STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215064	A. BUILDING _____ B. WING _____	**03/18/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ADELPHI NURSING AND REHABILITATION CENTER	**1801 METZEROTT ROAD ADELPHI, MD 20783**

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 0557 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interview it was determined that facility staff failed to ensure that all residents were treated with respect and dignity by receiving permission from residents before entering resident's rooms. This was evident for 1 out of 10 residents who were interviewed involving (R#8) observed during the survey process. The findings include: On 03/11/20 at 11:37 A.M. during a bedside interview with Resident #8 the Surveyor observed and witnessed staff member #2 Geriatric Nursing Assistant (GNA) knock on room [ROOM NUMBER]'s door and just walk into the room without time for the resident's response or giving permission to enter the room. Staff member #2 apologized and stated to Resident #8, I didn't know the surveyor was in the room with you. Resident #8 replied, I'm in my interview with the State, I don't need anything right now. After the staff member left the room Resident #8 replied to this writer, the staff always just walk into your room and you can be unpresentable. On 3/11/20 at 11:40 A.M. an interview was conducted with staff member #2 who shared facilities policy on dignity all facility staff are to wait for permission from the resident before entering their rooms. I didn't wait this time. On 3/11/20 at 1:30 P.M. during staff interview with Director of Nursing (DON) the surveyor was informed that all staff must knock before entering any resident's room. It's in the policy. The finding was discussed with the Administrator and the Director of Nursing who were made aware of the dignity concerns prior to and during the survey exit.
F 0561 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and medical record review it was determined that the facility staff failed to: 1) bathe a resident according to his/her preference, 2) to have a process in place to make meal choices available to those residents who ate in their room and wanted a different meal, and 3) to provide an escort for those individuals who need extensive assistance when out on an appointment. This was evident for 3 (#46, #35, #16) of 5 residents reviewed for Choices during the facility's annual Medicare/Medicaid Survey. The findings include: 1) On 3/10/20 at 2:28 PM, during an interview with Resident #46 when asked, do you choose how many times a week you take a bath or a shower? Resident #46 indicated that he/she has only had four showers the whole time he/she has been living at the facility. Resident #46 indicated that he/she would prefer to get showers routinely. When asked if he/she has discussed that concern at care plan meetings, Resident #46 responded that he/she has not been to any care plan meetings. Review of Resident #46's medical record on 3/16/20, revealed that the resident was admitted to the facility in June of 2018. Review of bathing documentation for the past 4 months ([DATE] to March 20) did not reveal any documentation related to the resident getting/receiving a shower. Review of the care plan progress notes revealed that there has only been two care plan meetings during this admission to the facility (7/6/18 and 2/23/20). The documented care meeting on 2/23/20 revealed that a meeting was held without the resident and did not explain why the resident was not in attendance. A discussion was held with Resident # 46 on 03/17/20 at 09:41 AM. The resident indicated that he/she could not remember the last time he/she had a shower, just that it was a long time ago. Resident #46 acknowledged that the assigned GNA was preparing to provide a bed bath. Resident #46 again shared his/hers wishes to get showers routinely. The facility lacked documentation of providing person centered care, as evident of not having care plan meetings. Resident #46 has the right to make choices about aspects of his or her life while at the facility. The facility must promote and facilitate residents self-determination. 2) On 3/16/20 at 12:34 PM an interview was held with Resident # 16. He /she stated that residents do not get a choice of meals or alternative selections. He/she stated that the meals are sent up to the units on trays and he/she gets what is on the tray and cannot order an alternative, because the phone # provided to residents to call the kitchen does not work. This surveyor spoke with the Director of the kitchen, staff # 5, who stated, his phone does not work and the facility is in the process of putting a new phone line in. This was also confirmed by Staff #7 the Maintenance Director. On 3/16/20 this surveyor spoke with staff # 5, Director of Dietary, who stated that every morning the resident receives a menu of what is being served for breakfast, lunch and dinner and what the substitutes are. There is, also, a menu that is always available. In the morning the resident makes their choices and tells the aid or nurse what they want. They call it down to the kitchen. The phone system is not working properly and at this time residents cannot call down to the kitchen themselves. Nurses and GNAs (Geriatric Nursing Assistants) must check to see if residents want a different meal. This surveyor also spoke with the Director of Activities, Staff # 9, who stated that every morning she gives out a paper to all residents that have information about the activities of the day and also has the alternative menus for the day and to call extension 3617. Resident # 16 called extension 3617 and the phone did not work. Activity Staff # 9 then said that residents are to notify nursing staff to get alternative meals. This surveyor stated that residents who eat in their rooms do not understand this new policy, because the old policy was given out to the residents. On 3/16/2020 activity staff gave all residents a new menu containing the new policy to notify GNA (Geriatric Nursing Assistant) or the Nurse for food alternatives and they will contact the kitchen. The Director of Nursing made aware. 3) On 03/10/20 12:42 PM an interview was held with Resident # 35. The resident stated that prior to March 2020, when Resident # 35 needed to go out for an appointment, he/she always had an escort. Now Resident # 35 stated that he does not get an escort and the resident wants an escort when out on an appointment. On 3/10/20 at 12:30 PM the Administrator stated, if a resident is alert and oriented, he/she may go out on an appointment on their own without an escort. If the resident is alert and oriented with a Brief Interview for Mental Status (BIMS) score of 15/15. According to the Minimum Data Set (MDS) and nursing staff, Resident # 35 is an (needs) extensive assistance. Resident #35 stated that he/she is able to get around in his/her wheelchair on the unit. But, it is very difficult to get around in a hospital setting and it takes him/her a long time to get to where he/she needs to go for appointments.
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.** **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.**

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215064	A. BUILDING _____ B. WING _____	03/18/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ADELPHI NURSING AND REHABILITATION CENTER	1801 METZEROTT ROAD ADELPHI, MD 20783

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 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview it was determined that the facility failed to obtain incapacity certifications and medical condition certifications prior to allowing a surrogate decision maker to withhold life sustaining treatments. This was evident for 1 (#124) of 1 resident reviewed for advanced directives. The findings include: Resident #124 was admitted to the facility on [DATE]. Resident #124's medical record was reviewed on [DATE]. Review of the Maryland Medical Orders for Life Sustaining Treatment (MOLST) form revealed that a no CPR order was written by the Certified Registered Nurse Practitioner on [DATE]. The MOLST form revealed that the decision to withhold CPR (Cardiac [MEDICAL CONDITION] Resuscitation) was based on the informed consent of Resident #124's surrogate decision maker. Review of the admission comprehensive assessment (dated [DATE]) revealed that Resident #124 had severely impaired cognition. There were not any physician certifications of incapacity and there were not any physician certifications of condition. In order for a surrogate decision maker to be legally adjudicated to withhold life-saving treatment (CPR) the resident must be certified to not have capacity to make an informed decision and there must be two physician certifications that the resident is in one of three conditions as; end stage, terminal, or persistent and vegetative state. The Social Service Director was interviewed on [DATE] at 10:20 AM. She indicated that there were not any physician certifications related to Resident #124's status. The Social Service Director revealed that she should have notified the physicians to make them aware that Resident #124 required an assessment of capacity and condition.
