

Office of Health Care Quality

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 02AL0244 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED R 02/10/2014 |
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| NAME OF PROVIDER OR SUPPLIER HEART HOMES AT BAY RIDGE II | STREET ADDRESS, CITY, STATE, ZIP CODE 3023-B ARUNDEL ON THE BAY ROAD ANNAPOLIS, MD 21403 |
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| E 000 | Initial Comments The following deficiencies are the result of an unannounced monitoring survey conducted at Heart Homes at Bay Ridge II on 2/10/14, for determining the facility ' s compliance with COMAR 10.17.14, Assisted Living Program Regulations. Survey activities included an environmental tour, interview with staff and residents and review of the facility ' s administrative records, six (6) resident records and seven (7) staff records. The facility ' s census at the time of survey was twelve (12) residents. | E 000 | | |
| E2550 | .19 B2 .19 Other Staff--Qualifications (2) As evidenced by a physician's statement be free from: (a) Tuberculosis, measles, mumps, rubella, and varicella through appropriate screening procedures such as tuberculosis skin tests, positive disease histories, or antibody serologies; and (b) Any impairment which would hinder the performance of assigned responsibilities; This REQUIREMENT is not met as evidenced by: 10.07.14.19. B.2 (a) Based on staff record review, the facility failed to provide documentation that staff is free from measles, mumps, rubella, and varicella as required to meet the qualifications of Regulation .19 B(2). Findings include: Review of Staff member # 4 ' s record revealed that the staff member did not have documentation that this staff member is free from measles, mumps, rubella, and varicella through appropriate | E2550 | | |

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

Office of Health Care Quality

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| E2550 | Continued From page 1 screening procedures. | E2550 | | |
| E3330 | .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: 10.07.14.26. B.2. (a-b) Based on resident record review, the facility failed to provide documentation of a completed full assessment on a resident within 48 hours but not later than required by nursing practice and the resident ' s condition after a significant change in condition, and each nonroutine hospitalization and at least annually. Findings include: Review of Resident #2 ' s record revealed that Resident #2 was hospitalized from 8/15/13-8/17/13 for a urinary tract infection. The most current full assessment of Resident #2 was completed on 4/12/13. | E3330 | | |
| E3400 | .27 B .27 Resident Record or Log B. Readmission of a Resident. (1) A resident shall be reassessed by the | E3400 | | |

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| E3400 | <p>Continued From page 2</p> <p>delegating nurse within 48 hours of readmission to the program if the following occurs: (a) Hospitalizations or a 15 day or greater stay in any skilled facility; or (b) There is a significant change in the resident's mental or physical status upon return to the program after an absence from the program. (2) When the delegating nurse determines in the nurse's clinical judgment that the resident does not require a full assessment within 48 hours, the delegating nurse shall: (a) Document the determination and the reasons for the determination in the resident's record; and (b) Ensure that a full assessment of the resident is conducted within 7 calendar days.</p> <p>This REQUIREMENT is not met as evidenced by: 10.07.14.27. B.1 (a) Based on resident record review, the delegating nurse failed to reassess a resident within 48 hours of readmission to the facility following a hospitalization.</p> <p>Findings include: Review of Resident #2 's record revealed that Resident #2 was hospitalized from 8/15/13-8/17/13 for a urinary tract infection. Documentation was unable to be found that the delegating nurse reassessed Resident #2 within 48 hours of readmission to the facility following this hospitalization.</p> | E3400 | | |
| E3420 | <p>.27 D .27 Resident Record or Log</p> <p>D. Resident Care Notes. (1) Appropriate staff shall write care notes for each resident: (a) On admission and at least weekly;</p> | E3420 | | |

