STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215301	A. BUILDING _____ B. WING _____	09/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MANOR CARE HEALTH SERVICES - ROLAND PARK	4669 FALLS ROAD BALTIMORE, MD 21209

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview it was determined that the facility failed to immediately consult with the resident's physician and notify the resident's representative after a significant change in the resident's physical, mental or psychosocial status. This was evident for two out of five residents (#4 and #5). The findings include: 1. On 9/2/20 review of Resident #5's medical record revealed a 6/6/20 progress note which stated excoriation to buttocks has upgraded, supervisor made aware and present to take measurement photo of wound and obtaining new orders. The facility could not provide documentation that the physician or resident's representative was notified at that time. Resident #5's physician did not see the resident until 3 days later on 6/9/20 in a telemedicine (online) visit. On 9/3/20 at 11:15 AM the facility's 3 skin assessments for Resident #5 were reviewed. The first skin assessment dated [DATE] had the wound measured 10.8 x 4.6 with an area of 33 sq. cm. The second skin assessment dated [DATE] had the wound measured 4.8 x 7.3 with an area of 29.6 sq. cm. The final skin assessment dated [DATE] had the wound measured 10.3 cm x 10.3 cm with an area of 82.3 cm. In an interview with the resident's representative on 9/3/2020 at 9:30 AM it was revealed that Resident #5's representative was never notified of any wounds or excoriation while Resident #5 was in the facility. Resident #5's representative stated they were only made aware of the severity of the pressure ulcer when Resident #5 was transferred to another facility on 6/17/20. Interview with the Administrator and Director of Nursing (DON) on 9/3/2020 at 11:15 AM, they confirmed the facility could not provide documentation that the resident's representative or physician were informed of these changes to Resident #5's wound size. The Administrator and DON were made aware of these findings on 9/3/2020 at 3:00 PM. Cross reference F 686. 2. When Resident # 4 entered the facility 3/24/20 the family was made aware the resident had a wound behind the ear and on the buttocks. On 7/21/20 the family received a call from the facility that the resident had wounds everywhere on her body. A review of documentation in the residents chart revealed that the resident had several wounds. The wounds consisted of: -Left foot 5th toe Blister 0.7 x 0.8 no treatment per Dr. orders; -Left 4th toe -cleanse with normal saline apply calcium alginate and dry dressing every day shift Deep tissue injury; -Left medial ankle -cleanse with normal saline apply calcium alginate and dry dressing every day shift Unstageable 1.3 cm x 0.8 cm; -Left ear - cleanse with normal saline apply calcium alginate and cover with dry dressing every day shift Stage 20.6x0.5cm -Left upper buttock cleanse with normal apply calcium alginate and cover with boarder dressing every day shift (Resolved); -Right ear - cleanse with normal saline apply calcium alginate and cover with dry dressing every day shift stage 2 not measurable (Resolved); -Right lateral ankle - cleanse with normal saline apply calcium alginate and dry dressing every day shift; Blister 0.7 x 1.1; -Sacrum -cleanse with [MEDICAL CONDITION]% solution pack wound with moist gauze soaked in hysept solution and cover with boarder dressing every day shift. Unstageable 7.2.cm x 6.3 Cm x2.0cm undermining 2.0 -Left Trochanter deep tissue injury 2.5 cm x 2.5 cm. After reviewing all the documentation, the facility could not confirm that that the responsible party was notified of all the wound that existed. The Director of Nursing and Administrator were made aware of this finding prior to the survey exit.
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.** Based on documentation review, the facility failed to start a Care Plan or revise a care plan with interventions for a Resident (#4) that had 9 falls while at the facility. This was evident for 1 out of 5 residents reviewed. The findings include: 1. Resident #4 entered the facility in March of 2020 with a history of falls. The resident's family had placed a sign on the door stating resident at risk for falls. Record review done on 9/4/20 at 9:00 AM revealed the resident had nine falls while residing at the facility. Resident #4's medical record documented falls on the following dates: 7/29/19, 9/23/19, 11/3/19, 11/17/19, 12/3/19, 12/6/19, 12/29/19, 1/1/20, 2/16/20. Review of resident #4's care plans revealed a care plan dated 4/14/20 with the following intervention: bed in low position. The care plan also documented the following: report development of pain, bruises, change in mental status, ADL function, appetite, or neurological status per facility guidelines post fall There were no other interventions noted related to falls. The Administrator and Director of Nursing were made aware of these finding prior to survey exit.
