| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 215069 | A. BUILDING _____ B. WING _____ | 08/27/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| ORCHARD HILL REHABILITATION AND HEALTHCARE CENTER | 111 WEST ROAD TOWSON, MD 21204 |

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 0578<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**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.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review and interview, it was determined that the facility staff failed to take steps to void an older MOLST form in the presence of 1 incongruent MOLST form. This was evident for 1 (Resident #1) of 11 residents reviewed during a complaint 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 (EMS) and other medical personnel regarding cardiopulmonary resuscitation (CPR) 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 #1's medical record on [DATE] at 7:50 AM revealed Resident #1 had two MOLST forms in his/her chart. The first valid MOLST form was dated [DATE] that indicated Resident #1 wanted to be a No CPR, option A-2, Do Not Intubate (DNI): Comprehensive efforts may include limited ventilatory support by [MEDICAL CONDITION] or [MEDICAL CONDITION], but do not intubate. Further review of Resident #1's medical record revealed a second valid MOLST form, dated [DATE], that was located in the history and physical section of the paper medical chart from a hospital that indicated Resident #1 wanted CPR if cardiac and/or [MEDICAL CONDITION] arrest occurred. The back page of the MOLST dated [DATE] form had not been completed except for the physician's signature, printed name, license number, phone number and date. The difference between Resident #1's [DATE] MOLST form and [DATE] MOLST form could potentially lead to the facility staff performing or not performing certain end of life care that Resident #1 did not choose. Interview of Resident #1 on [DATE] at 8:05 AM revealed the resident wanted CPR if his/her heart stopped beating. On [DATE] at 8:17 AM the Director of Nursing (DON) was looking at Resident #1's medical record with the surveyor and confirmed both MOLST forms. On [DATE] at 8:23 AM the DON stated they were immediately doing a facility wide audit to make sure all MOLST forms were accurate. On [DATE] at 8:40 AM both social workers were interviewed and asked what the process was for MOLST forms. Both stated that there should only be 1 active MOLST in the resident's medical record and since the [DATE] MOLST was the latest MOLST, that the [DATE] MOLST should be followed. Both staff stated, we were going to start doing an audit and start going through the charts but were concentrating on the new admissions. The social workers stated they were going to go talk to the resident to ensure that the correct MOLST was in place. On [DATE] at 9:50 AM the DON brought the surveyor a full house audit of MOLST forms which documented that all resident medical records only had 1 active MOLST form. |
| F 0656<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on medical record review and staff interview, it was determined the facility failed to develop and implement a comprehensive person-centered care plan with appropriate measurable goals related to Advanced Directives. This was evident for 3 (#1, #2, #11) of 11 residents reviewed during a complaint survey. The findings include: A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess and evaluate the effectiveness of the resident. 1) Resident #1's medical record was reviewed on [DATE] at 8:00 AM. 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 (EMS) and other medical personnel regarding cardiopulmonary resuscitation (CPR) and other life-sustaining treatment options for a specific patient. Review of Resident #1's medical record on [DATE] at 7:50 AM revealed Resident #1 had two MOLST forms in his/her chart. The first valid MOLST form was dated [DATE] that indicated Resident #1 wanted to be a No CPR, option A-2, Do Not Intubate (DNI): Comprehensive efforts may include limited ventilatory support by [MEDICAL CONDITION] or [MEDICAL CONDITION], but do not intubate. The second valid MOLST form, dated [DATE], that was located in the history and physical section of the paper medical chart from a hospital that indicated Resident #1 wanted CPR if cardiac and/or [MEDICAL CONDITION] arrest occurred. Interview of Resident #1 on [DATE] at 8:05 AM revealed the resident wanted CPR if his/her heart stopped beating. Review of Resident #1's comprehensive care plans failed to produce a care plan regarding Advanced Directives. On [DATE] at 8:16 AM. Staff #19 was interviewed and asked if residents normally had a care plan for Advanced Directives. Staff #19 stated that a care plan should be initiated upon admission. Staff #19 stated, I was doing audits in [DATE] and did not get to that in [DATE]. I was concentrating on new admissions and making sure they had a MOLST care plan. For the older residents that have been here, I should have gone back to make sure they had a MOLST care plan. Staff #19 stated, I do have a policy for doing care plans and sometimes I don't follow my own policy. 2) Review of Resident #2 and Resident #11's medical record on [DATE] at 8:00 AM revealed there was not a care plan for Advanced Directives. Staff #19 confirmed on [DATE] at 8:20 AM. Discussed with the Director of Nursing on [DATE] at 10:45 AM. |
| F 0657<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on medical record review and staff interview, it was determined the facility staff failed to review and revise the interdisciplinary care plans to reveal accurate interventions. This was evident for 1 (#3) of 11 residents reviewed during a complaint survey. The findings include: A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess and evaluate the effectiveness of the resident's care. 1) Review of Resident #3's medical record on 8/24/2020 at 2:00 PM revealed Resident #3 had a wound vac that was used to aide in the healing of a surgical wound. A wound vac is used to assist in the closure of a wound. During the treatment, the device decreases air pressure on the wound. Review of August 2020 physician's orders [REDACTED]. The care plan was not updated to reflect a rescue dressing and the care plan did not have any other interventions related to the surgical wound. 2) Review of Resident #3's care plan, I have |

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.

