital discharge (d/c) summary dated [DATE] documented the discharge plan as

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 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted** **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 develop and then provide residents and/or their representative with a summary of the baseline care plan within 48 hours of admission to the facility. This was evident for 3 (Resident #6, #11, #12) of 3 residents reviewed during a complaint survey for baseline care plan. 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) Review of Resident #6's electronic and paper medical record on [DATE] at 8:00 AM revealed Resident #6 was admitted to the facility on [DATE]. Review of the medical record failed to reveal documentation that a baseline care plan was developed within 48 hours of admission and that a copy was provided to the resident/resident representative. The Director of Nursing (DON) was interviewed on [DATE] at 10:04 AM and confirmed that facility staff failed to initiate a baseline care plan for Resident #6 within 48 hours of admission. The DON stated, I saw it was lacking and I started a process that the supervisors are now to start the baseline care plan. Resident #6's family member confirmed on [DATE] at 10:31 AM that she did not receive a copy of the baseline care plan and had to request a copy of the care plan during Resident #6's stay at the facility. 2) Review of Resident #12's electronic and paper medical record on [DATE] at 11:15 AM revealed Resident #12 was admitted to the facility on [DATE]. The medical record failed to reveal documentation that a baseline care plan was developed within 48 hours of admission and that a copy was provided to the resident/resident representative. 3) Review of Resident #11's electronic and paper medical record on [DATE] at 11:43 AM revealed Resident #11 was admitted to the facility on [DATE]. The medical record failed to reveal documentation that a baseline care plan was developed within 48 hours of admission and that a copy was provided to the resident/resident representative. During an interview with the DON on [DATE] at 1:00 PM, the DON provided a sign-in sheet stating the sign-in sheet confirmed a meeting was held for the baseline care plan. The DON acknowledged that Resident #11 and Resident #12 and/or their representative (RR) did not receive copy of the baseline care plan. The DON stated baseline care plans were executed within 48 hours of admission, however, did not appear in (name of electronic medical system) as a baseline care plan. The goal was to have a care plan completed within the first 24 hours.
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 and family and staff interview, it was determined the facility failed to develop and implement a comprehensive person-centered care plan with appropriate measurable goals related to urinary incontinence. This was evident for 1 (Resident #6) of 6 residents reviewed during a complaint survey. 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. Review of Resident #6's medical record on [DATE] at 8:44 AM revealed documentation on the nursing admission assessment dated [DATE] at 18:42 (6:42 PM) that Resident #6 was incontinent of both bowel and bladder. A 12/16/19 at 16:00 (4:00 PM) nurse's note by Licensed Practical Nurse (LPN) #7 documented that the resident was incontinent of urine, the urine was clear, used a urinal and was on a toileting program. A 12/17/19 at 16:00 note by Registered Nurse (RN) #15 documented the resident was incontinent of urine, pads and briefs were the toileting devices and the resident was not on a toileting program. A 12/17/19 at 20:09 (8:09 PM) nursing note by LPN #7 documented the resident was incontinent of urine, used a urinal and was on a toileting program. Continued review of nursing nurse notes dated 12/17/19 to 12/23/19 continued to document discrepancies between the RN and LPN as to whether the resident was on a toileting program and whether the resident used a urinal or incontinent pads and briefs. Family Member #1 for Resident #6 stated during an interview on [DATE] at 10:33 AM that she was with Resident #6 during the entire admission assessment and the question about urinary incontinence was never brought up. Family member #1 stated that Resident #6 was not incontinent of urine before he/she went into the hospital. During hospitalization Resident #6 became incontinent due to surgery and the amount of time in the intensive care unit, however, when he/she entered the nursing facility he/she was not incontinent, and the family would help the resident with toileting. Review of Geriatric Nursing Assistant (GNA) documentation revealed scores ranging from urinary incontinence on admission [DATE] through 12/23/19 and urinary continence on day shift on 12/24, 12/25, 12/27, 12/28 and 12/31/19 and urinary continence on evening shift on 12/27, 12/28 and 12/29/19. Review of Resident #6's care plan for bladder incontinence related to disease process, that was initiated on 12/20/19 had the goal, will remain free from skin breakdown due to incontinence and brief use through the review date. The goal did not address how to help Resident #6 regain urinary continence. Interventions on the care plan were as follows: check me (freq) and as required for incontinence. Wash, rinse and dry perineum. Change clothing PRN (when necessary) after incontinence episodes. Monitor/document for s/sx (signs and symptoms) of UTI (urinary tract infection) Monitor/document/report to MD PRN possible medical cause of incontinence. The interventions were not specific to Resident #6's urinary incontinence. The interventions did not mention toileting every 2 hours or to put the resident on a toileting schedule. The lack of a person centered care plan for Resident #6 was discussed with the Director of Nursing and the Nursing Home Administrator on [DATE] at 11:39 AM
