

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 01AL0051	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/21/2013
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NAME OF PROVIDER OR SUPPLIER ASSISTED LIVING AT FROSTBURG VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 VILLAGE PARKWAY FROSTBURG, MD 21532
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E 000	<p>Initial Comments</p> <p>From November 19, through 21, 2013, a renewal survey was conducted at the above named facility for the purpose of determining the facility's compliance with COMAR 10.07.14, Assisted Living Regulations. Survey activities included the review of: policy and procedures, three (3) resident records, five (5) staff records, administrative records, interviews with the Assisted Living Manager (ALM), Alternate Assisted Living Manager (AALM) and Delegating Nurse/Case Manager (DN/CM). A tour of the facility was completed on November 21, 2013. Based on the renewal survey findings, the following deficiencies were identified.</p> <p>The facility's census on November 19, 2013 was twenty eight (28) residents;</p>	E 000		
E2600	<p>.19 B6,7 .19 Other Staff--Qualifications</p> <p>(6) Receive initial and annual training in: (a) Fire and life safety, including the use of fire extinguishers; (b) Infection control, including standard precautions, contact precautions, and hand hygiene; (c) Basic food safety; (d) Emergency disaster plans; and (e) Basic first aid by a certified first aid instructor; (7) Have training or experience in: (a) The health and psychosocial needs of the population being served as appropriate to their job responsibilities; (b) The resident assessment process; (c) The use of service plans; and (d) Resident's rights; and</p> <p>This REQUIREMENT is not met as evidenced</p>	E2600		

OHCQ
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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E2600	<p>Continued From page 1</p> <p>by: Based on staff record reviews and interview with the ALM, the facility failed to ensure documentation was available to support initial and on-going/annual training's were completed.</p> <p>Findings included:</p> <p>1.) The Alternate Assisted Living Manager (AALM) training record failed to contain documentation to support initial training in basic first aid with certification of training.</p> <p>2.) The DN/CM training record failed to contain documentation to support on-going/annual training in basic first aid with certification of training. The DN/CM's first aid training expired in August 2013.</p> <p>3.) Staff #1's training record failed to contain documentation to support re-certification of first aid training, initial training in resident assessment process and the use of service plans.</p> <p>4.) Staff #2's training record failed to contain documentation to support initial training in first aid, resident assessment process and the use of service plans.</p>	E2600		
E2730	<p>.19 G4 .19 Other Staff--Qualifications</p> <p>(4) Ongoing training in cognitive impairment and mental illness shall be provided annually consisting of, at a minimum:</p> <p>(a) 2 hours for employees whose job duties involve the provision of personal care services as described in Regulation .28D of this chapter; and</p> <p>(b) 1 hour for employees whose job duties do not involve the provision of personal care services as</p>	E2730		

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E2730	Continued From page 2 described in Regulation .28D of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff record reviews, the ALM failed to ensure documentation was available to support a minimum of two (2) hours of on-going training in cognitive impairment and mental illness was completed annually for all staff providing resident care services. Findings include: The DN/CM and Staff #1's records documented two (2) one (1) hour training's courses in cognitive impairment for 2013; the training's were called Understanding Alzheimer's Disease / Dementia and Care of the Cognitively Impaired. But the staffs' records failed to contain documentation to support mental illness training was received as part of the two hour training	E2730		
E2780	.20 C .20 Delegating Nurse C. Duties. The delegating nurse shall: (1) Be on-site to observe each resident at least every 45 days; (2) Be available on call as required under this chapter or have a qualified alternate delegating nurse available on call; and (3) Have the overall responsibility for: (a) Managing the clinical oversight of resident care in the assisted living program; (b) Issuing nursing or clinical orders, based upon the needs of residents; (c) Reviewing the assisted living manager's assessment of residents; (d) Appropriate delegation of nursing tasks; and (e) Notifying the OHCQ:	E2780		