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| F 0657<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | (continued... from page 1)<br>an ADL (activities of daily living) Self Care Performance Deficit r/t Impaired balance, impaired mobility, that was initiated on 2/20/19, documented the goal, I will maintain current level of function in Bed Mobility, Transfers, Eating, Dressing, Toilet Use and Personal Hygiene; ADL Score through the review date. The new target date to achieve the goal was 11/30/2020. Interventions included, I am independent with my bed mobility, I am independent with dressing, I am independent with toilet use, I am independent with transfers, and I use(walker)assistive device to transfer. The MDS is part of the Resident Assessment Instrument that was Federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned based on those individualized needs, and that the care is provided as planned to meet the needs of each resident. Review of Resident #3's quarterly Minimum Data Set (MDS) with an assessment reference date of 7/29/2020, Section G, functional status, documented that the resident required extensive assistance with at least 2 people for bed mobility and transfers and required extensive assistance with 1 person assist with personal hygiene and dressing. The MDS also documented that the resident did not ambulate during that time period. This was not reflected in the care plan that documented the resident was independent in those activities. 3) Review of the care plan, I have a behavior problem r/t noncompliant of clear liquid diet, that was initiated on 6/10/2020, documented the goal, (Resident #3) will have fewer episodes of (Specify: behavior) COMPLIANCE TO DIET (Specify: daily/weekly) by review date that was initiated 6/12/2020 with a target date of 11/30/2020. The care plan was incomplete, not specific and not updated. A care plan meeting was held on 8/18/2020 and it was documented at 1:56 PM in the progress note section of the resident's medical record, Care plan meeting held with idt (interdisciplinary team). Medications and care plans reviewed and updated at this time. Discussed with the Director of Nursing on 8/27/2020 at 10:40 AM. |
| F 0689<br><br>**Level of harm -** Actual harm<br><br>**Residents Affected -** Few | **Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview and record review, it was determined the facility failed to prevent an accident with injury to Resident #1 during transport in a facility van/shuttle bus after placing Resident #1 in a wheelchair with no assessment or evaluation of the Resident's needs regarding the assistive device. As a result, Resident #1 suffered a fall with harm (injury and significant pain restricting his/her freedom of movement). This was evident for 1 (#1) of 11 residents reviewed during a complaint survey. The findings include: In the State Operations Manual, Appendix PP last updated 11/28/17, the Centers for Medicare and Medicaid Services (CMS) indicated that an avoidable accident means that an accident occurred because the facility failed to identify environmental hazards and/or assess individual resident risk of an accident, including the need for supervision and/or assistive devices; and/or the facility failed to evaluate/analyze the hazards and risks and eliminate them, if possible, or, if not possible, identify and implement measures to reduce the hazards/risks as much as possible. CMS indicates that assistance device or assistive device refers to any item (e.g., fixtures such as handrails, grab bars, and mechanical devices/equipment such as stand- alone or overhead transfer lifts, canes, wheelchairs, and walkers, etc.) that is used by, or in the care of a resident to promote, supplement, or enhance the resident's function and/or safety. CMS indicates that hazards refer to elements of the resident environment that have the potential to cause injury or illness. Hazards over which the facility has control are those hazards in the resident environment where reasonable efforts by the facility could influence the risk for resulting injury or illness. Free of accident hazards as is possible refers to being free of accident hazards over which the facility has control. Anti-tippers attach to any wheelchair and, like training wheels, prevent the chair from tipping over backwards. On 8/7/20, per interview with Resident #1 on 8/25/2020 and review of a facility incident report, the facility provided Resident #1 an assistive device (wheelchair without tipping precautions) and placed Resident #1 on a van for transport without securing the chair appropriately. During transport the chair tipped over resulting in harm to Resident #1. In interview on 8/25/20, Resident #1 stated that during the prior week, last week, he/she stayed in bed later in the day due to pain in his/her ribs after suffering a fall in a wheelchair while in the facility transport van. This was corroborated in interview with Resident #8, (Resident #1's roommate) on 8/26/2020 at 7:54 AM. Resident #1 stated, they didn't have me in my normal wheelchair which is this electric wheelchair. They said they couldn't use my electric wheelchair. I don't think the wheelchair they had me in was secure and it tipped backwards when the driver stepped on the gas after sitting at a stop light. I hit the back of my head and my ribs hurt. When asked if he/she went to the hospital the resident stated, no, they didn't ask me if I wanted to go. They got an x-ray and they did it in my room. An interview was conducted on 8/25/2020 at 9:35 AM with the driver of the van/shuttle bus. He stated, we were going to the bank. The way the van is set up is he/she can't be transported