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 that the facility failed to provide treatment and care in accordance with professional standards of practice. This was evident for two out of five residents (#4 and #5). The findings include: On 9/2/20 at 12:00 PM review of Resident #5's physician orders [REDACTED]. Z guard is a skin protectant paste used to protect skin from irritation and seal out moisture. Resident #5's electronic Treatment Administration Record (eTAR) for May 2020 revealed that Z guard was not applied as ordered on [DATE] for the 3-11 pm shift or the 11-7 shift. Further review of June 2020's eTAR revealed that Z guard was not applied as ordered on [DATE] during the 3-11pm shift. Further review of Resident #5's medical record revealed documentation of a telemedicine visit from 6/9/20 where Resident #5's physician wrote skin - coccyx - 10.8 x 4.6 x 0.2 cm - stage IV under the Physical Exam section. Further down on the telemedicine visit under the Plan section the physician wrote Patient has developed stage IV ulcer on the coccyx. Continue wound care apply central dressing. Continue nutritional support change of position. Prosource (protein supplement) 30 mL twice a day. Wound consult. Review of Resident #5's orders revealed that the order for Prosource 30 mL twice a day was not ordered until 6/17/20, eight days after Resident #5's telemedicine visit. Further review of Resident #5's electronic Medication Administration Record [REDACTED]. The Administrator and Director of Nursing were made aware of these findings on 9/3/2020 at 3:00 PM. Cross reference F 686. 2. Review of complaint MD 392 on 9/4/20 revealed allegations that Resident #4's family member had expressed concerns about the resident's hand that was beginning to get contracted. The concerns were expressed to the facility's former Administrator. The family member requested a rolled up sock be placed in the resident's hand, but was told by the former Administrator this was not possible, however a carrot (therapeutic device) could be used. Review of the resident's medical

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

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F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) record failed to reveal documentation of a care plan or referral to physical therapy to evaluate Resident #4 for the use of a carrot. The facility's former Administrator was onsite in the facility on 9/4/2020 and acknowledged that he/she was aware of the request and remembered stating no to rolled up sock, but that a carrot could be placed. The current Administrator was made aware of this concern.
F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview and resident representative interview it was determined that the facility failed to provide necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This was evident for 1 of 5 residents (#5). This failure resulted in actual harm to Resident #5. The findings include: On 9/2/20 an investigation of complaint MD 332 was conducted in regard to allegations of a worsening pressure ulcer for Resident #5. Review of Resident #5's medical records at 11:54 AM on 9/2/20 revealed that Resident #5 was admitted to the facility on [DATE] with a wound described on the facility's admission paperwork as excoriation on the sacrum. An excoriation is an abrasion on the skin usually only involving the epidermis or top layer of the skin. Resident #5's [DIAGNOSES REDACTED]. Further review of the record revealed that Resident #5 had a Percutaneous Endoscopic Gastronomy (PEG) which is a medical procedure where a tube (PEG tube) is passed through the patient's abdominal wall and into their stomach to provide a means of feeding when oral intake is not sufficient. These [DIAGNOSES REDACTED].#5 at higher risk of developing pressure ulcers. Upon admission on 5/27/20 the facility completed a Braden Scale for Predicting Pressure Sore Risk which is a tool used to assess a resident's risk for developing pressure ulcers. Resident #5 was assessed as a 13.0 out of 18.0 which is a Moderate Risk. On 9/2/20 at 12:00 PM review of Resident #5's orders revealed a physician's orders [REDACTED]. Z guard is a skin protectant paste used to protect skin from irritation and seal out moisture. Resident #5's electronic Treatment Administration Record (eTAR) for May 2020 revealed that Z guard was not applied as ordered on [DATE] for the 3-11 pm shift or the 11-7 shift. Further review of June 2020's eTAR revealed that Z guard was not applied as ordered on [DATE] during the 