STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215232	A. BUILDING _____ B. WING _____	09/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OAKLAND NURSING & REHABILITATION CENTER	**706 EAST ALDER STREET OAKLAND, MD 21550**

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 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 record review and staff interview, it was determined that facility staff failed to develop and initiate a care plan for potential for elopement/wandering and for the use of TED stockings. This was evident for 2 (#3, #5) of 25 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's care. 1) On 9/8/2020 at 1:08 PM, a review of Resident #3's medical record revealed the resident was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. A 7/13/19 at 12:55 AM nursing note documented the resident stated, I'm leaving. A 7/13/19 at 5:40 AM nursing note documented that the resident was found multiple times ambulating without a walker or wheelchair and had required one on one staff monitoring throughout the shift. On 7/15/19 at 2:34 AM, the nursing note documented the resident was tearful and stated he/she wanted to go home. On 7/19/19 at 5:54 AM, it was documented that the resident had been up all night, was crying and wanted to go to his/her brother and sister's house. On 7/21/19 at 12:28 AM, it was documented that the resident wanted to call the police to take him/her to his/her apartment. On 7/21/2019 at 2:15 PM, a written statement from an investigation documented that the resident was seen out front of the facility on the front sidewalk and would not come back inside the facility. Review of the baseline care plan and admission care plan failed to reveal a care plan for wandering and elopement risk. Discussed with the Director of Nursing on 9/10/2020 at 10:45 AM. 2) On 9/8/2020 at 3:00 PM, observation was made of Resident #5 sitting in a wheelchair in the resident's room. The resident was wearing white crew socks with black shoes. A second observation of Resident #5 was made on 9/9/2020 at 8:43 AM. Resident #5 was sitting in a wheelchair and was wearing gray slipper socks and TED hose on the left leg. A third observation was made of Resident #5 on 9/10/2020 at 12:45 PM sitting in a wheelchair shoes with white crew socks. Review of Resident #5's medical record on 9/9/2020 at 9:15 AM revealed a physician's orders [REDACTED]. Ted ([MEDICAL CONDITION]-[MEDICAL CONDITION] Deterrent) stockings are also known as compression stockings or anti-embolism stockings. They help reduce the risk of developing a [MEDICAL CONDITIONS] or blood clot and help reduce the risk of swelling. Review of the care plan, needs assist with ADLs (activity of daily living) did not have the intervention about putting TED stockings on. There was no care plan for Resident #5 that mentioned TED stockings.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** Based on medical record and facility documentation review and staff interview, it was determined the facility staff failed to review and revise the interdisciplinary care plans to reveal accurate interventions. This was evident for 1 (#21) of 25 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's care. Review of facility incident report MD 287 on 9/9/2020 at 3:00 PM revealed that Resident #21 had received toileting assistance on 11/30/18 and felt that Staff #4, a geriatric nursing assistant (GNA), was rushed and sat Resident #21 down abruptly, causing pain to the rib area. It was documented that the resident stated that the GNA was using the gait belt to pivot transfer the resident. A written statement from Staff #4 documented that she took the resident to the bathroom and used a gait belt to assist him/her. 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. Review of the MDS wi,th an assessment reference date of 11/29/18 revealed documentation that Resident #21 required extensive assistance with 2+ staff for transfers. Review of the care plan at risk for falls and injuries had the intervention that was initiated on 6/7/18, extensive assist of 2 with transfer and ambulation as needed. The care plan was not followed. On 9/10/2020 at 9:55 AM, an interview with the Director of Nursing (DON) revealed the resident was able to transfer with 1 assist. The DON stated the resident was in therapy and the care plan should have been updated. The DON provided the surveyor with therapy notes on 9/10/2020 at 10:27 AM which documented the resident was minimal assist.