in an electric wheelchair because there is a 450 lb. weight limit on the lift gate and the electric wheelchair weighs a lot. Therapy put the resident in a regular wheelchair instead of the electric wheelchair. Once we put Resident #1 on the bus, the GNA (geriatric nursing assistant) strapped the resident in. There were 4 straps to support Resident #1 on each corner of the wheelchair and one around the resident's waist. Resident #1's weight is in the back because there is no front support. When I pulled off from the light, Resident #1 just went back. When I turned the corner, he went back, and I turned around and helped him up. There was nothing to support Resident #1's weight in the front. The lift gate is slow when you use the electric wheelchair and it blows the fuse because it doesn't support the weight of the wheelchair. The chair is several hundred pounds. The driver stated, I have never transported Resident #1 before in a regular wheelchair. Resident #1 usually goes out with (name) (contracted transport company) in his/her electric wheelchair. I may have taken him/her 1 time before and we noticed the lift gate wouldn't support the chair. We knew that was the one (wheelchair) that was blowing the fuse. At 9:45 AM on 8/25/2020 the van/shuttle bus driver and maintenance director took the surveyor out to see the van. The van was a mid-sized bus. Behind the driver's seat were 2 rows of 2 seats on each side of the bus. Behind the second row were metal strips on the floor. There was an approximate 10 ft. open space from behind the second row to the back of the bus. There was 5 ft. between the front metal strips and the back metal strips. There were 2 hooks, (1) on each end of the front strip and 3 hooks on the back strip, (1) on each end and 1 that was attached to a strap that would wrap from behind the wheelchair, around the resident's waist to a black stationary object to the left of the strips. The van driver stated that normally residents will hold onto the head rest bar on the back of the second row seat. He stated that Resident #1 did not hold onto the head rest bar. The van driver also stated that the brakes were locked on the wheelchair and the GNA was not seated beside or behind the resident but rather sat in a seat in front of the resident. The van driver stated that the GNA hooked the resident in and then he checked the wheelchair to make sure it was secure before driving. On 8/25/2020 at 10:35 AM the Director of Nursing (DON) gave the surveyor a copy of the incident report. Accidents/falls were recorded in a section of the electronic system titled QA (Quality Assurance). Resident #1's incident number 6722, was documented on 8/7/2020 at 12:45 PM. The report was 2 pages. The surveyor asked the DON if there were any other pages to the report. The DON gave the surveyor 1 page of physician's orders [REDACTED].#1. The surveyor asked 3 times if there were any other papers or if there was any further investigation. The DON responded, I gave you everything. Review of the x-ray report on 8/25/2020 at 11:40 AM, of the chest and pelvis that the physician ordered stat after the fall on 8/7/2020, revealed the findings were within normal limits. On 8/25/2020 at 11:40 AM the DON gave the surveyor the Off-Premise Activities policy which documented, c. Prior to departure and upon return to the facility the van driver will perform a safety check of the bus/van. This will include verification that wheelchairs are secured to the floor of the vehicle and the resident's safety belts are secured. On 8/25/2020 at 12:34 PM Staff #10, the therapy director, was interviewed and asked if the resident had been assessed for a proper wheelchair prior to going out on the van. Staff #10 stated that Resident #1 was not on the therapy case load, therefore therapy did not pick out a wheelchair for the resident. Staff #10 stated none of her staff stated that they helped the resident with the wheelchair. An interview was conducted with GNA #8 on 8/25/2020 at 12:38 PM. GNA #8 was the escort on 8/7/2020 when Resident #1 was going to the bank. GNA #8 stated that he got in the bus, strapped the resident in and the bus drove off and they came to a traffic light. GNA #8 stated, we stopped at a light and then the bus jumped forward to go and the weight of the resident pushed him/her back. The whole wheelchair flipped backwards. The wheelchair wasn't stable enough for him/her for his/her weight. Both me and the driver strapped him/her in. I strapped the wheelchair back and the front tire and the seat belt attached around the resident to a hook on the floor of the bus. He/she was in there secure. GNA #8 was asked if he got the wheelchair for the resident and he said, no, I think therapy picked out the wheelchair. I was told the next morning that they already got the chair. When asked if Resident #1 had an injury, GNA #8 stated that the resident had a bruise on a finger and that the resident hit his/her head, but they didn't see any |