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **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 ensure a resident with urinary incontinence received the appropriate services to achieve or maintain as much normal bladder function as possible. This was evident for 1 (Resident #6) of 6 residents reviewed during a complaint survey. The findings include: Review of Resident #6's medical record on [DATE] at 8:44 AM revealed documentation on the nursing admission assessment dated [DATE] at 18:42 (6:42 PM) that Resident #6 was incontinent of both bowel and bladder. A 12/16/19 at 16:00 (4:00 PM) nurse's note by Licensed Practical Nurse (LPN) #7 documented that the resident was incontinent of urine, the urine was clear, used a urinal

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F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) and was on a toileting program. A 12/17/19 at 16:00 note by Registered Nurse (RN) #15 documented the resident was incontinent of urine, pads and briefs were the toileting devices and the resident was not on a toileting program. A 12/17/19 at 20:09 (8:09 PM) nursing note by LPN #7 documented the resident was incontinent of urine, used a urinal and was on a toileting program. Continued review of nursing nurse notes dated 12/17/19 to 12/23/19 continued to document discrepancies between the RN and LPN as to whether the resident was on a toileting program and whether the resident used a urinal or incontinent pads and briefs. Family Member #1 for Resident #6 stated during an interview on [DATE] at 10:33 AM that she was with Resident #6 during the entire admission assessment and the question about urinary incontinence was never brought up. Family member #1 stated that Resident #6 was not incontinent of urine before he/she went into the hospital. During hospitalization Resident #6 became incontinent due to surgery and the amount of time in the intensive care unit, however, when he/she entered the nursing facility he/she was not incontinent, and the family would help the resident with toileting. Family Member #2 for Resident #6 stated during an interview on [DATE] at 11:07 AM that on 12/16/19 the nurse inserted a Foley catheter but wouldn't tell her how much urine was obtained and when she came in the next day the Foley catheter was gone. A Foley Catheter is an indwelling urinary catheter (tube) in the bladder that is a pliable catheter that drains urine from the bladder into a bag outside the body. A common reason to have an indwelling catheter is [MEDICAL CONDITION] (not being able to urinate). A physician's note dated 12/17/19 documented, the pt. (patient) was noted to be retaining urine overnight. Foley catheterization revealed 700 cc of urine. The physician's note continued, [MEDICAL CONDITION]: I will d/c Foley catheter. We will order bladder scan q (every) 6 hrs. for 3 days. We will also straight cath if retain more than 350 cc. if the pt. does not develop the urge to urinate and continues to have [MEDICAL CONDITION] I will refer the pt. to the urologist. The straight catheter, also called an intermittent catheter, is a soft, thin tube used to pass urine from the body. Straight catheters are usually made of plastic (PVC) and are only used one time and then thrown away. An interview was conducted on [DATE] at 12:00 PM with the Director of Nursing (DON). The DON was asked about the Foley catheter being inserted without documentation that it was inserted. The DON stated that there was no Foley catheter and the resident had a straight catheterization and that the family member must have misinterpreted the straight cath for a Foley catheter. An interview was conducted with LPN #7 on [DATE] at 3:26 PM with the DON present. LPN #7 was asked if he inserted a Foley catheter into Resident #6. LPN #7 stated that he did insert a Foley catheter and it was in for about 3 to 4 hours. LPN #7 stated that the on-call physician instructed him to do that. LPN #7 stated he wrote the order in the medical record. Continued review of the medical record on [DATE] at 3:30 PM failed to produce a physician's orders [REDACTED]. There was no documentation in the medical record from LPN #7 that he inserted a Foley catheter along with the size of the catheter, explanation to Resident #6 or any precautions taken after insertion of the catheter. Further review of Resident #6's medical record on [DATE] failed to produce bladder assessments, failed to produce evidence that a plan was implemented to put the resident on a toileting schedule and failed to have a care plan in place to assist the resident to return to having urinary continence. The DON and the Nursing Home Administrator were informed on [DATE] at 11:39 AM.