F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation and staff interview it was determined the facility staff failed to provide housekeeping and maintenance services necessary to keep the building clean, neat, attractive and in good repair. This was evident throughout the survey and on multi-levels of the facility. The findings include: The following environmental concerns were observed during the survey and a tour was conducted with the Maintenance Director on 3/18/20 at 12:30 PM: room [ROOM NUMBER] there was a large section of missing wallpaper on the left-hand side of the window and heating unit. room [ROOM NUMBER] noticeable from the hallway door entrance were multiple areas with wallpaper seam separations. room [ROOM NUMBER] was discussed as another surveyor had previously informed him the wallpaper was peeling off the wall. On the 1B Unit one of the shower rooms was utilized as storage for a mechanical lift. The handle to the shower was broken and there was not a shower head on the handheld water line. The Director of Maintenance indicated that he did not know that this shower room was not operational. room [ROOM NUMBER] (first noted on 3/9/20) an approximately 8 x 10-inch missing section of wall board observed in the toilet room with exposed plumbing. Maintenance Director indicated this was related to a water leak from the floor above. Additionally, there was markings and indentations in the wall above the head of the first bed. The first-floor utility room was found to have a broken faucet handle. The Maintenance Director indicated that he was not made aware of the broken handle. We had discussed that hand sinks in the clean and dirty utility rooms are to have paddle blades and a goose neck faucet. There was an inoperative refrigerator stored in the utility room. On the 1A side of the first floor one of the two shower rooms was noted with dark discolorations along the bottom of the back tiled wall (along the grout line between floor and wall and on the tiled surfaces). On the second floor the room identified as #250 central bath was shown to have a chipped and broken tiled threshold on the floor surface of the shower room. Upon entrance there was noted discolorations and missing tiles on the right-hand side adjacent to the door frame. room [ROOM NUMBER] was reviewed with the Maintenance Director as he was informed of the observed condition behind the 1st bed on 3/9/20 related to discoloration and chipping of the wall surface. Multiple worn finished areas and some with irregular grooves and gashes were observed in the wooden handrails that line the 2nd floor corridors. Most noticeable at the corner junctions with rough exposed areas of the wood and/or misaligned junctions. The Maintenance Director revealed that another 2nd floor shower room has been out of service for months with additional repair delays related to the new ownership. In room [ROOM NUMBER] the wall behind the empty bed was noted in disrepair with water stains on the wall border.
F 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** **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 notify the resident/resident representative in writing of a transfer/discharge of a resident to an acute care facility along with the reason for the transfer. This was evident for 3 (#15, #90, #81) of 5 residents reviewed for transfer to an acute care facility. The findings include: 1) Review of the medical record for Resident #15 on 3/16/20 revealed documentation that the resident was sent out to an acute care facility on 5/28/19 due to having a [MEDICAL CONDITION]. There was no documentation found in the medical record that indicated the resident's responsible party was notified in writing of the transfer. Interview of the Director of Nursing on 3/18/19 confirmed the findings that the facility did not notify the resident or family in writing when the facility had initiated the discharge to the hospital. 2) Review of the medical record on 3/10/20 at 11:47AM for Resident #90 revealed documentation, that Resident # 90 was sent out to an acute care facility on 1/29/20 for abnormal labs. There was no documentation found in the medical record that indicated that the resident's responsible party was notified in writing of the transfer. Interview with the DON (Director of Nursing) on 3/11/20 confirmed the findings that the facility did not notify the resident or family in writing when the facility initiates a transfer or discharge to an acute care facility. 3) Resident #81's medical record was reviewed on 3/17/20 at 2:35 PM. During the review, it was found that the resident was transferred out at the beginning of March, 2020. Although evidence could be found that the resident's responsible party was notified by phone that the resident was admitted to the hospital, the review of the medical record failed to reveal that the resident's responsible party was notified of this transfer in writing. During an interview that took place on 3/18/20 at 11:00 AM, the Director of Nursing (DON) and the Administrator stated, as staff protocol, the facility does not send any documentation of transfer to family members for residents.
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, it was determined the facility staff failed to ensure that Minimum Data Set (MDS) assessments were accurately coded. This was evident for 2(#132) and (# 90) of 2 residents reviewed for MDS accuracy. The findings include: The MDS (minimum data set) is part of the Resident Assessment Instrument (RAI) 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. 1. On 03/18/20 09:58 AM a review of resident medical records was conducted. Resident # 132 was admitted to this facility in December of 2019. 0n 12/29/19 nursing note states resident scheduled to discharge to his/her friend home today 12/29/19, alert and verbally responsive with no acute distress noted. The MDS, dated [DATE], stated the resident went to the hospital not home/community. The Director of Nursing (DON) was made aware. 2. On 03/12/20 at 10:35 AM a record review was conducted for Resident # 90 who has VRE ([MEDICATION NAME]-resistant [MEDICATION NAME]) of wound and is on isolation, the MDS dated on 2/11/20 under active [DIAGNOSES REDACTED]. The Director of Nursing was made aware.
F 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, the facility failed to develop a baseline care plan for Resident #90 who had [MEDICAL CONDITION] and went to [MEDICAL TREATMENT] 3 times per week. This was evident for 1 out of 1 residents that did not have a baseline

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215064	A. BUILDING _____ B. WING _____	03/18/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ADELPHI NURSING AND REHABILITATION CENTER	1801 METZEROTT ROAD ADELPHI, MD 20783

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 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) care plan. The findings include: On 3/12/20 a medical record review was conducted for Resident # 90. Resident # 90 was admitted to this facility on 1/9/2020. He/she has a history of , C- Diff. On 1/10/20 the resident was placed on [MEDICATION NAME] 2 mg 1 now for loose stools with an order to collect stool for [MEDICAL CONDITION]. On 1/11/20 the culture came back positive for [MEDICAL CONDITION]. Resident # 90 was placed on contact isolation. There was no baseline care plan for the [MEDICAL CONDITION] [DIAGNOSES REDACTED].#90. On 3/12/20 at 2:14 PM a medical record review was conducted for Resident # 90. Resident # 90 was admitted to this facility on 1/9/2020. He/she has a history of [MEDICAL TREATMENT] and end stage [MEDICAL CONDITION]. Resident #90 goes to [MEDICAL TREATMENT] 3 times per week. All [MEDICAL TREATMENT] communication paperwork had been filled out. There is no baseline care plan for [MEDICAL TREATMENT].