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| F 0689<br><br>**Level of harm** - Actual harm<br><br>**Residents Affected** - Few | (continued... from page 2)<br>physical injury to the head. Review of Resident #1's medical record on 8/25/2020 at 12:45 PM revealed Resident #1 had [DIAGNOSES REDACTED]. Review of Resident #1's quarterly MDS (minimum data set) with an assessment reference date of 6/3/2020 revealed the resident required total assistance with at least 2 people for transfers. Further review of Resident #1's medical record revealed a physician's progress note dated 8/9/2020 which documented, BKA (below knee amputation) status [REDACTED]. The [DIAGNOSES REDACTED]. [MEDICATION NAME] is the brand name for [MEDICATION NAME]. [MEDICATION NAME] is a narcotic to treat moderate to severe pain, is an opioid and carries a high risk of addiction. Review of Resident #1's August 2020 Medication Administration Record [REDACTED]. The resident received [MEDICATION NAME] on 8/9, twice on 8/10 and 8/11, 8/13, 8/14, 8/15, 8/16, 8/17, 8/, 8/20, 8/21 and 8/22 for pain scale ranges from 5 to 9 on a scale of 1 to 10 with 10 being the worst pain, 1 being the least amount of pain. Review of nursing progress notes revealed the following documentation: 8/7 at 17:32 hoyered into bed. Bilateral side pain, 8/8 at 21:41 generalized pain 6/10, 8/10 at 14:23 side pain, no apparent discoloration, 8/10 at 22:49 rib pain, 6/10, 8/11 at 15:47 pain across abdomen left to right, 8/12 at 16:01 rib pain, 8/15 at 15:07 general body pain and 8/19 at 13:00 body pain. On 8/25/2020 at 1:22 PM an interview was conducted with Staff #11 who had the roles of Quality Assurance Nurse, Assistant Director of Nursing, Infection Control and Educator. Staff #11 was asked if the incident had been discussed in quality assurance. Staff #11 stated that they discussed in clinical stand-up meeting and that the incident would be under QA in the system. Staff #11 confirmed that the QA paper that the DON gave the surveyor was the only paperwork regarding the incident. When asked if they did a risk/cause analysis she said that is the QA report that the DON gave the surveyor. The surveyor asked where the analysis was, and Staff #11 stated it was the investigative statements. Staff #11 stated after someone falls, they gather around and do a huddle. Staff #11 could not provide documentation to the surveyor. Staff #11 stated she talked to Staff #8 and the van driver. When asked if staff were educated Staff #11 stated, right after that I went on vacation. The unit managers talked to the staff.<br>Typically, when an issue arises, we talk to the unit and then the whole building. I would be responsible. I did educate the GNA, the nurse and the driver. I told them to ensure that the patient is in a good sitting position and strapped in. I did not give any literature or have anyone watch a video. I demonstrated. Staff #11 went to her office and looked through a binder of education sign-in sheets and confirmed there were no educational sign-in sheets done for that incident. On 8/25/2020 at 1:50 PM Staff #12, the RN unit manager was asked if any education had been done after the incident. Staff #12 stated, I told the driver to next time be careful and to use the belt. Staff #12 stated again, next time has to be careful. Staff #12 stated she told Staff #8 to use the right Hoyer pad. A Hoyer lift is a mechanical lift used for transfers when a person requires 90 to 100% assistance to get into and out of bed. A Hoyer pad is placed under a person's body in the bed and connects with chains to the Hoyer lift frame. The pad will stay under the person while in the wheelchair and is disconnected from the frame. Staff #12 stated, I told the GNA to use the right Hoyer pad, that sometimes they use the wrong one. When asked if the right Hoyer pad was used that day Staff #12 said yes. She said she also spoke to the nurse on duty that day about using the right pad. The surveyor stated in the presence of Staff #11, I thought the chair tipped backwards and Staff #11 stated, yes, it did. It was not from the pad. On 8/25/2020 at 1:58 PM the van driver was asked if he had received education after the incident and he said no. He stated he was just asked by his supervisor what happened. He said he had training the first day when he started working at the facility but nothing since then. On 8/25/2020 at 3:02 PM Staff #8 was asked if he had any training or education after the incident and he replied, the unit manager did not talk to me and I did not receive any education after the incident. On 8/25/2020 at 2:20 PM Staff #10 informed the surveyor that Staff #13, the physical therapist, was the one that gave the wheelchair to the resident. Staff #10 placed a phone call to Staff #13 in the presence of the surveyor, NHA, DON and ADON and put her on speaker phone. On 8/25/2020 at 2:26 PM Staff #13 was asked by the surveyor if she assessed Resident #1 for an appropriate wheelchair. Staff #13 stated, I didn't have time to make an assessment. He/she is not on (therapy) case load. I looked around and got him/her a wheelchair and took it to his/her room. It was a big one for his/her size. I was on my way to assess another patient. When asked if the wheelchair had anti-tippers, she said she did not remember. At that time Staff #10 was asked if the resident should have been assessed prior to a wheelchair being given to the resident and the response was yes. According to the website https://www.ncbi.nlm.nih.gov/ which is the National Center for Biotechnology Information, National Library of Medicine, National Institute of Health website, the following wheelchair measurements must be taken before seat fitting: seat width, depth and height; patient hip, trunk and shoulder widths, patient shoulder and axillae heights, wheelchair leg length, arm height, back height, wheelchair width, height and size; knee to seat depth; knee to heel length; seat to back support angle; seat to lower leg support angle and lower leg support to foot support angle. On 8/26/2020 at 8:05 AM Resident #1 stated, it took 4 people to get me up from the fall. I didn't think I was badly hurt at the time but in the afternoon before the van came back to pick me up from the bank I took a deep breathe, and I said, oh that hurt and when I got back here and got in bed I stiffened up. The therapist gave me a w/c that (didn't fit me). They hooked it to the floor. The forward motion caused it to go back. It was a plain wheelchair and it didn't have those things to prevent it from going backwards. You know, they have an unofficial rule about no electric wheelchair because they are afraid the van will break. They have a manual bar they could use. The last time I went out was back in February. I normally go with (name), but they were not taking people places for a while. I was told I would have to go in a regular wheelchair. The surveyor was informed on 8/27/2020 at 10:25 AM by the DON and Corporate Nurse that the van driver stated he had been doing safety checks monthly and now he would be doing them daily. |