F 0711 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview it was determined the consultant physician notes were not in the medical record after each visit. This was evident for 1 (#6) of 6 residents reviewed during a complaint survey. The findings include: Review of the medical record for Resident #6 on [DATE] at 8:44 AM revealed a physician's note dated 12/17/19 which stated, CKD ([MEDICAL CONDITION]), Stage IV, Notes: I will place the nephrology consult. We will continue to monitor CMP (Complete Metabolic Profile) if patient has worsening kidney function. I will refer the patient for [MEDICAL TREATMENT]. A CMP is a comprehensive metabolic panel which is a blood test that gives doctors information about the body's fluid balance, levels of electrolytes like sodium and potassium, and how well the kidneys and liver are working. A 12/20/19 physician's note documented, [MEDICAL CONDITION], stage IV (severe), Notes: I will repeat CMP and follow-up. Avoid nephrotoxic agents. Emphasized on optimal glycemic and blood pressure control, [MEDICAL CONDITION]. A 1/6/2020 physician's note documented, [MEDICAL CONDITION], stage IV (severe), Notes: Creatinine is slowly improving. The patient is being followed by nephrologist. Review of physician orders [REDACTED]. Further review of Resident #6's paper and electronic medical record failed to produce physician notes from the nephrology consultant. The Director of Nursing (DON) was interviewed on [DATE] at 12:00 PM and stated, the nephrologist saw the resident and is an in house nephrologist and keeps a list of the patients and what he wants. He doesn't document a consult in the resident's medical record. He doesn't document any notes in the resident's medical record even though he physically sees the resident. The nephrologist was interviewed on [DATE] at 12:45 PM. He stated, I document in my program booklet. If I have an order for [REDACTED]. I see the patient and make recommendations and it is communicated to the physician. A consult is a different process. If the physician writes an order for [REDACTED]. If acute or if something changes, I would consult on them and I would write a note. It would be very redundant if I had to do it both ways. I think it is a nomenclature issue. I run the CKD and [MEDICAL CONDITION] (End Stage [MEDICAL CONDITION]) program. If I receive a stipend I shouldn't bill unless it is requested as a consult note. The program is set up that there is a CKD booklet and the documentation occurs in the booklet. It is well documented within my booklet. The surveyor requested on [DATE] at 12:50 PM to see the nephrology notes. Review of the nephrology notes that were given to the surveyor on [DATE] at 1:00 PM revealed that all residents seen by the nephrologist were listed on the meeting minutes along with labs. There were no individual notes that were provided to the surveyor. Resident #6's attending physician, Physician #8 was interviewed on [DATE] at 3:02 PM and stated she would expect to see nephrology notes in the resident's medical record. On [DATE] at 11:39 AM the Medical Director stated, we have a CKD program and consults can form under the CKD program. So, it is kind of like the charting system. We maintain in a hybrid system, no one place, and no one place for all documents, some in the hard chart, some in (electronic record name). That chart is a hybrid, the consult is in a hybrid chart. If all medical records were requested, we would send the notes in the hybrid chart along with the resident's individual chart.
