STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215323	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CRESCENT CITIES NURSING & REHABILITATION CENTER	4409 EAST WEST HIGHWAY RIVERDALE, MD 20737

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 review of resident medical records and interview with facility staff, it was determined that the facility failed to ensure that a resident's attending physician was notified of aggressive and exit seeking behaviors exhibited by a resident with a [DIAGNOSES REDACTED].#1) of 1 resident reviewed during the survey. The findings include: Resident #1's medical record was reviewed on 7/10/20 at 1:10 PM. During the review, it was noted that the resident was admitted to the facility in mid March, 2020 with a [DIAGNOSES REDACTED]. A wandering assessment was found that had been completed on 3/17/20 and indicated that the resident was at low risk for elopement. A nursing note written by Licensed Practical Nurse (LPN) #4 on 4/7/20 was found that stated, (Resident #1) eloped the nursing home building (on 4/6/20) at about 4:50 PM stated s/he was going home. 911 was called and s/he was brought back into the facility by a police officer and was stable. Review of the resident's care plan revealed that an additional focus was initiated for Resident #1 on 4/8/20. The new focus stated, Mr. (NAME REDACTED) will not leave the facility unattended through 90 days, and listed interventions to be taken by staff to reduce distress associated with wandering and to reduce the risk of elopement. A follow up wandering assessment was found that had been completed on 4/18/20 in which it was marked that Resident #1 cannot follow instructions . has a history of wandering . has wandered within the home without leaving the grounds . has wandered in the past month. The wandering assessment concluded that the resident was at a high risk to wander. There was no nursing note or assessment that indicated the resident's attending physician had been notified of the elopement on 4/6/20. The Director of Nursing (DON) was interviewed on 7/13/20 at 2:07 PM. During the interview, the DON indicated that, on 4/6/20 around 5:00 PM, Resident #1 attempted to leave the facility, making it as far as the facility's parking lot before being redirected by the DON and returning to the facility. The DON stated that the resident was cursing, violent, and saying that s/he was going home. The DON also stated that the facility utilizes wanderguards, devices that are worn by wandering residents and alarm when the resident approaches an exit to the facility. When asked if the episode described by the DON indicated the resident would benefit from a wanderguard, the DON stated yes, s/he sounds like the kind of person who would benefit. The Medical Director was interviewed on 7/13/20 at 3:10 PM. During the interview, the Medical Director confirmed that he was also the attending physician for Resident #1. The Medical Director stated that he did not recall the resident being disoriented or exhibiting behaviors that would place the resident at risk, such as wandering or aggressive behavior. The Medical Director said that he did not recall being notified of a time when the resident had left the building. Nurse Practitioner (NP) #5 was interviewed on 7/14/20 at 1:05 PM. During the interview, NP #5 indicated that she had provided care for Resident #1 as a physician extender for the Medical Director. NP #5 indicated that she would receive updates about the resident on days that she saw the resident and would be available to see the resident if she was in the building at the time a change of condition occurred. NP #5 also stated that she recalled that the resident would wander from one side of his/her unit to the other and to express an interest in going home but that NP #5 never considered Resident #1 to be an elopement risk. When asked if she had ever been told that Resident #1 had left the building without supervision, NP #5 stated, No. NP #5 also indicated that she had never been told of the events of 4/6/20.
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 review of resident medical records and interview with facility staff, it was determined that the facility failed to ensure that Resident #1's medical record was complete, accurate, and reflected the resident's total program of care. This was evident for 1 of 1 resident reviewed during the complaint survey. The findings include: Resident #1's medical record was reviewed on 7/10/20 at 1:10 PM. During the review, it was noted that the resident was admitted to the facility in mid March, 2020 with a [DIAGNOSES REDACTED]. Further review of the resident's medical record revealed [REDACTED]. The wandering assessment documented that the resident did not have a [DIAGNOSES REDACTED]. A nursing note written by Licensed Practical Nurse (LPN) #4 on 4/7/20 was found during the same medical record review that stated, (Resident #1) eloped from the nursing home building (on 4/6/20) at about 4:50 PM stated s/he was going home. 911 was called and s/he was brought back into the facility by a police officer and was stable. The Director of Nursing (DON) was interviewed on 7/13/20 at 2:07 PM. During the interview, the DON indicated that, on 4/6/20 around 5:00 PM, Resident #1 attempted to leave the facility, making it as far as the facility's parking lot before being redirected by the DON and returning to the facility. The DON stated that the resident was cursing, violent, and saying that s/he was going home. The DON also indicated that the nursing note written about the event was inaccurate but that it had already been written and shouldn't be changed. During the medical record review that took place on 7/10/20 at 1:10 PM, a note written by LPN #8 was found with a date of 4/24/20 at 1:20 PM that stated, Resident (leaving) against physician advice, voluntarily discharge himself/herself from the center. Signed the papers. Patient was alert and responsive, able to make needs known. LPN #8 was interviewed on 7/14/20 at 9:42 AM. during the interview, LPN #8 indicated that she had called the Administrator, the Director of Nursing, and the Medical Director (who was serving as Resident #1's attending physician) prior to proceding with Resident #1 leaving against medical advice. LPN #8 could not explain why this additional information was not part of the medical record. LPN #8 further indicated that the Medical Director stated on the phone call that if Resident #1 was able to leave, that s/he should not be held against his/her will. LPN #8 stated that the Assistant Director of Nursing was present for this phone call. During an interview that took place on 7/13/20 at 3:10 PM, the Medical Director stated that it was very likely that he had been called on the day of Resident #1's discharge from the facility against medical advice, but that he could not specifcally recall it.

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.