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interview and medical record review it was determined that the facility failed to develop and implement comprehensive person-centered care plans. This was evident/exemplified for 6 (#127, #181, #52, #60, #90, #105) of 41 residents reviewed. 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) Resident #127 was interviewed on 3/10/20. When asked, the resident acknowledged that Resident #127 was incontinent of bowel and bladder and briefs were utilized. Resident #127's medical record was reviewed on 3/16/20. The resident was sent out to an acute care facility on 1/17/20 and returned to the facility on [DATE]. A 5-day comprehensive admission MDS (minimum data set) assessment was dated 1/30/20 and another MDS assessment was dated 2/25/20. Review of the resident's current care plans revealed that all the plans of care had an initiation date of 1/27/20 or 1/28/20. On both MDS assessments of 1/30/20 and 2/25/20 assessed the resident to be incontinent of both bowel and urine. A care plan with a focus of bowel incontinence related to impaired mobility was developed. An intervention written as toilet at established times was not person centered for Resident #127. There was not any indication in the medical record of what were the established times as the resident did not utilize the toilet. There were only three interventions for this focus area and none of the interventions include the use of briefs for incontinent care. The MDS assessments indicate that the resident requires extensive assistance with the assist of one person for eating. There was a care focus area for nutritional status as evidenced by actual/potential weight loss/gain related to end Stage [MEDICAL CONDITION], therapeutic diet, Underweight, and low [MEDICATION NAME], weight loss in December 2019, weight loss in January 2020. None of the written interventions for this care area included assisting and/or feeding the resident based on the assessment. Per the MDS assessments of 1/30/20 and 2/25/20 the resident is dependent on staff for bed mobility and transfers. Per the compressive assessment Resident #127 requires the assistance of two staff. (On 3/10/20 Resident #127 was observed being transferred by two staff into bed via the use of a Maxi lift). A care area focus was written as at risk for falls due to impaired balance/poor coordination. The goal for the care area was Minimize risk for falls. There were three written interventions as; 1) Bed in low position, 2) Encourage to transfer and change positions slowly and 3) Have commonly used articles within easy reach. This plan of care was not resident centered as this plan of care did not indicate the need for a mechanical lift with two staff for transfers. 2) Resident #181 was admitted to the facility on [DATE]. The resident was admitted with a Foley catheter. (A Foley catheter is a flexible tube passed through the urethra and into the bladder to drain urine.) Review of Resident #181's plans of care on 3/11/20 revealed that the facility had failed to develop a plan of care for the use of the Foley catheter. 3) Resident #52's medical record was reviewed on 3/17/20 at 11:20 AM. During the review, it was noted that Resident #52's care plan did not include any topic regarding recreational preferences the resident had regarding activities and engagements while at the facility. The Activities Director was interviewed on 3/18/20 at 10:38 AM. During the interview, the Activities Director noted that activity documentation is done on a flowsheet that tracks what activities are provided to a resident in a given period as well as the resident's response to those activities. Those activity logs were provided by the facility to the surveyor. The Activities Director was asked to provide evidence that a care plan was prepared for Resident #52 regarding activity preferences. On 3/18/20 at 11:55 AM, the Activities Director informed the survey team that there was no activities care plan for Resident #52. She noted that she was responsible for making those care plans and that she would make one for Resident #52. 4) On 03/17/20 at 08:33 AM Resident #60's medical record was reviewed for pressure ulcers. In the medical chart It was documented that the resident was noted to have an unstageable (full thickness skin or tissue loss with unknown depth) pressure wound to the left heel on 2/1/19. The wound measured 4.5x5 cm at that time and advanced up to as much as 12.6x1 cm at one point. Healing of the pressure ulcer was complicated with multiple hospitalization s. The resident went in and out of the hospital in July, September, and December. Further review of the medical record revealed that there was no care plan with interventions for managing this resident's wound while the resident is in the facility. The Director of Nursing (DON) was notified of the problem prior to the exit. 5) On 3/12/20 a record review was conducted for Resident # 90. Resident # 90 was admitted to this facility in January 2020. He/she has a history of abscess of buttocks (VRE), [MEDICAL CONDITION], and end stage [MEDICAL CONDITION]. Resident #90 goes to [MEDICAL TREATMENT] 3 times per week. All [MEDICAL TREATMENT] communication paperwork had been filled out. There was no comprehensive care plan for Resident # 90 who is on [MEDICAL TREATMENT], has [MEDICAL CONDITION] and VRE of the wound. The Director of Nursing was made aware. 6) Resident# 105 was originally admitted to this facility in December of 2007 and readmitted from the hospital on [DATE]. A record review was conducted for Resident # 105 on 3/10/20. Resident # 105 has a history of Alzheimer's, [MEDICAL CONDITIONS], Hypertension Chronic [MEDICAL CONDITION] Embolism, Hypoxemia and other diagnosis. On 3/9/20 at 11:55AM, this surveyor went into room [ROOM NUMBER]-1 to interview Resident # 105. Resident # 105 was not in the room but outside the doorway sitting in a geri chair resting. The resident had an O2 concentrator (An oxygen concentrator is a device that concentrates the oxygen from a gas supply (typically ambient air) by selectively removing nitrogen to supply an oxygen-[MEDICATION NAME] product gas stream.) next to her and there was 5 liters of O2 (oxygen) that was infusing via a nasal cannula. There was no oxygen order on the physician's orders [REDACTED]. There was a care plan in the medical record/chart but there were no interventions for the use of oxygen. This was confirmed by the DON (Director of Nursing) on 3/10/20.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, and staff interview it was determined that the facility failed to have an effective system in place to ensure that a care plan meeting was held after each resident assessment, failed to ensure that care plans were thoroughly evaluated and revised by the interdisciplinary team after each assessment, and failed to ensure the documentation of why the resident or responsible party was unable to attend a care plan meeting. This is exemplified for 7 residents (#46, #127, #15, #52, #7, #16 and #10). 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) An interview was conducted with Resident #46 on 3/10/20 at 2:28 PM. The resident was asked; if s/he attends care plan meetings? The resident responded that s/he has not been to any care plan meetings. Review of Resident #46's medical record on 3/16/20, revealed that the resident was admitted to the facility in June of 2018. Review of the care plan progress notes revealed that there have only been two care plan meetings during this admission to the facility (7/6/18 and 2/23/20). The documented care meeting of 2/23/20 revealed a meeting was held without the resident and did not explain why the resident was not in attendance. Review of the residents written plan of care revealed 29 pages of care plans. In addition to the facility not having any care plan meetings for over 1 years, there was not any documentation to indicate that the care plans were evaluated on the resident's progress or lack of progress toward achieving his/her written goals. The care plans were not accurate as exemplified in the following two plans of care. A focus area written as Patient does not show potential for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215064	A. BUILDING _____ B. WING _____	03/18/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ADELPHI NURSING AND REHABILITATION CENTER	1801 METZEROTT ROAD ADELPHI, MD 20783