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E2780	<p>Continued From page 3</p> <p>(i) If the delegating nurse's contract or employment with the assisted living program is terminated; and</p> <p>(ii) Of the reason why the contract or employment was terminated.</p> <p>This REQUIREMENT is not met as evidenced by: Based on resident record reviews and interview with the ALM, the Delegating Nurse/Case Manager (DN/CM) failed to assume overall responsibility for: 1.) Ensuring adequate 45-day reviews are completed, 2.) Ensuring a qualified alternate delegating nurse is available, 3.) Ensuring all medications are administered consistently with applicable requirements of COMAR 10.27.11 (Nurse Practice Act)-and Maryland Board of Nursing (MBON) Medication Technicians' (MT) Course; 4.) Managing the clinical oversight of residents' service plans, 5.) Oversight of the unlicensed Medication Technicians'.</p> <p>Findings include:</p> <p>1. Based on interview with the ALM, the facility does not currently have an alternate DN/CM. The plan is for the AALM to take the DN/CM course and be the back-up DN/CM. The facility was unable to support when the AALM would be enrolled into a DN/CM course and the facility has been without a back DN/CM for over 10 months.</p> <p>2. All three (3) residents' current 45-day reviews failed to document medication errors and adequate oversight of the residents' medical conditions. (Refer to Tag #3650)</p> <p>3. Resident #3's service plans failed to be</p>	E2780		

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E2780	<p>Continued From page 4</p> <p>completed within the 30 day of admission. (Refer to Tag #3370)</p> <p>4. The DN/CM failed to ensure the services that were documented in Resident #1's service plan was being completed by the unlicensed staff. (Refer to Tag #3360 oversight of food intake related to unstable B/S levels).</p> <p>5. Resident #1 The DN/CM failed to ensure appropriate procedures were defined and followed for reporting and documenting B/S over 400. The resident's orders document to call the physician for B/S over 400. Review of the resident's November 2013 MAR revealed the resident had a B/S result of 423 at 11:00 am on 11/2/13 and 15 units of Novolin was administered. The resident's sliding scale (S/S) orders documented the highest dose of insulin at 12 units. No documentation was found in the resident's record or was provided by the ALM or DN/CM to support a physician's order to administer 15 units of Novolin. The DN/CM is responsible for the actions taken by the unlicensed staff that administers medications. Sliding scale Novolin insulin is considered a high risk medication.</p>	E2780		
E2820	<p>.21 B1,2,3 .21 Preadmission Requirements</p> <p>B. Resident Assessment Tool. (1) Within 30 days before admission, the assisted living program shall collect, on the Resident Assessment Tool written information about a potential resident's physical condition and medical status. (2) Information on the Resident Assessment Tool shall be based on an examination conducted by a primary physician, certified nurse practitioner,</p>	E2820		

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E2820	<p>Continued From page 5</p> <p>certified registered nurse midwife, registered nurse, or physician assistant who shall certify that the information on the Assessment reflects the resident's current health status.</p> <p>(3) If the potential resident is admitted on an emergency basis by a local department of social services, the required assessment using the Resident Assessment Tool shall be completed as soon as possible but no later than 14 days of the emergency admission.</p> <p>This REQUIREMENT is not met as evidenced by: Based on resident record reviews and interview with the DN/CM, the facility failed to ensure the Residents' Full Assessments (Resident Assessment Tool, Functional Assessment, and Scoring Tool) were completed prior to the resident's admission to the facility.</p> <p>Findings include:</p> <p>1.) Resident #1's record review revealed the resident was admitted to the facility on 7/17/13. The resident's Resident Assessment Tool was signed as completed on 7/15/13, the functional assessment was dated 7/29/13 and the scoring tool was not completed.</p> <p>2.) Resident #3's record review revealed the resident was admitted to the facility on 7/30/13. The resident's Resident Assessment Tool was signed as completed on 7/30/13, the functional assessment was dated 9/26/13 and the scoring tool was dated 10/17/13. All three components of the full assessment are required to be completed at the same general time and prior to the resident's admission.</p>	E2820		