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| E3420 | <p>Continued From page 3</p> <p>(b) With any significant changes in the resident's condition, including when incidents occur and any follow-up action is taken;</p> <p>(c) When the resident is transferred from the facility to another skilled facility;</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: 10.07.14.27. D (1) Based on resident record review, the staff failed to write care notes on admission, at least weekly and with any significant changes in the resident ' s condition, including when incidents occur and any follow-up action is taken.</p> <p>Findings include: Review of Resident #1 ' s record revealed a medical order written on 2/6/14 for wound care to the right lateral ankle- cleanse and apply aqua foam/medi-honey, every 3-4 days and as needed. Review of the care notes for Resident #1 revealed no documentation of this significant change of resident #1 ' s ankle.</p> | E3420 | | |
| E3470 | <p>.28 C .28 Services</p> <p>C. Nursing Services. The assisted living manager, in consultation with the delegating nurse, shall ensure that all nursing services are</p> | E3470 | | |

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| E3470 | <p>Continued From page 4</p> <p>provided consistent with the Nurse Practice Act, Health Occupations Article, Title 10, Annotated Code of Maryland.</p> <p>This REQUIREMENT is not met as evidenced by: 10.07.14.28. C Based on resident record review, the assisted living manager, in consultation with the delegating nurse, shall ensure that all nursing services are provided consistent with the Nurse Practice Act, Health Occupations Article, Title 10, Annotated Code of Maryland.</p> <p>Findings include: Resident #5 was admitted to the facility on 9/18/13. The Nurse Practice Act requires that a nurse complete a full nursing assessment of a resident before allowing unlicensed staff to administer medications to this resident. Review of Resident #5 ' s record revealed that a nursing assessment was not completed until 10/4/13.</p> | E3470 | | |
| E3680 | <p>.29 M .29 Medication Management and Administration</p> <p>M. Medications and treatments shall be administered consistent with current signed medical orders and using professional standards of practice.</p> <p>This REQUIREMENT is not met as evidenced by: 10.07.14.29. M Based on record review, medications and treatments failed to be administered consistent with current signed medical orders and using professional standards of practice.</p> | E3680 | | |

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| E3680 | Continued From page 5 Findings include: Resident #2, an insulin dependent diabetic, has the following medical orders: Check BG (blood glucose) at 6:30 am, 4:30 pm and 9 pm daily, call MD if BG >400 (mgs/dl) or < 60; administer Levemir 20 units q (every) am, hold if BG <75 and administer Levemir 10 u q pm, hold if BG < 75. Resident has another order for Humulin R insulin (U-100) -inject 10 units subcutaneously q 6 hours prn (as needed for) glucose > 350 (mgs/dl). Review of the December, 2013 medication administration record (MAR) revealed that on 12/14/13 at 4:30 pm, Resident #2 had a BG of 356 and on 12/15/13 at 4:30 pm Resident #2 had a BG of 363 and on 12/22/13 at 9 pm, Resident #2 had a BG of 365. Documentation was unable to be found that Resident #2 received the medically ordered Humulin R insulin. On January 25, 2014 Resident #2 had a BG of 392 at 9 pm. Documentation was unable to be found that Resident #2 received the medically ordered Humulin R insulin. | E3680 | | |
| E3710 | .29 O .29 Medication Management and Administration O. Accounting for Narcotic and Controlled Drugs. (1) Staff shall count and record controlled drugs, such as narcotics, before the close of every shift. (2) The daily record shall account for all controlled drugs documented as administered on the medication administration record. (3) All Schedule II and III narcotics shall be maintained under a double lock system. This REQUIREMENT is not met as evidenced by: 10.07.14.29.0 (2) | E3710 | | |

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| E3710 | <p>Continued From page 6</p> <p>Based on review of resident records, medical orders, the resident ' s medication and the controlled drug book, the daily record failed to account for all controlled drugs documented as administered on the medication administration record (MAR).</p> <p>Findings include: Review of Resident #6 ' s record, medical orders, the resident ' s medication and the controlled drug book failed to reconcile the daily record in the MAR and the controlled drug book resulting in a discrepancy. Resident # 6 has a medical order for lorazepam 1 mg- take 1 tablet by mouth before showers/ ADL (activities of daily living) care/labs/hairdresser as needed. The controlled drug sheet for this medication for Resident #6 listed 26 tablets. The physical count of this medication for Resident #6 was 25 tablets.</p> | E3710 | | |