| F 0711<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on medical record review and staff interview it was determined physician/Certified Registered Nurse Practitioner (CRNP) progress notes were not in the medical record after each visit. This was evident for 3 (#1, #9, #10) of 11 residents reviewed during a complaint survey. The findings include: 1) A review of Resident #1's medical record on 8/26/2020 at 7:40 AM revealed the last physician's progress note in the medical record was dated 10/16/2019. On 8/26/2020 at 7:45 AM Staff #13 looked through the medical record and could not find the physician's progress notes. At 8:12 AM Staff #13 informed the surveyor that the Director of Nursing (DON) was going to call the physician's office and have the notes sent over. On 8/26/2020 at 8:17 AM the DON looked through Resident #1's medical record and could not find any physician notes. The DON confirmed the last note in the medical record was dated 10/16/19. On 8/26/2020 at 2:00 PM the DON provided the surveyor with copies of (7) physician visits dated 12/8/2019, 2/16/2020, 4/5/2020, 5/13/2020, 6/11/2020, 7/19/2020 and 8/9/2020. 2) A review of Resident #9's medical record on 8/26/2020 at 8:20 AM revealed there were no physician progress notes [REDACTED]. On 8/26/2020 at 2:00 PM the DON provided the surveyor with copies of (7) physician visits dated 2/2/2020, 4/6/2020, 5/28/2020, 6/2/2020, 6/3/2020, 6/15/2020 and 7/2/2020. 3) A review of Resident #10's medical record on 8/26/2020 at 8:25 AM revealed there were no physician progress notes [REDACTED]. On 8/26/2020 at 2:00 PM the DON provided the surveyor with copies of (3) physician visits dated 6/29/2020, 7/7/2020 and 8/25/2020. On 8/26/2020 at 2:00 PM the DON stated that the Medical Records Coordinator was responsible for filing the physician's notes, however she was behind since she was also responsible for ordering and maintaining supplies for the facility. |
| F 0725<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and review of documentation, it was determined the facility 1) failed to ensure sufficient and competent staffing when physical therapy provided Resident #1 an unsafe wheelchair without assessing his/her needs and when the Quality Assessment nurse (who was also acting as the Assistant Director of Nursing, Infection Control and the facility Educator) failed to conduct a thorough investigation for an accident that resulted in harm to Resident #1 and 2) failed to ensure that sufficient staff were available to meet the needs of resident's based on resident acuity and personal health and medical needs. This was evident for 4 (#1, #3, #8, #11) of 11 residents reviewed and 10 of 11 staff members interviewed during a complaint survey. The findings include: A wheelchair assessment involves looking at a resident's muscle strength, trunk and neck strength, balance, motor control, pelvic position, posture, range of motion and assessing the resident's ability to safely use the equipment. Anti-tippers attach to any wheelchair and, like training wheels, |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |
|---|---|
| F 0725<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | (continued... from page 3)<br>prevent the chair from tipping over backwards. 1) The physical therapist selected an unsafe wheelchair for use for Resident #1 during transport without conducting an assessment of the resident's needs. On 8/25/2020 at 2:20 PM Staff #10 informed the surveyor that Staff #13, the physical therapist, was the one that gave the wheelchair to Resident #1. Staff #10 placed a phone call to Staff #13 in the presence of the surveyor, Nursing Home Administrator (NHA), Director of Nursing (DON) and Assistant Director of Nursing (ADON) and put her on speaker phone. On 8/25/2020 at 2:26 PM Staff #13 was asked by the surveyor if she assessed Resident #1 for an appropriate wheelchair. Staff #13 stated, I didn't have time to make an assessment. He/she is not on case load. I looked around and got him/her a wheelchair and took it to his/her room. It was a big one for his/her size. I was on my way to assess another patient. When asked if the wheelchair had anti-tippers, she said she did not remember. At that time Staff #10 was asked if the resident should have been assessed prior to a wheelchair being given to the resident and the response was yes. 2. Resident #1 suffered a fall with harm which was not sufficiently investigated, and which did not result in facility wide education to ensure a similar event would not recur. Resident #1 was placed on a facility van in an unsafe wheelchair that was selected by a physical therapist without assessing the resident's needs. The selected chair did not have tippers and the chair was not secured in a manner that kept the chair from tipping over. Resident #1 suffered a fall with harm when the chair tipped over in the van during transport (cross reference Federal Survey Tag F-689.) On 8/25/2020 at 1:22 PM an interview was conducted with Staff #11 who had the roles of Quality Assurance Nurse, Assistant Director of Nursing, Infection Control and Educator. Staff #11 was asked if the incident had been discussed in quality assurance. Staff #11 stated that they discussed in clinical stand-up meeting and that the incident would be under QA in the system. Staff #11 confirmed that the QA paper that the DON gave the surveyor was the only paperwork regarding the incident. When asked if they did a risk/cause analysis she said that is the QA report that the DON gave the surveyor. The surveyor asked where the analysis was, and Staff #11 stated it was the investigative statements. Staff #11 stated after someone falls, they gather around and do a huddle. Staff #11 could not provide documentation to the surveyor. Staff #11 stated she talked to Staff #8 and the van driver. When asked if staff were educated Staff #11 stated, right after that I went on vacation. The unit managers talked to the staff. Typically, when an issue arises, we talk to the unit and then the whole building. I would be responsible. I did educate the GNA, the nurse and the driver. I told them to ensure that the patient is in a good sitting position and strapped in. I did not give any literature or have anyone watch a video. I demonstrated. Staff #11 went to her office and looked through a binder of education sign-in sheets and confirmed there were no educational sign-in sheets done for that incident. On 8/25/2020 at 1:50 PM Staff #12, the RN unit manager was asked if any education had been done after the incident. Staff #12 stated, I told the driver to next time be careful and to use the belt. Staff #12 stated again, next time has to be careful. Staff #12 stated she told Staff #8 to use the right Hoyer pad. A Hoyer lift is a mechanical lift used for transfers when a person requires 90 to 100% assistance to get into and out of bed. A Hoyer pad is placed under a person's body in the bed and connects with chains to the Hoyer lift frame. The pad will stay under the person while in the wheelchair and is disconnected from the frame. Staff #12 stated, I told the GNA to use the right Hoyer pad, that sometimes they use the wrong one. When asked if the right Hoyer pad was used that day Staff #12 said yes. She said she also spoke to the nurse on duty that day about using the right pad. The surveyor stated in the presence of Staff #11, I thought the chair tipped backwards and Staff #11 stated, yes, it did. It was not from the pad. On 8/25/2020 at 1:58 PM the van driver was asked if he had received education after the incident and he said no. He stated he was just asked by his supervisor what happened. He said he had training the first day when he started working at the facility but nothing since then. On 8/25/2020 at 3:02 PM Staff #8 was asked if he had any training or education after the incident and he replied, the unit manager did not talk to me and I did not receive any education after the incident. 3) An interview was conducted with Resident #3 on 8/24/2020 at 10:55 AM. As the surveyor walked into the resident's room the surveyor asked if it was a good time to talk to the resident. The resident stated, it's ok but I have a concern about staffing because I put my call light on at 9:30 AM because I was wet, and I didn't want my bandage to get wet and I am still laying here wet. Resident #3 stated that Staff #5 (caring partner) came in and said he was only passing ice and couldn't help. He said he would get the nurse. No one came in until 10:58 AM, after the surveyor walked into the room. At that time the surveyor left the room during care. On 8/24/2020 at 11:00 AM Staff #4 was asked when she had been in Resident #3's room prior to just walking in and she said around 7:00 AM. She said she was just coming in to do morning care. She said she had brought a towel and washcloth in before and brought in the breakfast tray. She said the resident had been sleeping, that is why she was just getting in there. When asked if they worked short staffed, she said they have the caring partners that help. On 8/24/2020 at 11:03 AM interview of Staff #5 (caring partner) revealed he answered the call light and the resident stated he/she wanted a nurse for personal reasons so he told the nurse (he nodded to the nurse standing behind him in the hallway which was Staff #6. He said he answered the light around 9:30 AM. On 8/24/2020 at 11:04 AM Staff #6 was interviewed, and she said Staff #5 did not come to her and she did not have the resident on her assignment. On 8/24/2020 at 11:23 AM Resident #3 was interviewed and stated that Staff #4 came and brought towels in around 7 and then the breakfast tray. She again stated about putting the call light on and telling Staff #5 that he/she needed to be changed and him saying he only passed ice water. Resident #3 stated, a lot of days are frustrating because they don't have enough people. I have issues with the food because I get a lot of what I don't like, chicken salad and tuna because I can't eat mayo. It is hard to exchange a meal because they are shorthanded and have to also feed other residents. It is worse on the weekends. Resident #3 stated, the wound vac came off yesterday and I needed to have a rescue dressing put on. At 12:30 PM I told the nurse that it had to be fixed and he said he was working a double and he finally came in at 5 PM to do it. I started to smell the wound. He should have been in here earlier. On 8/24/2020 at 4 PM Staff #21 stated, we work short staffed, can't get to last rounds or charting. Sometimes can't toilet the residents or turn them. Staff #22 stated on 8/24/2020 at 4:08 PM, we work short staffed, they won't use agency due to cost. We