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on family interview, medical record review and staff interview it was determined the facility failed to provide medications in a timely manner. This was evident for 1 (Resident #4) of 4 complaints reviewed during a complaint survey. The findings include: 1) On [DATE] at 9:58 AM an interview was conducted with Resident #4's family member who stated Resident #4 had issues with getting medications timely. Resident #4 has since transferred out of the facility. Resident #4's medical record was reviewed on [DATE] at 10:30 AM. The April 2019 Medication Administration Record [REDACTED]. On 4/25/19 at 21:24 (9:24 PM) the medication [MEDICATION NAME] Allergy Tablet was not available on hand. The June 2019 Medication Administration Record [REDACTED]. The July 2019 MAR indicated [REDACTED]. On 7/27/19 at 7:43 AM the MAR indicated [REDACTED]. The October 2019 MAR indicated [REDACTED]. On 10/16/19 at 9:26 AM the MAR indicated [REDACTED]. On 10/16/19 at 20:59 (8:59 PM), [MEDICATION NAME] 75 MG Capsule, give 1 capsule orally two times a day for Pain, not done. Continued review of Resident #4's medical record revealed a 6/6/19 care plan meeting note which documented, Resident medication concerns addressed by nursing department, who will follow up. A 9/19/19 care plan meeting note documented, Resident medication concerns addressed by nursing department, who will follow up. Review of Resident Council meeting minutes on [DATE] at 2:00 PM for a 9/[DATE]9 meeting documented, Medication - make sure residents receive medications from pharmacist in a timely manner. An interview was conducted on [DATE] at 11:15 AM with RN #16 about the process for reordering resident medications. RN #16 stated, the process is when you start getting low on meds you can either re-order it through the computer or pull the sticker off the box. I usually count the pills and when I get down to around 5 pills left I will re-order. If the medication isn't there, I will call pharmacy. I will also get permission to pull from the interim box if the medication is in there and I will call the physician to let them know. An interview was conducted on [DATE] at 11:44 AM with the Director of Nursing (DON) and the Nursing Home Administrator (NHA). The NHA stated he came in the middle of August 2019 and didn't recall off hand if there were any problems and was still learning the processes of the facility. The DON did not start at the facility until October 2019. The DON stated that she would expect the physician to

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F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) be notified and stated that CVS pharmacy can deliver medications.
F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interviews, it was determined that facility staff failed to ensure residents were free from significant medication errors as evidenced by failing to follow a physician's orders [REDACTED]. This was evident for 2 (Resident #6, #14) of 6 residents reviewed during a complaint survey. The findings include: 1) Review of Resident #6's medical record on [DATE] at 8:44 AM revealed a 1/2/2020 physician's orders [REDACTED]. The order stated to hold if systolic was less than 110 and diastolic was less than 60 and if pulse was less than 60. The top number refers to the amount of pressure in the arteries during the contraction of the heart muscle. This is called systolic pressure. The bottom number refers to the blood pressure when the heart muscle is between beats. This is called diastolic pressure. Review of Resident #6's January 2020 Medication Administration Record [REDACTED]. The blood pressure was given on these dates even though the blood pressure readings were outside of parameters. There was no documentation found in the medical record that the physician was notified of the blood pressure readings. An interview was conducted with Physician #8 on [DATE] at 3:02 PM. Physician #8 stated she would expect to be notified if the blood pressure was outside of parameters and she would have expected the blood pressure medication to be held. An interview was conducted with Licensed Practical Nurse (LPN) #7 on [DATE] at 3:26 PM with the Director of Nursing (DON) present. LPN #7 stated that he only held the blood pressure medications maybe 1 or 2 times. If the blood pressure was low, we will hold medication. Any time I come in I take the blood pressure and then I take the blood pressure when I am about to give the medication. I always write it down on the paper. There was no documentation that the medication was held on those specific times and dates. 2) On [DATE] at 11:25 AM review of Resident #14's February 2020 MAR indicated [REDACTED]. The MAR indicated [REDACTED]. [MEDICATION NAME] and [MEDICATION NAME] had an order to hold the medications if SBP (systolic blood pressure) was less than 110 mmHg or pulse was less than 60 bpm. Both medications were administered by Staff#11 when outside of the physician ordered parameters. On [DATE] at 12:30 PM, during interview, Staff#11 stated when a resident has a specified parameter regarding blood pressure, she always takes the blood pressure prior to administering the medication. Staff #11 acknowledged the MAR indicated [REDACTED]. Staff#11 stated she documented in error on both days and that the medications were not given because of the parameters. The significant medication errors were discussed with the Director of Nursing and the Nursing Home Administrator on [DATE] at 11:39 AM.