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E3330 E3330	Continued From page 6 .26 B1,2 .26 Service Plan B. Assessment of Condition. (1) The resident's service plan shall be based on assessments of the resident's health, function, and psychosocial status using the Resident Assessment Tool. (2) A full assessment of the resident shall be completed: (a) Within 48 hours but not later than required by nursing practice and the patient's condition after: (i) A significant change of condition; and (ii) Each nonroutine hospitalization; and (b) At least annually. This REQUIREMENT is not met as evidenced by: Based on Resident #2's record review the facility failed to ensure the following requirements were meant; 1.) A full Assessment was completed within 48 hours of a significant change, 2.) Service Plan review after the significant change and 3.) Annual renewal of the full assessment was completed. Findings included: 1. The resident was transferred to the local emergency room on 8/26/13 after a fall with complaints of hip pain. The facility failed to initiate a new full assessment to address the resident significant change. 2. Review of the resident's service plan revealed the service plan was not documented as reviewed for changes related to the emergency room visit on 8/26/13. 3. Review of Resident #2's record revealed a full assessment that was dated December 2011 with a review date of 6/19/12. The facility was unable to produce the annual full assessment that was	E3330 E3330		

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E3330	Continued From page 7 due in December 2012. Interview with the DN/CM acknowledged that some paper work for the residents' is behind, because up until recently she was only part time. The DN/CM stated that she is now full time and working on getting the residents' paper work up dated as required.	E3330		
E3360	.26 C1 .26 Service Plan C. The assisted living manager, or designee, shall ensure that: (1) A written service plan or other documentation sufficiently recorded in the resident's record is developed by staff, which at a minimum addresses: (a) The services to be provided to the resident, which are based on the assessment of the resident; (b) When and how often the services are to be provided; and (c) How and by whom the services are to be provided; This REQUIREMENT is not met as evidenced by: Based on resident record reviews, the residents' service plan failed to document detailed, individualized services to meet the resident's needs that are identified in the residents' records. Findings included: Resident #1 The resident's record review revealed the resident was admitted to the facility on 7/17/13 with the diagnosis of Diabetes Mellitus. Review of the resident's service plan revealed the following services were not documented; blood sugar parameters, monitoring for signs and symptoms	E3360		

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E3360	Continued From page 8 of hyperglycemia and hypoglycemia. The service plan documented the need to monitor the resident's inappropriate food choices; however after the first month and a half staff stopped documenting the resident's reportedly poor food choices. (Refer to Tag 2780)	E3360		
E3370	.26 C2 .26 Service Plan (2) The service plan is developed within 30 days of admission to the assisted living program; and This REQUIREMENT is not met as evidenced by: Based on Resident #3's record review and interview with the DN/CM the facility failed to ensure a service plans was completed within 30 days of the resident's admission. Findings include: Resident #3 Review of the resident's record on 11/20/13 and interview with the DN/CM revealed that the resident's service plan was not initiated until 11/20/13. The resident was admitted to the facility on 7/30/13.	E3370		
E3420	.27 D .27 Resident Record or Log D. Resident Care Notes. (1) Appropriate staff shall write care notes for each resident: (a) On admission and at least weekly; (b) With any significant changes in the resident's condition, including when incidents occur and any follow-up action is taken; (c) When the resident is transferred from the facility to another skilled facility;	E3420		

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E3420	<p>Continued From page 9</p> <p>(d) On return from medical appointments and when seen in home by any health care provider;</p> <p>(e) On return from nonroutine leaves of absence; and</p> <p>(f) When the resident is discharged permanently from the facility, including the location and manner of discharge.</p> <p>(2) Staff shall write care notes that are individualized, legible, chronological, and signed by the writer.</p> <p>This REQUIREMENT is not met as evidenced by: Based on resident record review the facility failed to ensure resident care notes were written weekly as required.</p> <p>Findings include:</p> <p>Review of three (3) out of three (3) resident's care notes revealed weekly care notes were not being completed as required.</p>	E3420		
E3650	<p>.29 K .29 Medication Management and Administration</p> <p>K. If a resident requires that staff administer medications as defined in Regulation .02B(3) of this chapter, and the administration of medications has been delegated to an unlicensed staff person pursuant to COMAR 10.27.11, the assisted living manager shall comply with COMAR 10.27.11 by arranging for an on-site review by the delegating registered nurse at least every 45 days. The delegating nurse shall make appropriate recommendations to the appropriate authorized prescriber, and the assisted living manager or designee.</p>	E3650		

