STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215250	A. BUILDING _____ B. WING _____	03/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOODWILL MENNONITE HOME, INC.	891 DORSEY HOTEL ROAD GRANTSVILLE, MD 21536

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 0553 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Allow resident to participate in the development and implementation of his or her person-centered plan of care.** Based on resident interview, record review and staff interviews, it was determined that the facility failed to ensure that residents were included in their plan of care. This was evident for 1 (#39) of resident of 2 residents reviewed for care plans during investigation phase. 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. During an interview with Resident #39 on 3/3/20 at 9:30 AM, the resident reported that he/she had not been invited to their care plan meetings. A record review on 3/6/20 at 8:18 AM, revealed care plan evaluation notes, dated 4/2[DATE]9, 10/15/19, and 1/14/20, that did not mention Resident #39 being present or declining to be at the care plan meeting. A care plan evaluation note, dated 7/17/19, stated that resident declined to attend the meeting. An interview with MDS Coordinators #10 and #11 on 3/6/20 at 8:56 AM, revealed that they go to the resident and invite them to the care plan meeting verbally and have them sign an Invitation Form. When MDS Coordinators #10 and #11 were asked about Resident #39, they provided an Invitation Form which documented the resident's signature, except for the meetings dated 7/17/19, 10/15/19 and 1/4/20. They were unable to provide a rationale for the reason Resident #39 had not been invited to the last two care plan meetings. The Director of Nursing (DON), Assistant Director of Nursing (ADON) #4, and ADON #5 were made of aware of findings on 3/6/20 at 12:16 PM.
F 0578 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, it was determined that the facility staff failed to void an older MOLST form located in a resident's active medical record. This was evident for 1 (Residents #97) of 2 residents reviewed for Advance Directives during an annual recertification survey. The findings include: A Maryland MOLST (Medical Orders for Life-Sustaining Treatment) form is used for documenting a resident's specific wishes related to life-sustaining treatments. The MOLST form includes medical orders for Emergency Medical Services (E[CONDITION]) and other medical personnel regarding cardiopulmonary resuscitation and other life-sustaining treatment options for a specific patient. Instructions for completing a Maryland MOLST include: A Physician, Nurse Practitioner (NP), or a Physician Assistant (PA) must be accurately and legibly complete the form and then sign and date it. Voiding the Form: to void this medical order form, a physician or nurse practitioner shall draw a line through the sheet, write VOID in large letters across the page, and sign and date below the line. A nurse may take a verbal order from a physician or nurse practitioner to void the MOLST order from. Keep the voided order form in the patient's active or archived medical record. Review of Resident #97's medical record, on [DATE] at 1:10 PM, revealed that Resident #97's health care agent and Resident #97's physician completed a Maryland MOLST form on [DATE], that indicated Resident #97 should be a No CPR, Option B, Palliative and Supportive Care: Prior to arrest, provide passive [MED]gen for comfort and control any external bleeding. Prior to arrest, provide medications for pain relief as needed, but no other medications. Do not intubate or use [MEDICAL CONDITION] or [MEDICAL CONDITION]. If cardiac and/or [MEDICAL CONDITION] arrest occurs, do not attempt resuscitation (No CPR). Allow death to occur naturally. Do not use any artificial ventilation (no intubation, [MEDICAL CONDITION] or [MEDICAL CONDITION]). May give any blood products, transfer to hospital for any situation requiring hospital-level care, may perform any medical tests indicated to diagnose and/or treat a medical condition, may use antibiotics. Do not provide artificially administered fluids or nutrition. Do not provide acute or chronic [MEDICAL TREATMENT]. Further review of Resident #97's medical record revealed a second active MOLST form, dated [DATE] at 10:00 AM, which revealed Resident #97's health care agent wanted Resident #97 to be a Full Code. The back page to the [DATE] MOLST form was left blank which indicated there were no restrictions to other forms of care Resident #97 could receive. In an interview on [DATE] at 1:15 PM, the facility social work director confirmed that there should not be 2 active MOLST forms in Resident #97's medical record. The facility social worker stated that Resident #97 had a recent hospitalization and that was when the new [DATE] MOLST form had been completed. The facility social worker correctly identified the incongruence of the 2 MOLST forms and that the facility staff needed to void the older MOLST form.