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 observation, medical record review, and staff interview, it was determined the facility failed to follow a physician's ordered treatment by failing to place TED stockings on a resident every morning. This was evident for 1 (#5) of 25 residents reviewed during a complaint survey. The findings include: Observation was made on 9/8/2020 at 3:00 PM of Resident #5 sitting in a wheelchair in the resident's room. The resident was wearing white crew socks with black shoes. A second observation of Resident #5 was made on 9/9/2020 at 8:43 AM. Resident #5 was sitting in a wheelchair and was wearing gray slipper socks with a TED stocking on the left leg. A third observation was made of Resident #5 on 9/10/2020 at 12:45 PM. Resident #5 was sitting in a wheelchair wearing black shoes and white crew socks. Record review on 9/9/2020 at 9:15 AM revealed a physician's order written on 12/13/18 which stated, Ted Hose stockings to be worn during day and removed at night. Ted ([MEDICAL CONDITION]-[MEDICAL CONDITION] Deterrent) stockings are also known as compression stockings or anti-embolism stockings. They help reduce the risk of developing a [MEDICAL CONDITIONS] or blood clot and help reduce the risk of swelling. Review of the care plan, needs assist with ADLs (activity of daily living) did not have the intervention about putting TED stockings on. There was no care plan for Resident #5 that mentioned TED stockings. On 9/10/2020 at 12:50, PM Staff #5 was interviewed and asked if the resident wore TED stockings and she stated, if you can find them. The nurse usually keeps them. Today we couldn't find them. Staff #5 stated that she did not have the resident today, that Staff #6 was assigned to Resident #5. On 9/10/2020 at 12:55 PM, Staff #6 was interviewed about the TED stockings and she stated, he is not wearing them today because we couldn't find them, and we were busy. He is supposed to wear everyday if we have time. On 9/10/2020 at 1:20 PM, the Director of Nursing (DON), who was working the medication cart because a staff member was sent home sick, was asked where it would be documented that a resident wore TED stockings. The DON stated it would be under ADLs. The DON looked at Resident #5's Treatment Administration Record (TAR) and it was not there. There was nowhere in the

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) medical record that TED stockings were signed off as administered per the physician's orders. The DON looked and said when the order was put in the system it was put under ADL, which was not the correct place to put the order for it to be signed off.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility investigation documentation, medical records and interview, it was determined the facility failed to prevent a resident with cognitive impairment from walking out the front door. The facility failed to properly assess that the resident was at risk for wandering and failed to initiate a care plan for wandering and potential elopement. This was evident for 1 (#3) of 2 residents reviewed for elopement/wandering during a complaint survey. The findings include: Review of Resident #3's medical record on 9/8/2020 at 1:08 PM revealed that the resident was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. 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. Resident #3's admission MDS, with an assessment reference date of 7/11/19, documented that the resident's BIMS score was 8. The BIMS (Brief Interview of Mental Status) test is used to get a snapshot of how well someone is functioning cognitively at that time. A score of 13 to 15 indicates intact cognition. A score of 8 to 12 indicates moderate impaired cognition and a score of 0 to 7 indicates severely impaired cognition. Resident #3's cognition state was moderately impaired. Further review of Resident #3's medical record revealed that an elopement risk assessment was initiated on 7/4/19 by a Licensed Practical Nurse (LPN) Staff #3. The elopement risk assessment revealed documentation that the resident was not alert and oriented to person, place and time. The resident was not aware of his/her surroundings and was confused. It documented that the resident did not have safe decision-making capabilities and that the resident did express a desire to leave the health care center. The final statement on the assessment documented that the resident did have a [DIAGNOSES REDACTED]. The elopement risk assessment was incomplete. Nursing notes revealed a note, dated 7/11/19 at 7:17 AM, that documented Resident #3 was alert and oriented to person, was more confused and wanted to leave to go home. A 7/13/19 at 12:55 AM nursing note revealed that the resident stated, I'm leaving. A 7/13/19 at 5:40 AM nursing note documented that the resident was found multiple times ambulating without a walker or wheelchair and had required one on one staff monitoring throughout the shift. On 7/15/19 at 2:34 AM, the nursing note indicated the resident was tearful and stated he/she wanted to go home. On 7/19/19 at 5:54 AM, it was written that the resident had been up all night, was crying and wanted to go to his/her brother and sister's house. On 7/21/19 at 12:28 AM, it was documented that the resident wanted to call the police to take him/her to his/her apartment. On 7/21/2019 at 2:15 PM, a written statement from an investigation documented that the resident was seen out front of the facility on the front sidewalk and would not come back inside the facility. Review of the baseline care plan that was completed on 7/12/19 failed to state that the resident was at risk for elopement. Further review of care plans after the elopement on 7/21/19 failed to produce a wandering/elopement care plan. Review of facility documentation revealed the resident was escorted back into the facility and the resident was moved to the secure unit. An interview was conducted with the Director of Nursing on 9/10/2020 at 10:45 AM who stated that the receptionist was new at the time, but did follow the resident outside and surveyor discussed with DON the lack of a complete elopement risk assessment, along with the failure to implement a care plan.