F 0770 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide timely, quality laboratory services/tests to meet the needs of residents.** **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 perform laboratory blood testing as ordered by the physician. This was evident for 1 (Resident #6) of 6 residents reviewed during a complaint survey. The findings include. A doctor analyzes the laboratory blood test to see if results fall within the normal range. The doctor may also compare the results to results from previous tests. Laboratory tests are often part of a routine checkup to look for changes in patient health. They also help doctors diagnose medical conditions, plan or evaluate treatments, and monitor diseases. Review of Resident #6's medical record on [DATE] at 8:44 AM revealed a physician's orders [REDACTED]. A CMP is a comprehensive metabolic panel which is a blood test that gives doctors information about the body's fluid balance, levels of electrolytes like sodium and potassium, and how well the kidneys and liver are working. Further review of physician's orders [REDACTED]. A CBC is a complete blood count which measures the red blood cells, white blood cells, platelets, hemoglobin and hematocrit in the blood. A CBC can also include measurements of chemicals and other substances in the blood. A phosphorus blood test is ordered because the [MEDICATION NAME] is absorbed through the intestines and is filtered and removed through the kidneys. Abnormal [MEDICATION NAME] levels may point to a kidney disorder. An interview was conducted with Resident #6's primary physician, Physician #8 on [DATE] at 3:02 PM. Physician #8 reviewed the paper medical record for Resident #6 and confirmed that the handwritten lab orders that she wrote and requested should have been done. Physician #8 stated, I wrote the order for the labs on 12/18/19 and 12/23/19 and I would have expected them to be done. The Director of Nursing was also present during the interview. Cross Reference F684
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, interviews and observations, it was determined the facility failed to maintain complete and accurate medical records in accordance with accepted professional standards as evidenced by: 1) nursing staff signing off on a Treatment Administration Record (TAR) that a weekly skin assessment was done when skin assessments were not found in the medical record, 2) failing to write a skilled nursing note at the time of the assessment and including vital signs that did not coordinate with the date of assessment, 3) documenting that a resident had [MED]gen on when the resident did not have [MED]gen, 4) inaccurate documentation of vital signs, 5) failing to document the insertion of a Foley catheter along with documenting a physician's orders [REDACTED]. This was evident for 1 (Resident #6) of 6 residents reviewed during a complaint survey. The findings include: 1) Review of Resident #6's medical record on [DATE] at 8:44 AM revealed a physician's orders [REDACTED]. Review of skin assessments in the electronic and paper medical record revealed a skin check was done on 12/21/19 and 12/28/19. There was no documented skin assessment for [DATE] and [DATE]20. Review of Resident #6's TAR revealed nurse's initials on [DATE] and [DATE]20 that indicated the skin assessment was done. An interview was conducted on [DATE] at 10:45 AM with Registered Nurse (RN) # 17. RN #17 stated that if there was an order for [REDACTED].#17 looked through the computer and she said she always does the skin assessments. She could not find the skin assessment dated [DATE] even though she signed it off as done on the January 2020 TAR. 2) Review of Resident #6's medical record on [DATE] at 9:30 AM revealed a 12/16/19 skilled note at 16:00 (4:00 PM) that was created on 12/17/19. The note had documented vital signs that were dated 12/17/19. The skilled nursing note used vital signs that were taken 24 hours after the observation and that did not pertain to the resident's current condition. The nursing note was written by LPN #7. A 12/18/19 at 20:09 (8:09 PM) nursing note by LPN #7 was created on 12/19/19 and vital signs documented in the skilled nursing note were dated 12/19/19, not 12/18/19 when the assessment was done. 3) Further review of Resident #6's medical record on [DATE] at 9:35 AM revealed a 12/18/19 at 7:40 AM progress note which documented, O2 ([MED]gen) via nasal cannula maintained. The resident did not have an order for [REDACTED].