F 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** Based on observations, record review, and staff interviews, it was determined that facility staff failed to develop and implement a resident-centered care plan for a resident with behaviors. This was evident for 1 (#98) of 36 residents reviewed for care plans. 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. The MDS (Minimum Data Set) is a complete assessment of the resident which provides the facility information necessary to develop a plan of care, provide the appropriate care and services to the resident, and to modify the care plan based on the resident's status. 1) An observation of Resident #98 on 3/3/20 at 9:41 AM and on 3/5/20 at 8:58 AM revealed the resident had facial hair and his/her hair was disheveled. A record review for Resident #98 on 3/5/20 at 2:20 PM, revealed that the facility staff failed to have a care plan in place for resistance to care and implemented interventions to assists staff when they attempt to give care. During an interview with Geriatric Nursing Assistant (GNA) #12 on 3/5/20 at 9:09 AM, she reported that the resident had been resistant to care for the last month. She reported that the resident's nurse was aware of the behavior. An interview with the Licensed Practical Nurse (LPN) #13 on 3/5/20 at 9:13 AM, revealed the resident had been resistive to care and was started on an as needed antianxiety medication for the behavior that day. She reported that the resistive behaviors had been going on for a month. When asked about the interventions that were in place, she stated that when the resident is resistive and staff re-approach him/her at a later time, the resident would be more cooperative. The Minimum Data Set (MDS) Coordinator #10 and #11 were interviewed on 3/6/20 at 9:13 PM, regarding the development and implementation of care plans. During this interview, MDS Coordinator #10 revealed that staff would make them aware of resident changes and they would update/revise the care plans. MDS Coordinator #11 reported that she was aware of the resistive behaviors with Resident #98,

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

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F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) however, was unable to provide a rationale as to why this had not been care planned and interventions put into place. The Director of Nursing and Assistant Director of Nursing #5 was made aware of the concerns on 3/6/20 at 12:16 pm.
F 0679 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide activities to meet all resident's needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interview, it was determined that staff failed to ensure that activities were provided to residents meet their individual needs and preferences. This was evident for 2 (#16 and #23) of 2 residents reviewed for activities. The findings include: The MDS (Minimum Data Set) is a complete assessment of the resident which provides the facility information necessary to develop a plan of care, provide the appropriate care and services to the resident, and to modify the care plan based on the resident's status. 1) A record review for Resident #16 on 3/5/20 at 12:00 PM, revealed that resident was admitted to the facility 2 years ago. The medical record indicated the resident had a [DIAGNOSES REDACTED]. Section F Preferences for Customary Routine and Activities documented resident enjoys listening to music, doing things in a group of people, and participating in favorite activities. A review of the resident's care plan revealed that, on 2/26/19, a care plan was initiated (Resident) needs sensory stimulation. (Resident) is dependent on staff for his/her leisure time. There was goal that stated the resident will be out of his/her room every day and will eat meals with his/her peers and listen to music. However, review of the activities documentation revealed resident had not had a room visit in 2/2020, and it was unknown regarding previous months because the documents had not be retained. Review of the activity's attendance records for 12/2019, 1/2020, and 2/2020, revealed the resident had not attended an activity since 1/2020. An observation of Resident #16 on 3/2/20 at 1:30 PM and 4:01 PM, revealed resident sitting in his/her room alone. A subsequent observation on 3/5/20 at 9:05 AM, revealed the resident was sitting in his/her room alone. 2) A record review for Resident #23 on 3/5/20 at 3:00 PM, revealed resident was admitted to the facility 5 years ago. The medical record indicated the resident had a [DIAGNOSES REDACTED]. The goal documented resident was to have peer to peer opportunities 5 times a week. However, review of the daily forms revealed resident had not had a room visit in 2/2020, and was unable to determine the last room visit because these forms were not retained. Review of the attendance logs for 12/2019, 1/2020, and 2/2020, revealed Resident #23 had not attended any activities during these months. An observation of the resident on 3/2/20 at 3:43 PM, revealed the resident sitting in his/her room dressed and groomed. A subsequent observation of Resident #23 on 3/5/20 at 2:58 PM and 3/6/20 at 9:33 AM, revealed the resident sitting in his/her room. An interview with the Activity Director on 3/5/20 at 1:24 PM, regarding documentation of activities for residents. She reported that a daily sheet was completed by the Activity Aids and they maintained an attendance sheet for group activities. An interview with the Activity Aid # on 3/5/20 at 1:47 PM, revealed that she worked two days a week. She reported that activity aides who worked in the evenings completed the daily sheets, she only documented on the attendance sheet. When asked about room visits and small groups she stated she only did the group activities when she was on duty. A subsequent interview with the Activities Director on 3/5/20 at 1:50 PM, revealed that the Activity Aids who work in the evenings completed the daily sheets. When asked how she determined which residents needed small group activities and room visits and how this was reported to staff she stated she reviewed the monthly attendance logs and those not participating needed room visits and small group activities. She stated she had no process to report to the Activity Aides which residents were in need of small groups and room visits. She reported that the Activity Aides were given the responsibility to choose what activities to do with the residents and they tended to have favorites that they did more frequently. She reported she was unable to determine the last activity provided to Resident #16 and Resident #23. The Activity Director was made aware of these concerns on 3/6/20 at 12:18 PM.