F 0804 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.** Based on review of complaints MD 309, MD 235, MD 180, resident interviews, resident council meeting minutes, temperature logs and observations of the kitchen services with the testing of a food tray, it was determined that the facility failed to serve food at a preferable/palatable temperature and failed to consistently monitor temperatures of food for 6 months. This was evident for 2 of 2 family interviews and 4 of 5 residents interviewed with the deficient practice having the potential to affect all residents. The findings include. 1) An interview was conducted with family member (FM) #1 on 9/8/2020 at 2:18 PM who stated concern about the temperature of the food served to the residents. 2) An interview was conducted with FM #2 on 9/8/2020 at 2:27 PM. FM #2 stated he was concerned about the quality of the meals and that the meals were not served at the proper temperature, that most meals were cold and not up to the appropriate temperature. 3) On 9/8/2020 at 3:00 PM, an interview was conducted with Resident #6. The resident was asked about the food and he/she stated the food was just alright, it could be a little warmer. 4) On 9/8/2020 at 3:05 PM, Resident #7 was asked about the food and stated it was seldom warm and he/she tolerated it. 5) On 9/8/2020 at 3:07 PM, Resident #8 stated the food was sometimes cold. When asked if they would reheat it, the resident stated that he/she had never asked for it to be reheated, that it was tolerable. 6) On 9/10/2020 at 12:40 PM, Resident #25 was asked about the food. Resident #25 stated the French fries were cold the other night. The coffee at lunch and dinner is lukewarm. Resident #25 would like to have fresh fruit in season instead of canned fruit. Resident #25 stated the food has good days and bad days and is chilly most of the time. Resident #25 stated, today was the best meal, normally not good. 7) On 9/10/2020 at 12:48 PM, Staff #7 was asked if any of the residents complained about the food and Staff #7 stated that breakfast was harder to keep warm. 8) On 9//9/2020 at 12:50 PM, with Staff #8, a test tray was checked for appropriate temperatures. The Italian green beans were 103.5 Fahrenheit (F). Staff #8 stated they are usually around 120 F. The sunshine pears were 65.3 F. Staff #8 stated they should have been around 34 to 36 F. The Spanish rice was 129.7 F, the pork loin 125.5 F, hard boiled eggs 102 F, coffee 118 F and the milk was 58 F. Staff #8 said the milk was warm because it was in the cart with the hot food. Staff #8 stated they have improved on the plate temperatures. Staff #8 stated, once in the cart it is out of our control. 9) Review of Nutrition Policies and Procedures: Safe Food Temperatures, #6 stated, Hold hot foods at 135 F or higher during meal service (on the tray line). Hold cold foods at 40 F or lower during meal service (on the tray line) Maintain and serve hot beverages at 135 F or higher. Number 8 stated, Monitor food temperatures at point of service to the patient/resident. 10) Review of resident council meeting minutes for 2/5/2020 revealed that meals were getting better at coming on time. Glass plates and warmers were in use at the time. Resident stated they were disappointed with the meal served for supper last evening 2/4/2020. The 3/4/2020 minutes documented that resident stated that food has been OK, and they have no complaints other than their hot chocolate is cold. The 7/1/2020 minute meeting notes documented a few dietary issues/preferences of other juices, hot tea for meals and one stated that her vegetables and coffee were cold. The 8/5/2020 meeting notes documented, issues from last month was resolved except coffee is cold at times and (name) stated that the bread sticks are hard when they are served. 