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 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) discharge to the community due to physical care needs Date initiated: 10/23/19 Revision on: 10/23/19. The goal was written as Care needs will continue to be met at facility Date initiated: 10/23/19 Target date: 6/8/20. The written goal was not measurable and there was only one intervention written on 10/23/19 as Support patient family and/or representative as needed. The second care plan was initiated on 12/24/19 with indication of Revision on 12/7/19. This focus area was written as Will be discharged to home when clinical and rehabilitation goals are met Date initiated 6/28/18. Revision on 12/7/19. Target date 6/8/20. There was not any indication of what the clinical and rehabilitation goals are to be met. The interventions did address the resident involvement with rehabilitation. These two plans of care contradict the other. There is two different goals and no statement/evaluation of the resident's progress toward either one. A follow up interview was held with the resident on 3/17/20. The resident had acknowledged receiving a notice for a care plan meeting in February 2020. The resident indicated her/his lack of attendance related to not feeling well on the day of the care plan meeting. 2) An initial interview of Resident #127 was held on 3/10/20 at 11:22 AM. Resident #127 was asked if s/he was invited to care plan meetings and did s/he attend? Resident #127 was unsure about having care plan meetings as s/he could not remember having a care plan meeting. Review of Resident #127's medical record on 3/16/20 revealed that an annual MDS (minimum data set) assessment was dated 12/15/19. A 5-day assessment was dated for 1/30/20 and a quarterly assessment was dated for 2/25/20. There was not any indication in the medical record that a care plan meeting was held after each assessment. The last care plan conference held was dated 1/29/19. There was not any indication that the care plans were evaluated and revised by the interdisciplinary team after each assessment. On 316/20 the Director of Nursing (DON) was asked about care plan documentation and where are the care plan evaluations documented? The DON indicated that the Social Service Director is trying to catch up as she indicated that she found that the care plan meetings were not happening. She could not concretely answer the question as to where the care plan evaluations were documented. She indicated that the Unit Managers are to evaluate the plans of resident care. 3) Resident #15's medical record was reviewed on 3/17/20. The resident was originally admitted to the facility in July of 2018. The resident was admitted to an acute care facility in August 2019 and returned to the facility on [DATE]. An admission MDS assessment was dated 9/11/19 and a quarterly assessment was dated 12/12/19. Documentation of care plan meetings following these assessments were not found in the medical record. The last documented care plan meeting was dated 8/21/19. Additionally, there was not any documented evidence of care plan evaluations after the two MDS assessments. 4) Resident #52's medical record was reviewed on 3/17/20 at 11:20 AM. During the review, it was noted that none of the care plan topics in the resident's care plan had been updated since March, 2019, when they had been initiated for the resident. Further review of the resident's medical record indicated that two care plan meetings had been held for the resident in 2019: in July and in October. One care plan meeting had been held in February, 2020. Review of care plan notes in the electronic health record revealed that multiple care plan topics had been addressed in the meeting and recommendations were made. However, none of the care plan topics in the actual care plan had been revised. During an interview that took place on 3/16/20 at 3:06 PM, the Director of Nursing (DON) indicated that social work services were in a catch up mode for care plans. The DON stated that a Quality Assurance and Improvement Plan meeting had developed a Performance Improvement Project (PIP) regarding care plans not being updated. There was no evidence of Resident #52's care plan being revised or provided by the facility by the end of the survey. 5) A record review was conducted for Resident # 7 on 3/12/2020 at 8:51 AM. The resident was admitted on [DATE]. She/he has a history of Dementia without behaviors, Contracture of left foot, Short of breath, Hypertension, [MEDICAL CONDITIONS], altered mental status, and muscle weakness. On 03/12/20 08:35 AM this surveyor went into Resident # 7's room and there was no splint on the left ankle and there had not been a splint on since arriving to this facility on 3/9/20, when the surveyor first saw the resident. The Splint was listed on the care plan starting on 9/25/18 and revised again on 2/29/20. The Care Plan stated that the left ankle splint was to be applied and worn twice a day for 4 hours in the AM and 4 hours in the PM. Monitor for skin alteration and discomfort. ROM (Range of Motion) to be done during AM activities of daily living. This surveyor spoke with Licensed Practical Nurse (LPN) staff # 15 to ask her about the splint and found that there was no order for a splint on the order sheet for March 2019. LPN staff # 15 looked at the Care Plan with this surveyor who pointed out the splint was in the care plan. The LPN left without saying anything. She made no mention that she would check this out. The surveyor spoke with Unit Manager, Staff # 8, who stated that a splint was ordered on [DATE] by therapy for the splint to be applied to the left lower extremity 4 hours on and 4 hours off 2 times per day. The order was never discontinued; however, the splint was unavailable and not on Resident #7. The Care Plan was not reviewed. The DON (Director of Nursing) was made aware of this deficient practice on 3/16/20 at 12:15PM. 6) On 03/16/20 12:00 PM a review of Resident # 16's medical record was conducted. It was found that Resident # 16 did not have a care plan meeting since 2/27/19. This was confirmed by the DON (Director of Nursing) on 3/16/20 at 12:15 PM. 7) The 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. Medical record review revealed that Resident #10 was admitted to the facility with [DIAGNOSES REDACTED]. On 03/09/20 at 12:49 P.M. during interview with (R#10) the surveyro observed the resident wiping his/her watery eyes. The resident stated that he/she was recently diagnosed with [REDACTED]. On 03/09/20 at 1:15 P.M. a review of Resident #10's medical record revealed impaired vision on the care plan created on 01/18/17 which was revised on 03/07/17 for post eye surgery which included nursing goals and interventions related to the vision care. On 03/09/20 at 1:30 P.M. further medical record review revealed the facility failed to revise the impaired vision care plan that addressed the resident's new eye infection which occurred on 03/09/20 with new medication and treatment of [REDACTED]. On 03/12/20 at 11:40 A.M. during staff interviews the nursing Unit Manager and Director of Nursing verified the vision care plan was not revised for Resident #10. All findings were discussed with the Administrator and Director of Nursing prior and during the survey exit.