are taught to double brief. Can't get to oral care, bathing. When we get here in the morning, we must do the care that couldn't get done overnight. Staff #23 stated on 8/24/2020 at 4:12 PM, we work short staffed. It is hard to get work done. We can't do the care that we need to do for the residents. Staff #24 stated on 8/24/2020 at 4:25 PM, we work short. We only have 2 GNAs today for 34 residents. We were using agency for a while during COVID but that stopped in June. Staff #25 stated on 8/24/2020 at 4:27 PM, a majority of the time we work short staffed. There is not enough linen available, not enough people passing trays. We turn residents 1 or 2 times per shift when we are short. Staff #7 approached the surveyor on 8/24/2020 at 4:30 PM and stated she heard that the surveyor was asking about staffing. Staff #7 stated that they had agency but stopped in June. Staff #7 stated that there was no need any more as staff were recovering and coming back to work. On 8/25/2020 at 7:03 AM Staff #26 was interviewed and stated, we are short staffed a lot. It is hard and sometimes we can't keep up. We can't get residents out of bed, we can't answer call lights fast enough, and we can't get there quick enough to change them. An interview was conducted with Resident #1 on 8/25/2020 at 8:50 AM. The conversation was initiated by the surveyor asking about staffing. The resident stated that they were short staffed and were lucky if they had 2 GNAs (geriatric nursing assistant) for 30 residents. They did not get me out of bed until 2:30 PM yesterday. I like to at least be out of bed by 11:30 AM. Resident #1 stated he/she required the use of a Hoyer lift and it takes 2 people to do that transfer. Resident #1 also stated that there are times when the GNA does the lift alone due to not having anyone to help. On 8/26/2020 at 7:54 AM an interview was conducted with Resident #8 (Roommate of Resident #1). Resident #8 stated he/she was, pretty independent but worried about his/her roommate. Resident #8 stated, sometimes he/she sits up until midnight waiting for them to have enough people to put him/her to bed, especially on weekends. They are pretty much short staffed all the time. My roommate always has to wait. On 8/26/2020 at 8:45 AM an interview with Staff #17 and Staff #18 revealed they both had staffing concerns and that there were not enough GNAs for resident care for the residents. Residents have complained that call bells take a long time to answer because either the residents need to be changed, use the restroom or have to be pulled up in bed. Residents have complained that they have been left wet for at least 30 minutes to an hour. Resident #11 stated on 8/26/2020 at 2:25 PM, we wait more than usual. I need help going to the bathroom and I have to wait at least 15 minutes. On 8/26/2020 at 2:30 PM Staff #20 stated, we work short. We are supposed to have 3 GNAs and sometimes on the weekend there is only 1 GNA. Last week there were no GNAs and 1 care partner. There were 2 nurses for 30 residents. After a GNA finished on another unit they came over to help. I had to pass meds, do treatments, do patient care along with everything else. In the [AGE] years I have been doing nursing I have never seen anything like this before. 4. A review was conducted of actual worked nursing schedules on 8/26/2020 at 1:30 PM that was given to the surveyor by the DON on 8/25/2020. The time period reviewed was from 8/17/2020 to 8/23/2020, which was 7 days. The resident census for Unit 2 fluctuated from 29 residents to 34 residents for the 7 day time period. For the 7:00 AM to 3:00 PM shift there were 6 days when 2 GNAs worked and 1 day where there was only 1 GNA. That equates to 15 to 17 residents per GNA during the day shift when there are 2 GNAs and 29 to 34 residents when there is 1 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 215069 | A. BUILDING _____ B. WING _____ | 08/27/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| ORCHARD HILL REHABILITATION AND HEALTHCARE CENTER | 111 WEST ROAD TOWSON, MD 21204 |

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| F 0725<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | (continued... from page 4)<br>GNA. The 3:00 PM to 11:00 PM actual worked schedule for Unit 2 documented there were 4 evenings were 2 GNAs worked and 3 evenings where there was only 1 GNA for the entire unit of 29 to 34 residents. For the 11:00 PM to 7:00 AM shift on 8/23/2020 there were no GNAs and 1 nurse for 29 residents on the actual worked schedule that was given to the surveyor. The resident census for Unit 3 fluctuated from 32 to 35 residents for the 7 day time period. For the 7:00 AM to 3:00 PM shift it was documented 1 day that the unit had 3 GNAs, 5 days there were 2 GNAs and 1 day had 1 GNA for 34 residents. For the 3:00 PM to 11:00 PM shift it was documented 1 evening where there were 2 GNAs for 8 hours and 1 GNA for 4 hours, 4 evenings in which there were 2 GNAs and 1 evening with 1 GNA, 1 evening with 1 GNA for 8 hours and 1 GNA for 6 hours and 1 evening with 1 GNA and 1 GNA on light duty. 5. Review of the Resident Census and Conditions of Residents that was given to the surveyor by the Director of Nursing (DON) on 8/25/2020 revealed out of the 105 residents, only 2 were independent with bathing, 1 was independent with dressing and 3 were independent with toilet use. The remainder of the residents were either an assist of 1 or 2 staff members or totally dependent on staff for care needs. The form documented that 90 of the residents were occasionally or frequently incontinent of their bladder, therefore would either require assistance or total dependence with toileting and changing of briefs. The form documented that 40 residents were dependent for transferring and 54 residents required the assistance of 1 or 2 staff members. The staffing concerns were discussed with the Corporate Director, NHA and DON throughout the survey and again on 8/27/2020 at 11:10 AM during the exit conference. |