11) Temperature logs of food during preparation in the kitchen revealed widespread noncompliance with taking temperatures during food preparation. A review of the temperature logs from 2/2/2020 through 9/6/2020 was done on 9/9/2020 at 3:00 PM and revealed the following findings: week of 2/2/2020: no beverage temperatures for 19 of 21 meals. week of 2/16/2020: no beverage temperatures for 19 of 21 meals, no lunch temperatures for 2 of 7 meals and no dinner temperatures for 3 of 7 meals. week of 2/23/2020: no beverage temperatures for 18 of 21 meals, no lunch temperatures for 1 of 7 meals and no dinner temperatures for 2 of 7 meals. week of 3/1/2020: no beverage temperatures for 11 of 21 meals, no dinner temperatures for 5 of 7 meals. week of 3/8/2020: no beverage temperatures for 11 of 21 meals, no lunch temperatures for 1 of 7 meals and no dinner temperatures for 2 of 7 meals. week of 3/15/2020: no beverage temperatures for 20 of 21 meals, no lunch temperatures for 3 of 7 meals and no dinner temperatures for 5 of 7 meals. week of 3/22/2020: there were no temperatures taken on any food Sunday 3/22 or Monday 3/23 and no temperatures taken Saturday 3/28 for the lunch and dinner meals. week of 3/29/2020: There were no temperatures taken from Sunday dinner 3/29 until Friday 4/3 breakfast, and no temperatures taken Friday 4/3 dinner and Saturday 4/4 dinner. week of 4/5/2020: no beverage temperatures take for 11 of 21 meals and for 4 of 7 dinner meals. week of 4/12/2020: no beverage temperatures for 10 of 21 meals, no lunch temperatures for 1 of 7 meals and no dinner temperatures for 4 of 7 dinners. week of 4/19/2020: no beverage temperatures for 18 of 21 meals and 4 of 7 dinner meals. week of 4/26/2020: no beverage temperatures for 21 of 21 meals, no temperatures of any meal from 4/28 thru 4/30, no dinner meal temperatures were taken for the entire week. week of 5/3/2020: no beverage temperatures for 21 of 21 meals, no temperatures for 2 of 7 lunches and 7 of 7 dinners. week of 5/10/2020: no temperatures on 5/13 or 5/14, no beverage temperatures for 19 of 21 meals and no temperatures for 3 of 7 lunches and 6 of 7 dinners. week of 5/17/2020: no beverage temperatures for 11 of 21 meals and no temperatures for 6 of 7 dinners. week of 5/24/2020: no beverage temperatures for 13 of 21 meals, and no temperatures for 2 of 7 lunches and 6 of 7 dinners. week of 5/31/2020: no beverage temperatures for 11

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F 0804 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 2) of 21 meals, and no temperatures for 1 of 7 lunches and 6 of 7 dinners. Week of 6/7/2020: no beverage temperatures for 7 of 21 meals and no temperatures for 7 of 7 dinners. Week of 6/14/2020: no beverage temperatures for 9 of 21 meals and no temperatures for 3 of 7 dinners, lunches and breakfast. Week of 6/21/2020: no temperatures taken from 6/22 to 6/25 at dinner, and no temperatures taken 6/26 or 6/27 for dinner. Week of 6/28/2020: no temperatures taken 7/2, 7/3 or 7/4, and no beverage or dessert temperatures taken all week. Week of 7/5/2020: no dinner temperatures for 7 of 7 meals and no dessert or beverage temperatures taken all week. Week of 7/12/2020: no dinner temperatures for 7 of 7 meals, no dessert or beverage temperatures taken all week and no temperatures taken on 7/17 and 7/18 of any meal. Week of 7/19: no temperature logs were given to the surveyor Week of 7/26/2020: no dessert or beverage temperatures were taken for any meal, no temperatures for 6 of 7 dinners, and no temperatures were taken on 8/1. Week of 8/1: there were no temperatures taken the entire week except for dinner on 8/7. Week of 8/8: there were no temperatures taken for the week except 8/15. For the weeks of 8/16, 8/23, 8/30 and 9/6/2020 temperature taking improved and were taken consistently. An interview was conducted on 9/9/2020 at 2:16 PM with Staff #8 who gave the surveyor the incomplete temperature logs. When asked what happened, Staff #8 stated she could not explain it. She stated, Busy, may not have written the temps down. Reviewed the findings with the Nursing Home Administrator on 9/10/2020 at 2:00 PM.