F 0676 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record and staff interview, it was determined that the facility staff failed, 1) to perform a routine 2 hour turning and 2) failed to apply splint to left lower extremity for resident who had a contracture of left ankle. This was evident for 2 (#9, #7) out of 3 residents investigated for activities of daily living. The findings include: 1) On 3/16/20 a complaint regarding the daily care of Resident # 9 was being investigated. The complaint alleged that on the morning of 11/23/19, the resident's daughter went to the facility to visit her mother and found the resident in her bed covered in urine and feces. The daughter alleged that the resident had been left lying in her stool for a long period of time. On 3/18/20 at 10:30 AM Geriatric Nursing Assistant, GNA #10, who was assigned to the resident the morning of 11/23/19 was interviewed. The GNA stated that on that morning in question the GNA was doing morning rounds and observed the resident in bed, covered up. The GNA stated that there was no odor in the room to suggest the resident needed cleaning. The GNA stated that around 10:30 AM the GNA was working with the resident's roommate when Resident #9's daughter came in. The daughter pulled the covers back and saw the stool on the Resident. According to the GNA there was a lot of stool. Due to the GNA stating that the resident was seen at 7:00 AM, and the GNA was in the resident's room at 10:30 AM, this writer asked the GNA if the resident had been turned (repositioned) as ordered every 2 hours; the GNA stated, No. The resident had not been turned in 3 and hours. 2) A record review was conducted for Resident # 7 on 3/12/2020 at 8:51 AM. Resident #7 was admitted to the facility in the winter of 2013. She/he has a history of Dementia without behaviors, Contracture of left foot, Short of breath, Hypertension, [MEDICAL CONDITIONS], altered mental status, and muscle weakness. On 03/12/20 at 08:35 AM this surveyor went into Resident # 7's room and there was no splint on the resident's left ankle. There had not been a splint on the resident at this facility on 3/9/20 when the surveyor first saw the resident. Record review revealed that the Splint was listed on the care plan starting on 9/25/18 and revised again on 2/29/20. The Care Plan documented that the left ankle splint was to be applied/worn twice a day, 4 hours in the AM and 4 hours in the PM. Monitor for skin alteration and discomfort. ROM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215064	A. BUILDING _____ B. WING _____	03/18/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ADELPHI NURSING AND REHABILITATION CENTER	1801 METZEROTT ROAD ADELPHI, MD 20783

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 0676 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) (Range of Motion) to be done during AM activities of daily living. This surveyor spoke with the LPN (Licensed Practical Nurse), staff # 15, to ask her about the splint. There was no order for a splint on the order sheet for March 2020. LPN staff # 15 looked at the Care Plan with this surveyor. The surveyor pointed out that the splint was in the care plan. The LPN left without saying anything. She made no mention that she would check this out. The surveyor spoke with Unit Manager, Staff # 8, who stated that a splint was ordered on [DATE]. Also, that the splint was ordered by therapy for Resident #7 to be applied to the left lower extremity 4 hours on and 4 hours off 2 times per day. Record review revealed that the order was never discontinued; however, the leg splint was unavailable and not on Resident #7. Nursing staff failed to review and implement Resident #7's Care Plan, as ordered.
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 resident and staff interview, the facility staff failed to follow up and treat Resident #60 for a change in bowel status. This was evident for 1 out of 41 residents investigated during the survey process. The findings include: On 3/12/20 when interviewing Resident #60 about any concerns, the resident stated that the resident was having a problem with constipation. When the writer asked if anything was being done about it, Resident #60 stated, no. The GNA's (geriatric nursing assistants) are responsible for documenting the residents bowel and bladder functioning on a daily basis. On 03/13/20 08:39 AM a review of the resident's continence records (whether the resident voluntarily controlled emptying the bladder and bowels) revealed that since 3/4/20 through 3/12/20 the resident had been having loose diarrhea. The writer interviewed the resident to clarify what was going on. When interviewed the same morning, the resident stated that he was confused. He was not constipated; he was having loose stools. Interview with the resident's nurse after speaking to Resident #60 revealed that the GNAs did not inform the resident's nurse that the resident was having diarrhea. The resident had not been treated for [REDACTED].# 10, who began to investigate the issue and verified the writer's findings.
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 medical records and staff interviews, it was determined the facility staff failed to provide adequate supervision to ensure the safety of Residents #20 ,#71 and #117 , who smoke. This was evident for 3 out of 4 residents investigated while smoking during the survey process. The findings include: A) On 3/11/20 during the 8:00 A.M. smoke time, Resident #20 and Resident #71 lit their own cigarettes with lighters in their own possession. At the 10:00 A.Mm smoke time, Resident #71 again, had his own lighter. Per the facility's smoking policy, retention, storage and distribution of smoking accessories are to be kept under the control of the facility staff when not in use . Staff #12, from the business office, informed the writer that staff number 12 is the one who takes the residents out for their smoke breaks. Staff stated the staff is trying to encourage the resident to turn in their cigarettes and lighter after each smoke break. From smoke break at 8:00 A.M. to smoke break at 10:00 A.M. it was not successful. B) The facility staff failed to assess Resident #117 for the ability to smoke safely, in a timely manner. The survey team entered the facility on 3/9/20 at 9:00 A.M. Resident #117 was admitted to the facility on [DATE]. On 03/11/20 at 01:31 P.M. a review of Resident #117's medical record by the writer revealed that the resident's smoking assessment was completed on 3/10/20. On 3/12/20, the resident was observed smoking during the 8:00 A.M. smoke break. On 03/13/20 at 08:35 A.M. during an interview with Resident #117, the resident was asked how long the resident has been smoking, the resident stated, a long time. When asked if the resident had been smoking since admission, the resident stated, yes.
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and record review, the nursing department failed to review orders and administer the correct liters of oxygen according to Doctors orders provided for Resident # 105 who receives oxygen. This was evident for 1 out of 41 residents. The findings include: On 3/9/2020, this surveyor went to room [ROOM NUMBER]-1 to interview the resident. Resident # 105 was sitting in the hallway outside her room because her/his room was being deep cleaned. Resident #105 was sitting in a geri chair reclined and appeared comfortable. There was an oxygen concentrator next to his/her chair with a humidifier attached and a nasal canula placed on the resident. The oxygen tank was set on 5 liters on O2. The resident was unable to speak and all activities of daily living must be done for him/her. A chart review was conducted on 3/11/20 at 1:20 PM. Resident # 105 has a history of [MEDICAL CONDITIONS], Hypertension, [DIAGNOSES REDACTED], Acidosis, Chronic [MEDICAL CONDITION] Embolism, Hyperemia, Dysphasia Diabetes Type 2 and many other diagnoses. This surveyor checked the monthly physician order [REDACTED]. There was no order for 02 in January and February of 2020 either. A discussion was held with the DON (Director of Nursing) and she was unable to find a progress note or order for the oxygen. The following day this surveyor spoke with the Unit Manager, staff # 8, at aprox. 10:20 AM. Staff # 8 got back to the surveyor later in the day and stated AN order was written for Resident # 105 on 10/26/18 for the resident to discontinue oxygen 5 liters and start oxygen 2 liters, as needed, via a nasal canula for shortness of breath. Another order was written on 11/6/19 by the Doctor, oxygen 2 litters as needed for shortness of breath. The order was never changed or carried over since 10/26/18 to present. Unit Manager, staff # 8, corrected the order and notified the Doctor. This surveyor stated this should be noted on the plan of correction.
