STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215043	A. Building B. Wing	11/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kensington Healthcare Center	3000 McComas Avenue Kensington, MD 20895

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 25623 Based on surveyor review of closed clinical records, review of facility administrative records and interviews with the facility staff, it was determined that the facility staff failed to ensure Resident #172 was free from abuse. This finding was evident for 1 of 7 residents selected for review of the abuse care area, which resulted in actual harm. This finding was identified during the investigation of a facility reported incident MD00159216. A review of the facility's plan of correction implemented after the facility gained knowledge of the abuse incident resulted in the deficiency being cited as past non-compliance. The correction date was 10-14-2020. The findings include: On 10-27-2020 a review of the closed clinical record for Resident #106 revealed on 10-09-2020 at 1:25 AM a concurrent review noted that Geriatric Nursing Assistant (GNA) #2 responded to the resident's room after hearing a loud noise. Upon entering the room, GNA #2 found Resident #106 holding a lamp stand. The resident's roommate (Resident #172) was bleeding from a forehead laceration. GNA #2 summoned Licensed Practical Nurse (LPN) #3 for assistance as he remained in the room with both residents. LPN #3 initiated an assessment of Resident #172, while Resident #106 was removed from the room by GNA #2. Further record review revealed that Registered Nurse (RN) #1, who was assigned to one to one (1:1) supervision of Resident #106 at the time of the incident, left the residents unattended for a bathroom break. RN #1 had thought that Resident #106 was asleep at the time of her leaving the room, which left Resident #106 in the room unsupervised with Resident #172. Facility staff immediately notified local law enforcement of the incident and they responded to the facility at 1:35 AM on 10-09-2020. Staff requested for law enforcement to transfer Resident #106 to the hospital secondary to violent behavior. However, law enforcement refused the transfer of Resident #106 after their assessment indicated that the resident did not display current violent behavior. Later on 10-09-2020, the attending physician responded to the facility and completed an emergency psychiatric petition in order to transfer Resident #6 for a hospital evaluation. Staff again notified law enforcement, who declined the emergency psychiatric petition citing that the information was documented on the wrong form. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215043	A. Building B. Wing	11/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kensington Healthcare Center	3000 McComas Avenue Kensington, MD 20895

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 0600 Level of Harm - Actual harm Residents Affected - Few	On 10-27-2020 closed record review of Resident #172 revealed upon LPN #3's assessment of the forehead laceration that first aid was provided, and the resident's attending physician and responsible party were notified. The physician ordered that the resident should be transferred to the hospital for an evaluation. The resident returned to the facility around 10:00 AM on 10-09-2020 and was transferred to a new room. At 10:15 AM the resident was transferred back to the hospital after a Computed Tomography (CT) (combination of X-rays and a computer to show more detail than a regular X-ray) results revealed Resident #172 had sustained a subdural hematoma. A subdural hematoma can occur from sudden blow to the head that tears blood vessels that run along the surface of the brain. Surveyor interview on 10-28-2020 at 6:38 AM with GNA #2 revealed on 10-09-2020 around 1:30 AM GNA #2 had been in the hallway and heard a loud noise from the room of Resident #106 and Resident #172. Upon entry, he observed Resident #106 holding a bedside lamp and was standing over Resident #172's bed. In addition, he observed Resident #172 bleeding from the forehead. GNA #2 summoned LPN #3 for assistance. Further interview revealed that RN #1 had been assigned to Resident #172 for 1:1 supervision for the shift, but was not in the resident's room when GNA #2 arrived. RN #1 also had not informed GNA #2 that she had planned to leave the resident unattended for a bathroom break. On 10-28-2020 at 6:47 AM interview with LPN #3 revealed that RN #1 had assigned herself for 1:1 supervision with Resident #106 when the initial assigned 1:1 worker had called out for the shift. Then around 1:34 AM she heard GNA #2 ask for assistance in the residents' room. Upon arrival, Resident #106 was observed standing over resident #172, who was in bed and bleeding. LPN #3 immediately applied pressure to the bleeding forehead laceration until RN #1 arrived. Upon RN #1's arrival, the police and ambulance were notified. Resident #172 was transferred to the hospital by 911 after their arrival. Interview on 10-28-2020 at 6:55 AM with RN #1 revealed, at the beginning of the 11:00 AM-7:00 PM shift on 10-08-2020, that the assigned 1:1 for Resident #106 had called out and the outgoing supervisor had been unsuccessful in finding a replacement. Therefore, RN #1 decided to be Resident #106's 1:1 sitter for the shift. Then around 1:23 AM, she left Resident #106's bedside when she thought the resident was sleeping, and went for a bathroom break. RN #1 admitted that she had not asked any other staff members to supervise the resident during that time, but had seen that GNA #2 was in close proximity to the resident's room. Further interview revealed that RN #1 had previously done 1:1 supervision with Resident #106 multiple times and had taken previous bathroom breaks without any incidents. RN #1 further stated she was aware that another staff member should have maintained the 1:1 supervision and the resident should not have been left unsupervised. On 10-28-2020 at 9:53 AM surveyor interview with the Director of Nursing and the facility's Staff Development Nurse revealed that Resident #106 had not returned to the facility and the hospital was looking into a more appropriate psychiatric placement. In addition, Resident #172's family had made the decision not to return the resident to the facility, but transferred to another facility after the hospitalization . Further interview revealed education and counseling was provided to RN #1 after the incident on 10-09-2020. Education was initiated to all licensed staff on 10-09-2020 regarding Abuse Prevention and 1:1 supervised responsibilities, which includes the coverage requirement of the resident. The coverage must be maintained even when the assigned worker needs any form of a break, that involves another staff member is informed to relieve the 1:1 worker, so the resident is not left unsupervised at any time. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215043	A. Building B. Wing	11/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kensington Healthcare Center	3000 McComas Avenue Kensington, MD 20895