| F 0732<br><br>**Level of harm** - Potential for minimal harm<br><br>**Residents Affected** - Many | **Post nurse staffing information every day.**<br><br>Based on observations, review of daily staffing records, and staff interview it was determined that the facility failed to 1) update the staffing boards with all of the staff names working that shift, at the beginning of the shift and 2) post the total number and actual hours worked by categories of Registered Nurses (RN), Licensed Practical Nurses(LPN), and Certified Geriatric Nurse Aides (GNA) per shift. This was evident for 3 of the 4 days of the survey, on 3 of 4 units observed. The findings include. Observation was made on 8/24/2020 of the Unit 3 staffing board at 10:30 AM. The resident census was 34, there were 2 nurse's names and 2 GNA names on the board. The 2 caring partners names were not on the staffing board. When the surveyor went back up to the board at 10:45 AM the Director of Nursing (DON) was in the hall and it was noted that the staffing boards were updated with the 2 names of the caring partners. There were no nursing hours on the board. Observation was made of Unit 1 and Unit 2 and there were no nursing hours on the staffing boards. Observation was made on 8/24/2020 at 4:14 PM of the Unit 2 staffing board. There were no names on the staffing board for GNAs. The names of the day shift nurses names were still on the board. There were no nursing hours. Observation was made on 8/24/2020 at 4:17 PM of the Unit 3 staffing board. The names of the 7-3 staff were still posted even though the 3-11 shift was on duty. The nursing hours were not posted. Observation was made on 8/25/2020 at 8:00 AM on Unit 2. The nursing hours were not posted. On 8/26/2020 the Unit 2 staffing board was observed at 10:40 AM. The resident Census was 30 and it was documented the GNA ratio was 1:12 which was incorrect as it should have been 1:15. There were no nursing hours. Discussed with the Corporate Director on 8/26/2020 at 9:00 AM. |
| F 0757<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Ensure each resident's drug regimen must be free from unnecessary drugs.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on medical record review and staff interview it was determined the facility failed to keep a resident's drug regimen free from unnecessary drugs by failing to obtain an adequate indication for use of PRN (when needed) medications for pain. This was evident for 2 (#1, #3) of 11 residents reviewed during a complaint survey. The findings include: 1) Review of Resident #1's medical record on 8/27/2020 at 9:00 AM revealed August 2020 physician's orders [REDACTED]. (2) tablets every 6 hours prn (as needed) for pain and an order for [REDACTED]. [MEDICATION NAME] is a narcotic to treat moderate to severe pain, is an opioid and carries a high risk of addiction. Review of Resident #1's August 2020 Medication Administration Record [REDACTED]. The resident received [MEDICATION NAME] on 8/9, twice on 8/10 and on 8/11, 8/13, 8/14, 8/15, 8/16, 8/17, 8/19, 8/20, 8/21 and 8/22 for pain scale ranges from 5 to 9 on a scale of 1 to 10 with 10 being the worst pain, 1 being the least amount of pain. There was no indication as to when to give which pain medication. 2) Review of Resident #3's August 2020 MAR indicated [REDACTED]. every 6 hrs. prn pain and [MEDICATION NAME] 50 mg. every 6 hrs. prn pain. Resident #3 received [MEDICATION NAME] once per day on 8/4, 6, 8, 11, 13, 14, 15, 17, 25; Twice per day on 8/2, 3, 5, 7, 9, 10, 12, 18, 19, 21, 22, 24 and three times in 1 day on 8/23/2020. Resident #3 did not receive Tylenol for pain the entire month of August. Pain levels ranged from 4 to 8 on a 1 to 10 pain scale. Review of Resident #3's July 2020 MAR indicated [REDACTED]. The resident did not receive Tylenol in the month of July. Pain levels ranged from 3-7 on a 1 to 10 pain scale. On 8/27/2020 at 10:30 AM Licensed Practical Nurse (LPN) #15 was interviewed and asked how she would choose which pain reliever to give to a resident who complained of pain. LPN #15 stated she would assess the resident's pain level and if the pain was between 4 or 5, she would give Tylenol. If the pain was above 5, she would give [MEDICATION NAME] and then re-assess to see if the medication was effective. On 8/27/2020 at 10:33 AM Registered Nurse (RN) #16 was asked how she would choose which pain reliever to give to a resident who complained of pain. RN #16 stated for a pain level of 1-4 she would give Tylenol and for a pain level of 5 and up she would give [MEDICATION NAME]. RN #16 was asked what she would do if the Resident wanted [MEDICATION NAME] instead of Tylenol and the pain level was below 5. RN #16 stated she would educate the resident on Tylenol and if the resident still insisted, she would notify the physician to get the authorization to give the medication. On 8/27/2020 at 10:37AM LPN #3 was asked the same question and she stated she would give Tylenol for a pain level of 1-4 and [MEDICATION NAME] for a pain level of 5 and up. On 8/27/2020 at 10:40 AM interview of the Director of Nursing (DON) revealed she would give Tylenol for a pain level of 1 to 4 and [MEDICATION NAME] for a pain level of 5 to 10, but the physician would need to be specific as to when to give each prn medication. At that time the DON was informed that, for both residents, the order was not specific. |