#6's family member. The family member stated that she was concerned about Resident #6's vital signs as the physician ordered vital signs every shift for 7 days after Resident #6 was admitted on [DATE]. The family member stated the nurse did not check on the resident every shift and take vital signs. Review of Resident #6's medical record was conducted on [DATE] at 1:10 PM. Review of the Medication Administration Record [REDACTED]. The vital signs which included blood pressure (b/p), temp (temperature), Pulse (heart rate) and resp (respirations) were documented. On [DATE] day shift and evening shift, all vital signs were the same; b/p 132/78, temp 98.1, pulse 72 and resp 18. On 12/16/19 the vital signs were the same on all 3 shifts; b/p 131/70, temp 98.1, pulse 68, resp 18. On 12/17/19 the vital signs were the same on all 3 shifts; b/p 117/89, temp 98.6, pulse 79, resp 18. On 12/19/19 the vital signs were the same on day and evening shift; b/p 91/62, temp 98.4, pulse 82, resp 18. On 12/20/19 the vital signs were the same on evening and night shift; b/p 117/63, temp 98.1, pulse 73 and resp 20. LPN #7's signature was the signature associated with the repeated, same vital sign readings. On [DATE] at 10:04 AM the surveyor reviewed the vital sign documentation with the Director of Nursing (DON). The DON stated that she agreed that the same vital sign numbers for all 3 shifts was not right and she agreed that vital sign readings should change every shift. On [DATE] at 3:02 PM Physician #8 was shown the vital sign documentation and asked if the vital sign readings would be the same every shift. Physician #8 stated she would not expect to see the same readings each shift. On [DATE] at 3:26 PM LPN # 7 was interviewed and stated he was in the resident's room more than 6 times per shift because the roommate kept putting the call light on. LPN #7 stated that anytime he goes in the vital signs were taken and he records them on a paper in the nurse's station. 4) Family Member #2 for Resident #6 stated during an interview on [DATE] at 11:07 AM that on 12/16/19 the nurse inserted a Foley catheter but wouldn't tell her how much urine was obtained and when she came in the next day the Foley catheter was gone. A Foley Catheter is an indwelling urinary catheter (tube) in the bladder that is a pliable catheter that drains urine from the bladder into a bag outside the body. A common reason to have an indwelling catheter is [MEDICAL CONDITION] (not being able to urinate). Review of Resident #6's medical record on [DATE] at 11:20 AM revealed a physician's note dated 12/17/19 which documented, the pt. (patient) was noted to be retaining urine overnight. Foley catheterization revealed 700

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215069	A. BUILDING _____ B. WING _____	03/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ORCHARD HILL REHABILITATION AND HEALTHCARE CENTER	111 WEST ROAD TOWSON, MD 21204

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 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) cc of urine. The physician's note continued, [MEDICAL CONDITION]: I will d/c (discontinue) Foley catheter. An interview was conducted on [DATE] at 12:00 PM with the DON. The DON was asked about the Foley catheter being inserted without documentation that it was inserted. The DON stated that there was no Foley catheter and the resident had a straight catheterization (cath) and that the family member must have misinterpreted the straight cath for a Foley catheter. An interview was conducted with LPN #7 on [DATE] at 3:26 PM with the DON present. LPN #7 was asked if he inserted a Foley catheter into Resident #6. LPN #7 stated that he did insert a Foley catheter and it was in for about 3 to 4 hours. LPN #7 stated that the on-call physician instructed him to do that. LPN #7 stated he wrote the order in the medical record. Continued review of the medical record on [DATE] at 3:30 PM failed to produce a physician's orders [REDACTED]. There was no documentation in the medical record from LPN #7 that he inserted a Foley catheter along with the size of the catheter, explanation to Resident #6 or any precautions taken after insertion of the catheter. 5) Review of Resident #6's medical record on [DATE] at 11:40 AM revealed a physician's orders [REDACTED]. (hours) x 3 days. If noted over 350 cc, do straight cath (catheterization). Review of Resident #6's December 2019 TAR documented nurse's initials from 12/17/19 at 1800 (6:00 PM) to 12/20/19 at 12:00 PM that the bladder scans were done. There was no volume of urine recorded on the TAR. Review of nursing notes revealed a 12/19/19 at 7:42 AM which documented urine output for 12:00 AM and 6:00 AM. A 12/20/19 at 7:06 AM nursing note documented, bladder scans checked as ordered with results ranging between 100 cc and 150 cc. A 12/20/19 at 18:01 (6:01 PM) nursing note documented, bladder scan as ordered, result 120 cc. There was no documentation of results of bladder scans on 12/17/19 at 6:00 PM, 12/18 at midnight, 6:00 AM, 12 noon and 6:00 PM, 12/19/19 at noon and 6:00 PM and 12/20/19 at noon. Review of the Bladder Scanner Utilization Policy that was given to the surveyor by the Director of Nursing on [DATE] at 12:00 PM revealed the documentation section which stated that the following information should be included in the resident's medical record, number 4, results of bladder scan i.e., volume of urine observed. On 03/05/2020 12: 00 PM the DON provided bladder scan documentation; however, the documentation was incomplete as it was not for all the days the bladder scan was ordered. The DON acknowledged the incomplete documentation. On [DATE] from 11:39 AM to 12:05 PM all concerns related to the medical records were discussed with the DON and Nursing Home Administrator.