F 0711 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit.** Based on the medical record review, it was determined that the facility staff failed to document an assessment of Resident #9 in a timely manner. This was evident for 1 out of 41 residents investigated during the survey process. The findings include: On 3/17/20 while investigating a complaint regarding Resident #9, this writer was reviewing the progress notes in the resident's chart surrounding the dates of concern related to the complaint. The chart revealed a Medical Professional's note from MD #11 that was written as a Late Entry. The effective date of the note read 11/21/19 at 10:58. Further review of the progress note revealed that the initiation of the note for 11/21/19 was written on 1/14/20, fifty-four (54) days after the assessment was completed on the resident, during that 21st day in November 2019.
F 0732 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Post nurse staffing information every day.** Based on observations, review of daily staffing records, and staff interview it was determined the facility failed to post the total number and actual hours worked by categories of Registered nurses, Licensed practical nurses, and Certified nursing aides per shift and failed to have the staff data requirements available in an accurate, clear and readable format. It was identified that the facility did not have staffing information readily available in a readable format for residents and visitors for 8 out of 8 days of the survey. The findings include:. Initial tour of the facility on 3/9/20 did not reveal a facility wide staff posting indicating the total number and actual hours worked by categories of Registered nurses (RN), Licensed practical nurses (LPN), and Certified nursing aides (CNA) per shift. The Federal requirements for the posting of staff was not observed on any subsequent day of the survey. On 3/18/20 upon request, the staff scheduler (staff #13) was asked to bring the historical staff postings for 1/1/20 and 3/3/20. The scheduler originally provided nine sheets of staff postings for 1/1/20 (1 for each shift for all three units). When asked for the total staffing by category a staffing sheet was provided indicating the total hours worked by categories of RNs, LPNs, and CNA's. The staffing sheet for 1/1/20 was printed on 12/31/19. This staffing sheet was not accurate as it indicated staff as a fraction of a person as number of scheduled RNs = 2.06, Number of Scheduled employees LPNs = 5.19 and Number of scheduled Aides = 11.73 for day shift. The Scheduler indicated that she was unable to provide the Federal staff posting requirements for 3/3/20 as asked. She revealed that the new ownership was unable to provide the required information. She indicated that she was unable to make this form available to the residents and visitors as the new company had not developed the capability to post the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215064	A. BUILDING _____ B. WING _____	03/18/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ADELPHI NURSING AND REHABILITATION CENTER	1801 METZEROTT ROAD ADELPHI, MD 20783

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 0732 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	(continued... from page 5) staff with the total number and actual hours worked by categories.
F 0744 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interviews it was determined that the facility staff failed to develop a care plan that is specific enough for Resident #55, with a [DIAGNOSES REDACTED]. The findings include: On 03/11/20 around 011:19 AM, this surveyor was reviewing Resident #55's medical record. It was noted that the resident has a [DIAGNOSES REDACTED]. A Care Plan is a formal process that includes correctly identifying existing needs, as well as recognizing potential needs or risks. This allows nursing to identify interventions to assist the resident with any barriers that interferes with the resident's optimal level of health. On 03/13/20 at 11:24 AM, staff #14, Licensed Practical Nurse (LPN) was interviewed about the resident's plan of care. Staff #14 was asked how staff provided dementia care for this particular resident. Staff #14 explained that the nurses have the same resident and they know when they change or act out of character. When they begin acting out, nurses then have to call the doctor. Per the LPN, the resident is able to make needs known. There was no documentation related to what particular symptoms or behaviors staff should be looking for.
F 0756 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interviews, it was determined that the consultant pharmacist failed to identify and/or ensure that the facility staff established perimeters for the continued use of anti-depression medication for Resident (#10). This was evident for 1 (R#10) out of 5 sampled residents reviewed for medication regimen review during the investigative portion of the survey process. The findings include: 1) [MEDICATION NAME] is anti-depressant medication used to treat depression, which is a serious disorder of the brain. There are a variety of causes, including genetic, biological, environmental and psychological factors. Depression can happen at any age. On 3/11/20 at 9:30 A.M. a record review was conducted for Resident (#10) who was admitted with a medical [DIAGNOSES REDACTED]. On that same date and time the record revealed a physician's orders [REDACTED]. Continued record review revealed a Maryland medication regimen review by the facility's licensed pharmacy consultant. A follow up medication regimen review, as indicated with written comments to the physician's last review, was conducted in Novemeber 2019 by that Pharmacist. However, the record failed to include evidence for the medication regimen reviews conducted for the months of December 2019 nor for, January, February and March of 2020. On 3/11/20 at 10:30 A.M., during an interview with staff member Registered Nurse, RN#1, who stated that the nursing home has new ownership who now uses a different Pharmacy Consultant contracted for monthly medication regimen reviews. The surveyor was informed that there has not been a medication review of any medication orders as of today, 3/11/20, for any residents. The Nursing Home Administrator and Director of Nursing were made aware of these findings during and prior to the survey exit. 2) The Licensed Nursing Home Administrator (NHA) was repeatedly asked for the facility's policies and procedures for the monthly medication regimen review throughout the survey. The NHA was asked again for Medication regimen review policy on 3/13/20 while in the conference room with the survey team. Follow up interview with the NHA on 3/17/20 at 11 AM revealed that the facility did not have policies and procedures for the monthly medication regimen review. The facility failed to have a medication regimen review policy that minimally should have address time frames for steps in the medication regimen review process, with steps the Pharmacist must take when an irregularity requires urgent action.