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 0600 Level of Harm - Actual harm Residents Affected - Few	The facility staff had failed to ensure Resident #172 was free of abuse from Resident #106 when staff did not maintain the 1:1 supervision of Resident #106. This resulted in the actual harm of Resident #172. This incident was found to be past noncompliance. Surveyor review of the administrative records on 10-28-2020 revealed immediate actions taken by the facility included: 1. Resident #106 was immediately removed from the room on 10-09-2020 after the incident. Unsuccessful attempts were made to transfer the resident for hospital psychiatric evaluation on 10-09-2020 and 10-12-2020. 2. Resident #106 was successfully transferred out of the facility on 10-13-2020 on an emergency psychiatric petition and has not returned to the facility since that transfer. 3. Resident #106 was remained on 1:1 supervision and in a private room immediately after the incident with a plan, upon the resident's return to the facility, to be maintained in a private room. 4. Resident #172 was immediately assessed after the incident on 10-09-2020 and transferred to the hospital for evaluation. Resident returned a few hours later to the facility on the same day, but was transferred back to the hospital after CT results revealed the resident had a subdural hematoma. The resident did not return to the facility after return to the hospital on 10-09-2020. 5. The facility on 10-09-2020 submitted an initial self report to the Office of Health Care Quality (OHCQ) and initiated an investigation into the incident. Employee statements were obtained that included statements from RN #1, GNA #2, and LPN #3. The final investigation was submitted to OHCQ on 10-14-2020. 6. On 10-09-2020 the facility conducted an Quality Assessment and Performance Improvement (QAPI) Ad Hoc meeting to review the incident with a Root Cause analysis completed. 7. Education on 10-09-2020 was completed by the facility to RN #1 regarding the reporting of abuse allegations, as well as 1:1 supervised responsibilities. 8. Education was also initiated on 10-09-2020 to all facility licensed staff regarding Abuse Prevention and 1:1 coverage and responsibilities, including when breaks are necessary that another staff member must relieve the 1:1 first. In addition, education was provided on how to deescalate a situation if a resident is agitated and around another resident. Education was completed for licensed staff as of 10/15/2020. At that point, Resident #106 was no longer in the facility and there were no other residents requiring 1:1 supervision within the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215043	A. Building B. Wing	11/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kensington Healthcare Center	3000 McComas Avenue Kensington, MD 20895