3-11pm shift. Further review of Resident #5's medical record revealed a 6/6/20 progress note which stated excoriation to buttocks has upgraded, supervisor made aware and present to take measurement photo of wound and obtaining new orders. The facility could not provide documentation that the physician or resident's representative was notified. The skin assessment dated [DATE] had the wound measured 10.8 x 4.6 with an area of 33 sq. cm. The next physician visit was via telemedicine (online) on 6/9/20 where Resident #5's physician wrote skin - coccyx - 10.8 x 4.6 x 0.2 cm - stage IV under the Physical Exam section. Further down on the telemedicine visit under the Plan section the physician wrote Patient has developed stage IV ulcer on the coccyx. Continue wound care apply central dressing. Continue nutritional support change of position. Prosource (protein supplement) 30 mL twice a day. Wound consult. The skin assessment dated [DATE] had the wound measured 4.8 x 7.3 with an area of 29.6 sq. cm The skin assessment dated [DATE] had the wound measured 10.3 cm x 10.3 cm with an area of 82.3 cm. Review of Resident #5's orders revealed that the order for Prosource 30 mL twice a day was not ordered until 6/17/20, eight days after Resident #5's telemedicine visit. Further review of Resident #5's electronic Medication Administration Record [REDACTED]. On 9/3/20 at 10:00 AM the Director of Nursing (DON) provided a wound consult dated 6/12/20, three days after the physician's telemedicine visit. The DON confirmed at this time that the wound consult on 6/12/20 was the only time Resident #5 was seen by the facility's wound physician. Further review of the wound consult dated 6/12/20 revealed the wound was referred to as Unstageable (due to necrosis) sacrum. Wound size was noted to be 5 x 8 x Not Measurable cm. At 11:15 AM on 9/3/2020 the facility's 3 skin assessments for Resident #5 were reviewed. These skin assessments showed an increase in size of 33 square cm to 82.3 square cm from 6/6/20 to 6/17/20 when Resident #5 was discharged per their representative's request. The Administrator and DON were made aware of these findings on 9/3/2020 at 3:00 PM. Cross reference F 580 and F 684.
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 record review and staff interview it was determined the facility failed to maintain complete medical records on each resident and provide vital documentation in the medical record. This was evident for 2 of 5 residents reviewed (#1 and #5). The findings include: 1. On 9/2/2020 Resident #5's physical medical record was reviewed. Within the chart were telemedicine visits (virtual appointments) between Resident #5 and their physician. These telemedicine visits were not found in Resident #5's electronic medical record. Interview with the Administrator and Director of Nursing on 9/3/20 at 10:00 AM confirmed that these telemedicine visits were missing from the resident's electronic record. On 9/3/20 at 10:00 AM the Director of Nursing (DON) provided a wound consult dated 6/12/20, for Resident #5. The 6/12/20 wound consult was not present in the resident's paper chart or electronic chart. Interview with the DON at this time confirmed that the facility had to log on to the outside wound consult's website to access the records and that they were not present in the resident's records. The Administrator and DON were made aware of these findings on 9/3/2020 at 3:00 PM. 2. Review of facility reported incident MD 030 on 9/2/20 at 9 AM revealed allegations from Resident #1 about mistreatment from a geriatric nursing assistant of the facility on 7/9/20. Review of Resident #1's medical record failed to reveal the allegations or made or documentation of a complaint/grievance. The only documentation found in the chart was from the social worker on 7/10/20 that stated resident felt safe in the facility. There was a note from nursing that stated the following: Resident alert and oriented x 3. No respiratory noted. C/O headache and aching chronic pain to the left leg, 5/10 on pain scale. Given [MEDICATION NAME] 10 ml which was effective. No bruising nor skin alteration noted to body. Bio-freeze gel applied to lower back as ordered for chronic back pain. [DEVICE] patent, no residual. Ate all dinner. Tolerated all medication via [DEVICE]. Assisted with turning and repositioning. Call bell, telephone, and remote within reach. Bed in low position. There was also a note that stated the resident was transferred to the ER per family request and that his/her physician and family were aware.