F 0806 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, observations, medical record review and staff interview it was determined that the facility failed to provide meals and food items that were high in fiber. This was evident for 1 (#181) of 2 residents reviewed for nutrition. The findings include. Resident # 181 was admitted to the facility on [DATE]. On 3/10/20 at 9:35 AM Resident #181 indicated that there was a communication issue with the kitchen. Resident #181 explained that s/he had gotten constipated while in the hospital and s/he received salads, and prune juice with no starch, rice, or potatoes. The resident stated; The facility here knew s/he was to be on a special diet, and they did not provide it. Resident #181 further indicated that the facility is giving her/him eggs and sausage and not oatmeal. The resident shared that she/he had an issue with bad hemorrhoids and was constipated and was recently given a laxative. Resident #181's lunch meal tray was observed on 3/11/20 at 12:25 PM. The meal/tray ticket indicated that the resident was prescribed a low sodium cardiac diet and prune juice three times per day. Upon receiving her/his lunch tray Resident #181 indicted that s/he could not eat the pork that was offered as it wound bound her/him up. Upon request, the resident's assigned geriatric nursing assistant (GNA) had a salad brought to the resident. The resident showed that s/he was disgusted with the salad, as the salad had cheese on it and the resident indicated that cheese binds her/him up. Resident #181's medical record was reviewed on 3/11/20 at 1 PM. Review of the hospital summary revealed that Resident #181 had become severely constipated while in the hospital requiring digital disimpaction. The resident's care plan had a focus area for constipation initiated on 2/25/20. The goal was written as the resident will pass stools comfortable through the review date. One of the interventions to meet the goal was written as Teach the resident/family/caregivers relationship of constipation to food, medicine, diet treatment regimen, disease process and psychosocial factors. Teach the resident /family/caregivers to identify and avoid causative factors (specify; lack of exercise, not enough fiber). The plan of care included another focus area as; Nutritional status as evidenced by therapeutic diet. Interventions were written as; honor food preferences and provide diet as ordered: Low sodium cardiac diet. As of 3/11/20 the resident was not prescribed a diet that was high in fiber. The resident was prescribed a low sodium cardiac diet. On 3/12/20 at 9:45 AM review of the Dietitian's nutritional assessment dated [DATE] indicated will continue with current diet order with foods high in fiber due to [DIAGNOSES REDACTED]. The Food Service Director (staff #5) was interviewed on 3/12/20 at 1:40 PM. Staff #5 was asked what high fiber foods does the facility have to offer. He indicated that they have figs as in fig-newtons, but the facility would get what ever they needed. The Food Service Director asked who was the resident that the surveyor was asking about? The Food Service Director looked the resident up on the computer and acknowledged that Resident #181 was not listed to receive foods high in fiber. Staff #5 continued to explore on the computer and revealed that the resident's milk should be limited, as well as, indicating that menu adjustments will need to be made. A follow up with the resident was conducted on 3/12/20 at 2:33 PM. Resident #181 was eating lunch. S/he revealed that s/he had received breakfast late as the original breakfast tray had eggs and sausage. Resident #181 had to complain and was provided oatmeal and turkey sausage. The Registered Dietitian (staff # 15) re-approached the surveyor on 3/13/20 at 9:50 AM. She indicated that she has written another note that the resident is requesting two servings of oatmeal for breakfast. She was asked as to; what high fiber items does the facility have to offer? She had responded beans, wheat bread, salads, and greens. Prior to surveyor intervention the resident was not receiving foods that were high in fiber.
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 staff observations of the facility's kitchen/ food services and staff interview, it was determined that the facility failed to maintain food service equipment in a manner that ensures sanitary food service operations. This was identified during an initial inspection of the facility's dish washing machine and dishwasher temperature logs. The proper dishwashing temperature was not maintained for 3 of 3 months of temperature logs reviewed. The findings include: An initial Tour of the kitchen was conducted on 3/9/20 at 9:35 AM. Review of the current dishwasher temperature log for March 2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215064	A. BUILDING _____ B. WING _____	03/18/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ADELPHI NURSING AND REHABILITATION CENTER	1801 METZEROTT ROAD ADELPHI, MD 20783

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 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 6) revealed multiple occasions when the wash temperature was below 160 degrees Fahrenheit. Inspection of the dishwashing machine did not have a data plate containing manufacturers specification. The Food Service Director (staff #5) was asked to provide the specifications for the dish washing machine. Review of the manufacture's specifications on 3/11/20 revealed that the dishwashing machine was a Holbert CL44e single tank model. The minimum temperatures for using high-temperature sanitizing was listed as 160 degrees Fahrenheit. Re-review of the dishwasher temperature log for March 2020 on 3/11/20 revealed instructions on the top of the log as; To assure sanitary eating utensils, check temperatures each meal if you notice temperatures lower than standards for the dish machine stop using the dish machine and notify your manager immediately. The unit standard temperatures for the water cycle and final rinse cycle was left blank. There was not any temperature recording the dinner meal of 3/9/20, Lunch of 3/10/20, and for breakfast on 3/11/20. Wash temperatures were recorded 18 times in March below the minimal temperature of 160 degrees Fahrenheit. Review of the dishwashing temperature log for February 2020 did list the minimum water cycle to be 160 degrees but there was at least 46 times when the temperature was recorded less than 160 degrees Fahrenheit. Noted for breakfast of 2/17/20, the wash temperature was recorded as 154 and the final rinse was less than the minimum 180 degrees Fahrenheit recorded at 176 degrees Fahrenheit. Additionally, the staff failed to record any temperatures for dinner time of 2/4/20. January's Dishwasher temperature logs revealed multiple occasions that the wash temperature was not meeting the minimum 160 degrees Fahrenheit. The staff had failed to stop using the dish machine and notify the manager as instructed on the dishwasher temperature logs. Interview of the Food Service Director on 3/13/20 at 1:15 PM revealed that the dishwasher temperature was not consistently maintaining a wash level of 160 degrees Fahrenheit or above. The facility was using disposable dishware (Styrofoam) and plastic utensils until an outside vendor serviced the dish machine. The dishwasher repair service was scheduled to come on the afternoon of 3/13/20. Follow up with the Food Service Director on 3/16/20 revealed that the dish washing machine repair service did not come on 3/13/20 and the facility was still using disposable dishware for the delivery of meals.
