STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215346	A. Building B. Wing	08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northwest Healthcare Center	4601 Pall Mall Road Baltimore, MD 21215

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30347 Based on interview, record review, and policy review, the facility failed to ensure residents either had an advanced directive in place or failed to provide the residents and/or their representatives written information of the right to accept or refuse medical or surgical treatment and/or formulate an advance directive for two residents (Resident (R) 61 and R55) of nine reviewed for Advanced Directives. Findings include: Review of the facility's policy titled Advance Directive (Resident's Right to Choose, dated 03/27/24, revealed, Policy Explanation and Compliance Guidelines: It is the policy of this facility to support and facilitate a resident's right to request, refuse and/or discontinue medical or surgical treatment and to formulate an Advance Directive. l. On admission, the facility will determine if the resident has executed an Advance Directive and if not, determine whether the resident would like to formulate an Advance Directive . 3. The facility will provide the resident or resident representative information, in a manner that is easy to understand, about the right to refuse medical or surgical treatment. The facility will provide the resident or resident representative with information on how to formulate an Advance Directive. The facility will offer to complete a new medical order for life-sustaining treatment based on the resident or resident representative's preference. 4. Upon admission, should the resident have an Advance Directive, copies will be made and placed on the hard chart medical record as well as communicated to the staff. 1. Review of R61's undated Admission Record, located in R61's EMR under the Profile tab, revealed R61 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of R61's EMR revealed no documentation that R61 had an Advance Directive or that the facility provided written information to the resident, or the resident representative concerning the right to accept or refuse medical or surgical treatment and/or formulate an advance directive. 2. Review of R55's undated Admission Record, located in R55's EMR under the Profile tab revealed R23 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of R55's EMR revealed no documentation that R23 had an Advance Directive or that the facility provided written information to the resident, or the resident representative concerning the right to accept or refuse medical or surgical treatment and/or formulate an advance directive. (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
	215346	A. Building B. Wing	08/26/2024

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/21/24 at 4:30 PM the Social Services Director (SSD) stated, The residents do not have an advance directive and there is no documentation available for review regarding advance directives or that they were ever given written information. The SSD also confirmed there was no information of a signed Admission Package which would have also included information about the Advance Directive.

