STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215262	A. BUILDING _____ B. WING _____	07/15/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RESORTS AT CHESTER RIVER MANOR CORP	200 MORGNEC ROAD CHESTERTOWN, MD 21620

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 0626 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interviews, it was determined that the facility failed to notify the resident and/or responsible party orally and in writing of a the facility's decision to not to allow a Resident (#1) to return to the facility after a brief emergency room visit. The facility did not provide a reason or allow the resident and/or responsible party the ability to appeal the discharge decision. This was evident for 1 of 3 residents reviewed for discharges. The findings include: A review of Resident #1's medical record on 7-14-2020 at 9:30 AM revealed Resident #1 was admitted to the facility on [DATE] to receive Physical and Occupational therapy, nursing care and in facility [MEDICAL TREATMENT]. Due to a clogged [MEDICAL TREATMENT] access catheter on 4-22-2020 Resident #1 was transported to the local hospital emergency room at 12:30 PM for a procedure to remove the blockage. The local hospital was unable to complete the procedure and made arrangements at another hospital to replace the [MEDICAL TREATMENT] access port on 4-23-2020 between 10:00 AM and 2:00 PM. Resident #1 was stable and the local hospital emergency room called The Resorts at(NAME)River Manor to return Resident #1 to her room until he/she was transported on 4-23-2020 for the same day procedure at another hospital. An interview with the local hospital emergency room Nursing Supervisor (ER Supervisor) and emergency room medical records review on 7-13-2020 at 2:45 PM revealed at 4:45 PM on 4-22-2020 the ER Supervisor was told by Resident #1's hospital nurse that the facility's Admission Director #13 (AD #13) said that the facility was unable to take the resident back. The ER Supervisor tried to to speak with AD #13 but they had hung up the telephone. The ER Supervisor tried twice to call AD #13 but with no answer. AD #13 called back and told the ER Supervisor that he/she had been on the telephone with the facility's billing department and Resident #1 was not allowed back due to a lack of a payer source. AD #13 said the Director of Nursing (DON) and the Administrator (NHA) had left for the day. AD #13 provided the ER Supervisor with the Administrator's phone number but the Administrator never returned the calls. Resident #1's Responsible Party (RP) was called by the ER Supervisor to come and get Resident #1. The RP explained that due to Resident #1's inability to walk and being dependent on the facility's staff for all care he/she could not come home with the RP. The local hospital ER admitted Resident #1 for the night and arranged the transport for the procedure on 4-23-2020 at another hospital. Interview with Resident #1 on 7-14-2020 at 9:18 AM via phone revealed he/she was at home. When asked about the night of 4-22-2020, he/she said, I don't remember much of the night of 4-22-2020. I was on a lot of meds (medications), fuzzy but I remember no one came to pick me up, I didn't get dinner, they got me crackers, no one came for me. Interview with Admission Director #13 (AD #13) on 7-15-2020 at 8:54 AM revealed that on the evening of 4-22-2020 he/she was unable to return the ER Supervisors' calls at first due to speaking the the facility's Vice President of Marketing and one of the facility's owners (Staff #15). Both individual's told AD #13 to refuse Resident #1 returning to the facility due to no payer source. AD #13 said he/she could not tell the hospital that the facility refused to take Resident #1 back so the Vice President of Marketing called the hospital and refused the return admission. Interviews with Staff #5 of Business Development on 7-13-2020 at 12:10 PM, Staff #10 of Minimum Data Set (MDS) on 7-13-2020 at 1:05 PM, Ombudsman #12 on 7-14-2020 at 9:49 AM, Director of Nursing (DON) on 7-13-2020 at 12:55 PM, Staff #3 of Quality of Life on 7-13-2020 at 12:25 PM and Physician #9 on 7-13-2020 at 3:00 PM revealed Resident #1 had a payer source but the private insurance source required authorizations and made the process difficult. Physician #9 made many peer to peer discussions with the insurance company to obtain the required authorizations. The facility failed to allow Resident #1 to return to the facility on [DATE], failed to provide Resident #1 and/or the RP with notification of discharge, and failed to provide with the ability to appeal. The above was confirmed with the DON at the exit conference on 7-15-2020 at 1:30 PM.
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.** Based on medical record review, observation and interview it was determined the facility staff failed to maintain the medical record in the most accurate form as possible for a resident (Resident #1). This was evident for 1 of 3 residents selected for review in this survey. The findings include: A medical record is the official documentation for a healthcare organization. As such, it must be maintained in a manner that follows applicable regulations, accreditation standards, professional practice standards, and legal standards. All entries to the record should be legible and accurate. A review of Resident #1's written medical record on 7-13-2020 at 3:00 PM revealed the Physician dictated progress notes for 4-30-2020, 5-4-2020, 5-7-2020, 5-10-2020, 5-14-2020, 5-24-2020, 5-28-2020, 6-1-2020, 6-4-2020, 6-8-2020, and 6-11-2020 were not in the medical record. Two progress notes from May 2020 with illegible dates were also not in the medical record. Interview with Physician #9 on 7-13-2020 at 3:25 PM revealed that he/she writes the dates of the visits in the progress notes and then the medical records clerk who has access to Physician #9's computer program is supposed to print off the dictated progress notes. The dictated progress notes are then placed in the medical record. The Director of Nursing and Physician #9 on 7-13-2020 at 3:30 PM confirmed this process was not occurring and the dictated progress notes were not in Resident #1's medical record.

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