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interview with staff, it was determined that the facility staff failed to perform hand hygiene when providing care. This was found to be evident on 1 out of 4 nursing units during a walking tour of the facility. The findings include: 1) An observation of the [LOC] was conducted on [DATE] at 8:45 AM. Observation was made of Geriatric Nursing Assistant (GNA) #14 entering room [ROOM NUMBER], providing care and exiting without sanitizing her hands. GNA #14 was stopped prior to entering another resident's room and immediately interviewed. During the interview GNA #14 stated she was expected to perform hand hygiene before and after providing care. GNA #14 acknowledged she failed to sanitize her hands after exiting room # 316. 2) Observation was made on the [LOC] on [DATE] at 2:00 PM. Licensed Practical Nurse (LPN) #12 removed a cereal box and a carton of milk from a silver container located on top of the medication cart and entered room [ROOM NUMBER]. LPN #12 provided the cereal to a resident and exited the room without sanitizing his hands. LPN #12 returned to the silver container and retrieved another box of cereal. LPN #12 was stopped prior to re-entering room [ROOM NUMBER]. LPN #12 was immediately interviewed. During interview, LPN #12 stated he was expected to perform hand hygiene before and after providing care but did not sanitize his hands because the milk and cereal cartons were unopened. On [DATE] at 10:00 AM the Director of Nursing (DON) stated that she expected all staff to follow the facility hand hygiene policy. All staff were expected to perform hand hygiene before and after providing care or when entering and exiting a resident's room. The DON provided the facility's hand hygiene policy which stated under #2, All personnel shall follow the handwashing/ hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. Number 7b stated, before and after direct contact with residents.
F 0921 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** Based on observations and staff interview, it was determined that the facility failed to ensure that the building was odor and clutter free. The odor was identified in 1 of 4 nursing units (the 300 hallway) nursing unit and clutter was identified in 4 of 4 nursing unit hallways. The findings include: A tour of the facility was conducted on [DATE] at 8:40 AM. Observation was made of the Station 1 nursing unit along the side of the hallway of (3) wheelchairs, a cooler on wheels, a treatment cart, (2) food serving carts, a medication cart, a linen cart, a serving cart with an Igloo cooler and a vital sign machine. While on the unit observation was made of staff members having to turn sideways to get down the hallway between the items on the right side of the hallway and food carts on the left side of the hallway. Residents in wheelchairs had to wait in order to proceed down the hallway. Observation of the Station 2 nursing unit hallway, on the side of the hallway, was a medication cart, a rolling 4 shelf cart, a stool, a cooler, a 3-shelf cart with an Igloo cooler, a vital sign machine, a treatment cart, 2 Hoyer lifts, a wheelchair and a tray table with a bladder scanner on top. Observation of the Station 3 nursing unit hallway, on the side of the hallway, were 3 geriatric chairs, 9 wheelchairs, a cooler, a 3-shelf serving tray with an Igloo cooler, a vital sign machine and a Hoyer lift. During the tour of this hallway there was an odor, some type of stench that was not readily identified. Observation of the Station 4 nursing unit hallway, on the side of the hallway, were 2 Hoyer lifts, a wheelchair scale, a 3-shelf serving cart on wheels, a linen cart, a medication cart, a treatment cart, cooler and a 3-shelf serving tray with an Igloo. Subsequent walking rounds were done on the nursing unit hallways on [DATE] and [DATE] at 11:20 AM. While in the 300 nursing unit hallway the surveyor noticed the same odor that was detected on [DATE]. The Regional Director was informed, and he stated, on that hall it is where trash and laundry are located, and we have tried to remove that smell. The surveyor advised the smell was strong and he said he would have them clean it again. The clutter in the nursing unit hallways and the odor in the 300 nursing unit hallway was discussed with the Director of Nursing and the Nursing Home Administrator on [DATE] at 11:39 AM. The NHA stated the odor was from the soiled utility room and they have been addressing the issue.