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	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 41323 Based on surveyor review of the clinical records, interviews with residents, resident's representatives and facility staff, it was determined that the facility failed to ensure timely interdisciplinary care conferences for residents. This finding was evident for 2 of 34 residents selected during the survey (Resident #26 and Resident #45). The findings include: 1. On 10-28-2020 surveyor review of Resident #26's clinical record revealed the resident had an admission comprehensive assessment completed by staff on 06-02-2020. However, there was no evidence of a care plan conference with the interdisciplinary team, resident, and/or resident's representative to review the plan of care. Further review of Resident #26's clinical record revealed the resident had a significant change assessment completed by staff on 08-01-2020. However, there was no evidence of a care plan conference with the interdisciplinary team, resident, and/or resident's representative to review the plan of care. On 10-29-2020 at 12:10 PM, surveyor interview with Resident #26's representative stated that they have never been contacted by the facility to participate in a care plan conference. On 10-29-20 at 12:30 PM, surveyor interview with the Director of Social Work revealed that she was newly employed to the facility. However there are no documented evidence of care plan conferences for Resident #26. On 11-02-2020 at 10:30 AM, surveyor interview with the Director of Nursing revealed no additional information. 25623 2. On 10-27-2020 at 11:10 AM surveyor interview with Resident #45 revealed that the resident has had a number of care issues concerns that were addressed in previous care plan conferences. However, the resident stated that there he/she has not been informed of any recent care plan conferences for some time now. Surveyor review of the clinical record for Resident #45 revealed the resident is his/her own responsible party. On 10-28-2020 surveyor review of Resident #45's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11-15-2019 had been completed by staff. However, there was no documented evidence that an interdisciplinary care conference was conducted that included the involvement of the resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215043	A. Building B. Wing	11/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kensington Healthcare Center	3000 McComas Avenue Kensington, MD 20895

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	The Minimum Data Set (MDS) is a mandated process for clinical assessment of all residents in Medicare or Medicaid certified nursing homes. This process provides a comprehensive and accurate assessment of each resident's functional capacity and health status to assist nursing home staff in identifying health problems. MDS assessments are required for residents on admission to the nursing facility and then periodically, within specific guidelines and time frames. An interdisciplinary care conference is held that includes the involvement of the resident and/or responsible party at the time frame of the completion of the assessment. Further review revealed a quarterly assessment MDS with an ARD of 08-15-2020. However there was no documented evidence that a quarterly interdisciplinary care conference had been conducted. On 10-29-2020 at 4:00 PM and 11-02-2020 at 11:00 AM surveyor interview with the Director of Social Services revealed no additional information. On 11-02-2020 at 3:00 PM interview with the Director of Nursing revealed no additional information.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215043	A. Building B. Wing	11/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kensington Healthcare Center	3000 McComas Avenue Kensington, MD 20895

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41323 Based on review of the clinical record, interview with Resident #26's representative and facility staff, it was determined that the facility failed to ensure standards of professional practice. This was evident for 1 of 34 residents selected for review during the survey (Resident #26). The findings include: On [DATE] review of Resident #26's clinical record revealed the Resident was readmitted to the facility on [DATE], after a hospitalization , with a percutaneous endoscopic gastrostomy tube (PEG) to receive artificial nutrition. A PEG tube is used to provide a route for artificial nutrition, hydration, and medication administration in residents who are likely to have prolonged inadequate or absent oral intake. Further review of Resident #26's clinical record revealed page 2 of the Maryland Medical Orders for Life-Sustaining Treatment (MOLST) was completed on [DATE] by Resident #26's attending physician. Page 2, section 7C was selected by the physician, which states, may give fluids for artificial hydration as a therapeutic trial, but do not give artificially administered nutrition. The Maryland MOLST form is a two-page portable and enduring medical order form covering options for cardiopulmonary resuscitation (CPR) and other life-sustaining treatments. The medical orders are based on a patient's/patient representative's wishes about medical treatments and makes those treatment wishes known to health care professionals. On [DATE] at 10:20 AM, surveyor interview with Resident #26's attending physician revealed that he had made an error selecting 7C on page 2 of the MOLST form. In addition, he stated he does not talk to residents or resident representatives to complete page 2 of the MOLST form. On [DATE] at 12:10 PM, surveyor interview Resident #26's representative stated that they had never received a call to review the MOLST with the attending physician nor had they receive a copy of the MOLST. On [DATE] at 10:30 AM, surveyor interview with the facility Administrator and the Director of Nursing revealed no additional information. According to the Maryland MOLST Training Task Force for Healthcare Professionals, updated in February 2020, the MOLST form is to be completed by the healthcare provider based on consultation with the patient or an authorized decision maker (health care agent, guardian, or surrogate) on behalf of an incapacitated patient and is to be signed by a physician, nurse practitioner, or physician assistant (i.e., an authorized practitioner).