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E3650	<p>Continued From page 10</p> <p>This REQUIREMENT is not met as evidenced by: Based on resident record reviews and interview with the DN/CMs' the DN/CMs' failed to ensure 1.) 45-day reviews accurately assessed the residents' health status noting wound complications and healing process 2.) Appropriate oversight of physician orders 3.) Appropriate oversight and monitoring of the Medication Technician (MT) medication/treatment practices.</p> <p>Findings include:</p> <p>Resident #1 Review of Resident #1's record revealed: a.) The resident's September, October and November MAR document the following two transcriptions; Clean glucose meter after each use and calibrate glucose machine every month on the 15th. Facility's unlicensed medication staff failed to document on the resident's 3 MAR the completion of cleaning and calibrating of the glucose machine. b.) The resident's last 45-day review failed to document oversight of the resident's B/S levels. The resident's B/S remains unstable fluctuating between 68 and 370 in October. c.) The order for Bacitracin/Polymyxin ointment was discontinued on the resident's September 2013 POS. However, the order for Bacitracin was transcribed onto the resident's November 2013 POS. The DN/CM signed the resident's November 2013 POS on 11/8/13 as reviewed. The physician signed the POS on 11/9/13 that renewed the Bacitracin order.</p> <p>Resident #2 Review of the resident's November 2013 MAR revealed the resident's Hydrocodone (pain</p>	E3650		

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E3650	<p>Continued From page 11</p> <p>medication) order was discontinued on 10/1/13. Review of the resident's October 2013 POS signed by the physician on 10/29/13 revealed the resident's Hydrocodone order had not been line through as discontinued. Therefore, the Hydrocodone order was again initiated on 10/29/13. The DN/CM completed a 45-day review on 11/8/13 and failed to address the medication documentation error.</p> <p>Resident #3 Review of the resident's last 45-day review dated 11/7/13 revealed the following documentation errors:</p> <p>a.) The resident's November 2013 POS and MAR documented "Calcium Carb 600 mg tablets, 1 tablet by mouth twice a day. However, the MAR only documented the administration of the 9 am dose. Review of the resident's record revealed an order dated 9/5/13 to decrease the Calcium to once a day. However the resident's September 2013 POS was signed and dated by the physician on 10/2/13 and the POS still documented the Calcium Carb order as twice a day.</p> <p>b.) The resident's November 2013 MAR documented the discontinuation of Primidone on 8/26/13. However the resident's September 2013 POS was signed and dated by the physician on 10/2/13 and the POS still documented the Primidone as a current order. The DN/CM failed to review the resident's medication orders with the residents' MAR as part of the residents' 45-day review process.</p> <p>c.) The DN/CM failed to document an assessment of the resident's wounds at least every 45-days to support oversight of care and services as required.</p>	E3650		

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E4910	Continued From page 12	E4910		
E4910	<p>.46 E3 .46 Emergency Preparedness</p> <p>(3) Semiannual Disaster Drill.</p> <p>(a) The assisted living program shall conduct a semiannual emergency and disaster drill on all shifts during which it practices evacuating residents or sheltering in-place so that each is practiced at least one time a year.</p> <p>(b) The drills may be conducted via a table-top exercise if the program can demonstrate that moving residents will be harmful to the residents.</p> <p>(c) Documentation. The assisted living program shall:</p> <p>(i) Document completion of each disaster drill or training session;</p> <p>(ii) Have all staff who participated in the drill or training sign the document;</p> <p>(iii) Document any opportunities for improvement as identified as a result of the drill; and</p> <p>(iv) Keep the documentation on file for a minimum of 2 years.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of the facility's disaster drills for 2012 and 2013, the facility failed to ensure evacuation drills were practiced at least once on each shift.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. The facility failed to have documentation to support evacuation drills were completed in 2012. 2. The ALM provided one (1) mock shelter in place drill that was completed between day and evening shift for the first half of 2013. The drill sheet failed to contain signatures of the staff that participated in the disaster drill. The facility failed 	E4910		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 01AL0051	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/21/2013
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NAME OF PROVIDER OR SUPPLIER ASSISTED LIVING AT FROSTBURG VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 100 VILLAGE PARKWAY FROSTBURG, MD 21532
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
E4910	Continued From page 13 to have documentation to support a night shift drill was completed during the first half of 2013.	E4910		