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation and interview, it was determined the facility failed to consistently maintain a sanitary environment in the kitchen. This was evident during 1 random observation during a complaint survey. This has the potential to affect any resident who consumes food from the kitchen. The findings include: On 9/9/2020 at 11:50 AM, observation was made in the kitchen of lunch preparation, specifically the operation of plating food on the tray line. From 11:50 AM to 12:40 PM, staff plated food for the meal carts for the nursing units. Staff #9 was plating the food and Staff #10 was watching him as it was his first day on the tray line. Staff #8 was placing bowls and beverages on the trays and placing the trays in the meal cart. Staff #9's face mask was worn down below his nostrils, cupping his chin for most of the 50 minute observation. Staff #9 kept pushing his mask up with his gloved hand. Several times during the observation, Staff #9 had to leave the tray line and walk over to a standing heating unit to get a bowl of food. Staff #9 would take his glove off his right hand and open the door to the heating unit, with a bare hand, and retrieve the bowl of food. Staff #9 would squish up the glove and throw it in the trash and then put a new glove on without first sanitizing his hands. Staff #9 would come back to the tray line and then continue the process of plating food with his mask below his nostrils and would continue to touch his mask with his gloved hand. While his mask was below his nostrils, he would lean over the conveyor belt where food was on the plate. There were times he did not have gloves on, and he kept touching his mask and pushing it up over his nostrils. The other staff members were watching and did not stop him from serving food with his mask down. While Staff #10 was observing Staff #9, Staff #10 was constantly pushing on her mask as the mask was constantly falling under the tip of her nose. Staff #10 was constantly pulling on the mask to reposition. Staff #10 retrieved a scoop for Staff #9 and pulled on her mask with bare hands before and after picking up the scoop. Staff #10 handed the scoop to Staff #9, wiped her hands on her uniform pants, and then touched the mask. She walked over to the phone that was hanging on the wall, picked up the phone and made a call. Staff #10 was not wearing gloves and Staff #10 did not wash her hands prior to walking back to the tray line. Staff #10 again pushed on her mask and then put gloves on to puree meat. Staff #10 took the gloves off, touched her mask and touched her uniform pants. Staff #10 stood over non-covered plated food with her mask worn under the tip of her nostril. She did not sanitize her hands after getting the ground meat and touching the facemask. An interview was conducted with Staff #8 about the observation and the concerns regarding handwashing and the masks that staff were wearing improperly on 9/9/2020 at 12:40 PM. Staff #8 stated that both the employees were newly hired.
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 and staff interview, it was determined the facility failed to document the use of a physician ordered treatment. This was evident for 1 (#5) of 25 residents reviewed during a complaint survey. The findings include: Review of Resident #5's medical record on 9/9/2020 at 9:15 AM revealed a physician's orders [REDACTED]. Ted ([MEDICAL CONDITION]-[MEDICAL CONDITION] Deterrent) stockings are also known as compression stockings or anti-embolism stockings. They help reduce the risk of developing a [MEDICAL CONDITIONS] or blood clot and help reduce the risk of swelling. Further review of the medical record failed to produce documentation that Resident #5 had been wearing the TED stockings or any type of evaluation whether the TED stockings were effective. On 9/10/2020 at 1:20 PM, the Director of Nursing (DON) was asked where it would be documented that the resident wore TED stockings. The DON stated it would be under ADLs. The DON looked at Resident #5's Treatment Administration Record (TAR) and it was not there. There was nowhere in the medical record that TED stockings were signed off as administered per the physician's orders [REDACTED]. That was not the correct place to place the order as it did not trigger the nurses to look at that every day and sign off that the TEDS were being placed on the resident.