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 interviews it was determined that the facility failed to have medical records readily available. This was evident with all medical records reviewed for multiple days of the survey. Additionally, the facility failed to carry over physician orders [REDACTED].# 26, Resident # 105, Resident 127 and Resident 181. This is evident for 2 out of 41 residents reviewed during the survey. The findings include. 1) Upon initiation of the survey on 3/9/20, the facility is requested to provide each surveyor with access to all resident electronic health records - do not exclude any information that should be part of the resident's medical record. It was noted by the survey team on 3/10/20 that there was not access to discharged residents. The Nursing Home Administrator (NHA) was informed of the surveyor lack of access to discharged residents. On 3/11/20 at 1:10 PM interview of the Dietitian (staff #15) revealed that she could not see her own dietary assessments for Resident #181. Resident #181 was admitted to the facility on [DATE]. Upon further medical record review and discussions with the NHA, revealed that there was not full access to current residents' data in the medical records prior to March 3, 2020. The NHA was informed repeatedly that the surveyors need to have access to the full record. The survey team was provided with access to the full medical record by the morning of 3/12/20. The survey team required two access codes to review all the records of the current residents (for medical data prior to 3/3/20) and for residents that were discharged prior to 3/3/20. The impediment of access to the full medical record for 4 days caused considerable delay in the survey process. On 3/16/20 at 11:05 AM an interview was conducted with the facility's wound nurse (staff #16), to discuss Resident # 127's chronic wounds. Resident #127 is seen weekly by a consultant wound physician. Review of the medical record did not reveal any of the weekly documentation. The wound nurse revealed that all of the consultants weekly wound documentation is kept in the wound nurse's office. The wound nurse indicated that all resident's seen by the wound physician, their medical documentation is kept in his office. The surveyor requested to review Resident #127's ongoing wound documentation sheets. The wound nurse revealed that the wound binder is also kept in his office. The wound documentation is not readily accessible to other members of the interdisciplinary team. 2) On 03/11/20 at 08:47 AM a review of Resident # 26's medical record was conducted. Resident # 26 had a history and physical completed on 12/21/2019. The Resident has a history of Diabetes, Hypertension, [MEDICAL CONDITION], Gerd, [MEDICAL CONDITION], [MEDICAL CONDITION] of Left extremity and is on chronic anticoagulants. The Resident has a Right Below Knee Amputation. A Pharmacy Review was done on 1/14/2020 and there was a pharmacy recommendation to start new order for Vit D3 50,000 units for low Vit D level. Dr. responded on 1/14/20 stating resident is on Vit D. An order was written in December 24, 2019 for Vitamin D3 50, 000 units every 2 weeks Vit. D3 was given on 1/8/2020 and 1/22/20. The order was not carried over to February 2020. This surveyor spoke with the DON (Director of Nursing) who was made aware. 3) On 3/9/2020, this surveyor went to room [ROOM NUMBER]-1 to interview the resident. Resident #105 was sitting in the hallway outside her room because her/his room was being deep cleaned. The resident was sitting in a geri chair reclined and appeared comfortable. There was an oxygen concentrator next to his/her chair with a humidifier attached and a nasal canula placed on the resident. Oxygen tank was set on 5 liters on O2. The resident was unable to speak, and all activities of daily living must be done for him/her. A chart review was conducted on 3/11/20 at 1:20 PM. Resident # 105 has a history of [MEDICAL CONDITIONS], Hypertension, [DIAGNOSES REDACTED], Acidosis, Chronic [MEDICAL CONDITION] Embolism, Hyperemia, Dysphasia Diabetes Type 2 and many other diagnoses. She/he was admitted to this facility in 12/22/07. This surveyor checked the monthly physician order [REDACTED]. There was no order for 02 in January and February of 2020 either. A discussion was held with the DON (Director of Nursing) and she was unable to find a progress note or order for the oxygen. The following day this surveyor spoke with the Unit Manager staff # 8 at approx. 10:20 AM. Staff # 8 got back to me later in the day and stated AN order was written for Resident # 105 on 10/26/18 for the resident to discontinue oxygen 5 liters and start oxygen 2 liters as needed via a nasal canula for shortness of breath. Another order was written on 11/6/19 by the Doctor, oxygen 2 litters as needed for shortness of breath. The Order was never changed or carried over since 10/26/18 to present. The Unit Manager staff # 8 corrected the order and notified the Doctor. This surveyor stated this should be noted on the plan of correction.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** Based on the review of the facilities infection control program, it was determined that the facility staff failed to ensure that a surveillance plan was established/ implemented in place. This was evident during the investigation of the facilities infection control program review during the survey process. The findings include: Long-term care facilities are required by federal and state agencies to have in place an infection control program following the Centers for Disease Control and Prevention (CDC) infection control guidance. The gap analysis for the prevention of healthcare-acquired infections in long-tern care facilities is an assessment tool used by facilities to guide them through the evaluation for the presence of best practice recommendations in the prevention of healthcare-acquired respiratory illnesses. On 3/12/20 at 9:29 A.M. during review of the facilities gap analysis for the prevention of healthcare-acquired Infection in long-term Care assessment tool revealed under the category's: Standard and transmission-based precautions: Question: 6). Do staff receive job-specific training and competency validation on proper use of PPE (personal protective equipment) at the time of employment? Answer=No. Question: 7). Do staff at your facility receive job-specific training and competency validation on proper use of PPE within the past 12 months? Answer=No. Question: 10). Does your facility routinely audit (monitor and document) compliance to standard and transmission-based precaution? Answer=No. Hand hygiene: Question: 2). Do staff receive training and competency validation on hand hygiene at the time of employment and yearly? Answer=Yes/No. No verification of Hand Hygiene training practices was documented by the facility. a). When to perform hand hygiene? Answer=No. b). How to perform hand hygiene, including when to use soap and water hand washing verses an alcohol-based hand rub (ABHR)? Answer=No. 3). Facility has a program for the auditing (monitoring and documenting) and feedback of hand hygiene practices? Answer=No. Environmental & Equipment Cleaning: Question: 1). Does your facility have written cleaning/disinfection policies which include daily, discharge, and terminal cleaning/disinfection of residents' rooms? Answer=No. a). Checklist of high-touch surfaces that should be regularly disinfected? Answer=No. Antibiotic Stewardship: Question: 5). The facility has implemented practices in place to improve antibiotic use. Answer=No. Question: 8). The facility provides clinical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215064	A. BUILDING _____ B. WING _____	**03/18/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ADELPHI NURSING AND REHABILITATION CENTER	**1801 METZEROTT ROAD ADELPHI, MD 20783**

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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 7) prescriber with feedback about their antibiotic prescribing practices. Answer=No. Question: 10). The facility has provided training on antibiotic use to all prescribers within the last 12 months. Answer=NO. On 3/12/20 at 9:29 A.M. during staff interview the CMS Regional Office surveyor asked the Nursing Home Administrator (NHA) and Director of Nursing (DON) what type of training the temperature takers received due to abnormally low temps not being recognized as abnormal. The NHA and DON were unable to provide evidence of staff training re: temperature taking. The NHA acknowledged that she/he received CMS policy of COVID-19 visitation restrictions. During the same date and time the DON was unable to find line listing requested by the Regional Office surveyor. The line listing was never provided to the survey team during the survey. The NHA with the DON was made aware of all findings during and prior to the survey team exit. Facilities are to ensure that an infection control program is in place with monitoring and evaluation of best practice recommendations for the prevention of micro-organism transmission to its resident's, staff and visitors.
F 0924 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Put firmly secured handrails on each side of hallways.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview it was determined the facility failed to equip corridors with firmly secured handrails. This was evident on 1 of 3 nursing units observed. The findings include: Observation was made during the survey of missing handrail after room [ROOM NUMBER] in the 2nd floor corridor. An approximately 10-foot section of wooden handrail was noted missing at the initiation of the survey. Interview of the Maintenance Director on 3/17/20 at 12:45 PM revealed that he was awaiting a pex card so that he could buy the supplies required to fix the missing section of handrail.