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.** Based on observations, reviews of a medical record and staff interview, it was determined that the facility staff failed to assess a resident's bruising timely. This was evident for 1 (Resident #82) of 2 residents reviewed for non-pressure related skin conditions during an annual recertification survey. The findings include: Review of Resident #82's medical record on [DATE]20 at 1:00 PM revealed Resident #82 was admitted to the facility 2 years ago and resided on the memory care unit. Resident #82's medical record indicated that Resident #82 suffered from dementia with behaviors that include hitting and kicking. During the initial tour of the facility on [DATE]20 at 1:00 PM, the surveyor observed discoloration and/or bruising to Resident #82's left hand and wrist. There was no bleeding observed. Resident #82 did not look to be in pain while sitting in a lounge chair on the unit. Review of Resident #82's medical record, on [DATE]20 at 1:00 PM, failed to reveal any assessment nor documentation of Resident #82's left hand bruising. In an interview on 03/04/2020 at 2:26 PM, the memory care unit manager was asked how Resident #82 obtained the bruising to the left hand. The memory care unit manager stated that she was not aware and indicated that she would inquire and follow up with the surveyor. In a follow up interview on 03/05/2020 at 9:00 AM, the memory care unit manager stated that the nursing staff were not aware of the bruising to Resident #82's left hand and wrist that was observed on [DATE]20 at 1:00 PM when the surveyor initially observed the bruising. The memory care unit manager stated the staff were only aware and documented bruising to Resident #82's right hand on 02/20/2020. The memory care unit manager stated the bruising to the left hand was new. In an interview on 03/05/2020 at 10:45 AM, the charge nurse for the Memory Care Unit stated Resident #82 tends to bang their hands on the doors at times.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation and interview with staff, it was determined the facility staff failed to properly store medications by failing to ensure schedule III - V medications were stored in separately locked, permanently affixed compartments. This was evident in 1 of 5 facility medication carts observed during medication storage review. Per the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970: Controlled substances are generally defined as medications that are considered easily abusable. Under the Controlled Substances Act, these medications are categorized into 5 schedules. Schedule I medications have the highest abuse potential, while medications in Schedule V have a low abuse potential. The findings include: On 3/5/20 at 9:22 AM, the surveyor observed the Memory Care medication cart. The cart contained a separately locked drawer containing [MEDICATION NAME] Patches and liquid [MEDICATION NAME]. Both were schedule II medications. A storage drawer located above the locked drawer contained the following medications: [REDACTED]#37; A punch card contained 13 capsules of [MED] ([MEDICATION NAME]) labeled for Resident #11; A punch card labeled with Resident #50's name contained 6 tablets of [MEDICATION NAME] 1 mg; Resident #97's name was on punch cards containing 27 tablets of [MEDICATION NAME] 0.5mg and 23 tablets of [MEDICATION NAME] [MED] 50 mg; 14 [MEDICATION NAME] [MED] 50 mg tablets were in a punch card labeled for Resident #83 and a punch card containing 7 [MEDICATION NAME] 0.5 mg Tablets, one containing 25 tablets of [MEDICATION NAME] 0.5 mg and 1 full punch card of [MEDICATION NAME] 25 mg were labeled for Resident #52. [MEDICATION NAME] and [MEDICATION NAME] are Schedule IV controlled drugs, [MED] ([MEDICATION NAME]) is Schedule V controlled drug. They were not located in a separately locked permanently affixed compartment. Staff #8 the Memory Care unit charge nurse was present during the observation. She was asked what criteria was used to determine which medications were kept in the locked drawer and which were not. She indicated that the [MEDICATION NAME] and [MEDICATION NAME] were given as needed but the other medications were given on a routine basis. The Director of Nursing was made aware of the above findings on 3/5/20 at 10:58 AM. She indicated that she thought that only schedule 2 medications required a double lock, which would be the lock on the medication cart and on the medication room door, and that she thought the medications would not all fit in the locked drawer. She confirmed that the medication cart is taken out of the medication room during medication passes and upon observation with the surveyor, she confirmed that all of the schedule II - V medications would fit in the locked drawer. During observations of the 3 medication carts on [LOC] on 3/5/20 at 11:03 AM and 1 medication cart on [LOC] on 3/5/20 at 11:15 AM, all schedule II - V medications were stored in the separately locked drawer of each

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F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) cart.
F 0804 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.** Based on staff interview and surveyor observation, it was determined the facility failed to provide food in a safe manner. This was evident for 1 (Resident #59) of 37 residents reviewed during an annual recertification survey. The findings include: Resident #59 has resided in the facility for 7 years and is totally dependent upon the facility staff for all aspects of his/her care including being fed all meals. On [DATE]20 at 12:35 PM, Resident #59 was observed being fed by staff member #6. Observed on Resident #59's lunch meal tray were large chunks of what appeared to be fruit pushed to one side of the plate. In an interview with staff member #6 at this time, staff member #6 stated that Resident #59 was on a pureed diet but the peaches that came with Resident #59's lunch meal tray were not entirely pureed. Staff member #6 pointed out the 2 large chunks that had not been totally pureed on Resident #57's lunch meal plate, and that she had moved the non- pureed peaches to the side of the plate. In an interview on [DATE]20 at 12:41 PM, the facility administrator was made aware that the peaches that came up on Resident #59's lunch meal tray had not been fully pureed.