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F 0600 Level of Harm - Minimal harm or potential for 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30347 Based on medical record review, administrative record review, and staff interview, the facility failed to protect the resident's right to be free from verbal, mental, and physical abuse (R70, R48, R73 #914).These failures affected 4 of 61 residents reviewed for abuse. Findings include: 1. Review of the 5-Day Incident Report, provided by the facility, for R61 and R70 revealed, On 02/08/24, R70 was standing near the vending machine heard two other residents arguing tried to stop argument and one resident (R61) punched him/her in his/her nose R70 visibly upset after the incident, had complaint of bleeding from the nose and was transferred to the hospital for further investigation .Resident denied pain. Resident assessed by inhouse physician, followed by psychological services. No other injuries noted . Conclusion: The allegations were verified .Corrective actions taken: All three residents were separated and placed in a safe area. Police notified and responded to the situation. Skin assessment for all three residents done. Pain assessment done for all three residents. R70 was transferred to hospital and now returned to facility. Physician notified and assessed the residents. Nurse Practitioner assessed all three residents. Psych followed up with all three residents. Social Worker consulted with all three residents. Investigation of incident completed - witness statements and interviews completed. Resident's Representative aware of the incident. Behavior monitoring done for residents. Care plans updated. Inservice education held with staff for Behavioral health training. Education provided to all residents for reporting of such incidents to management staff. 1:1 monitoring completed for R61. Review of R70's undated Admission Record, located in R70's electronic medical record (EMR) under the Profile tab, showed a facility admitted [DATE] and a readmitted [DATE], with medical diagnoses that included anoxic brain damage, altered mental status, and undifferentiated schizophrenia. Review of R70's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/02/24, revealed the facility assessed R70 to have a Brief Interview for Mental Status (BIMS) score of five out of 15 which indicated R70 was severely impaired. Review of Progress Notes, dated 02/08/24 and located in the EMR Progress Note tab, revealed, [R70] was standing near the vending machine heard two other residents arguing tried to stop argument and one resident [R61] punched him in his nose. Review of R61's undated Admission Record, located in R61's EMR under the Profile tab, revealed R61 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that include paranoid schizophrenia, malingerer. Review of the quarterly MDS with an ARD of 06/25/24, located under the EMR MDS tab, revealed a BIMS score of 12 out of 15 which indicated R61 was moderately impaired. Review of Progress Notes, dated 02/08/24 and located in the EMR Progress Note tab, revealed, [R61] had physical altercation with another resident [R70] no injuries noted . (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/21/24 at 1:50 PM, the Administrator stated, Based on the facility investigation the incident between R70 and R61 did happen. Abuse situations with residents should not happen. 2. Review of the The 5-Day Incident Report, provided by the facility, for R29 and R48 revealed, On 05/03/24, R48 was in the hallway when R29 was displaying agitation, s/he was shoved by R29 and R48 shoved him/her back .R48 was taken to his/her room, the physician was notified, the family was notified, and the police were notified. Psychological services were called to review R29's medications. Staff are doing increased checks on R29 as s/he is refusing one on one observation .Preventative measures to prevent further incidents of similar nature, both residents had PTSD (Post Traumatic Stress Disorder) completed with no signs of trauma. No further interaction between residents. Medications were reviewed with no changes. Review of R48's undated Admission Record, located in R48's EMR under the Profile tab, revealed R48 was admitted to the facility on [DATE] with diagnoses that include schizophrenia, vascular dementia, disturbance, psychotic disturbance. Review of the quarterly MDS with an ARD of 05/05/24, located under the EMR MDS tab, revealed a BIMS score of 99 which indicated R48 was unable to complete the interview. Review of Progress Notes, dated 05/03/23 and located in the EMR Progress Note tab, revealed, .[R48] was in the hallway when another resident [R29] was displaying agitation, s/he was shoved by [R29] and [R48] shoved back. They were immediately separated, and a skin assessment was conducted to check for injuries, no injuries were noted . Review of R29's undated Admission Record, located in R29's EMR under the Profile tab, revealed R29 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that include schizophrenia, generalized anxiety. Review of the quarterly MDS with an ARD of 06/13/24, located under the EMR MDS tab, revealed a BIMS score of seven out of 15 which indicated R61 was severely impaired. Review of Progress Notes, dated 02/08/24 and located in the EMR Progress Note tab, revealed, .[R29] presented with increased agitation and fell while ambulating her walker . During an interview on 08/22/24 at 9:30 AM, the Administrator confirmed the incident between R48 and R29 did happen. Review of the facilities undated policy Maryland Abuse, Neglect & Misappropriation, revealed, .VI. Protection from Abuse: 2. When the alleged abuse involves a resident-to-resident altercation the residents will be separated by the staff and the appropriate physical assessments will be completed on each resident .VII. 1. All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately .8. Facility staff members, upon hire, are in-serviced on how to and to whom they may report concerns, incidents and grievance with the fear of retribution . 42886 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.) Administrative record review of a facility investigation of alleged employee verbal abuse of a resident on 8/26/24 at 8:00 AM revealed a witness statement from Licensed Practical Nurse #5 (LPN #5) who witnessed the physical and verbal abuse of resident #914 on 1/18/23 at approximately 1:00 PM in the hallway outside of the resident's room. LPN #5 stated that he/she heard Geriatric Nurse Assistant #8 (GNA #8) tell the resident that he/she was being punished. LPN #5 then witnessed GNA #8 direct the resident's wheelchair to face the hallway wall with the wheelchair locked in place. LPN #5 asked GNA #8 while he/she positioned the resident at the wall. GNA #8 did not answer. LPN #5 then turned the resident's wheelchair around so the resident was able to face the hallway. Later in the afternoon, at approximately 2:00 PM, LPN #5 returned to the resident's previous location and noticed the resident's wheelchair was positioned again with the resident's face turned toward the wall. LPN #5 asked GNA #8 if he/she repositioned the resident's wheelchair. GNA #8 would not answer the LPN #5 and began to yell at the resident and LPN #5. LPN #5 then reported the incident to the Director of Nursing (DON). Continued review of administrative records on 8/26/24 at 8:20 PM revealed another witness statement from the facility investigation of alleged physical and verbal abuse of resident #914. This witness statement, dated 1/18/23, was from LPN #6 which corroborated LPN #5's witness statement. LPN #6's witness statement also added that GNA #8 was yelling at resident #914 for his/her shift on 1/18/23. Further review of administrative records on 8/26/4 at 8:30 AM revealed the witness statement from GNA #8 dated 1/18/23. GNA #8 stated that resident #914 asked to be turned toward the wall. GNA #8 also stated in his/her witness statement that he/she was unaware of the resident's diagnosis of altered mental status and if he/she was aware of the diagnosis prior to the incident, he/she would not have positioned the resident's wheelchair towards the hallway wall. Medical record review on 8/26/24 at 9:20 AM revealed resident #914 had instances of altered mental status and the resident's BIMS was 3/15 as of 12/8/22. Review of progress notes revealed that LPN #5 also placed a progress note in the resident's medical record which stated that GNA #8 told the resident, Get off, take your hands off the chair. You are facing the wall. That's your punishment. During an interview with the Executive Director on 8/26/24 at 1:30 PM, the Executive Director admitted that GNA #8 what physically and verbally abusive to resident #914 based on the statement of events listed in the facility investigation of the incident. The Executive Director also stated that GNA #8 was terminated from the facility on 1/18/23.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20243 Based on record review, staff interviews, and facility policy review, the facility failed to ensure an injury of unknown origin for 4 of 58 (R8, R35, #20 and #14) reviewed was reported to the state agency and in a timely manner. Specifically, the facility failed to ensure an initial incident report was submitted to the state survey agency within two hours as well as failed to submit the 5- day report following the investigation. This deficient practice had the potential to affect other residents at the facility that had unidentified pain, an injury of unknown origin, unwitnessed fall, or allegations of abuse. Findings include: 1. Review of R8's undated Admission Record, located under the Profile tab in the EMR, revealed R8 was admitted to the facility on [DATE] with diagnoses that included dementia with psychotic disturbance, encephalopathy, and convulsions. Review of R8's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/30/23, revealed a Brief Interview for Mental Status (BIMS) with a score of five out of 15, which indicated severe cognitive impairment. Review of R8's modified quarterly MDS with an ARD of 02/21/24, revealed a BIMS with a score of two out of 15, which indicated severe cognitive impairment Review of the Facility Reported Incidents Initial Report, provided by the facility, revealed that on 02/05/24 at 2:15 AM there was an allegation of injury of unknown origin that was identified for R8. The administrator was made aware on 02/05/24 at 10:00 AM. The incident documented that Staff reported resident had c/o (complaint of) pain in RT (right) sided pain in rib cage. Staff reported it to the physician. Resident assessed by Physician and chest x-ray and RT rib x-ray was ordered. Results of x-ray indicated Mildly deformed acute fractures lateral aspects right 9th, 8th and 7th rib. The facility documented that the incident occurred 02/05/24 at 2:00 AM. The report was documented as reported on 02/05/24 at 1:00 PM and submitted on 02/05/24 at 1:15 PM. During an interview on 08/22/24 at 4:18 PM, Administrator stated that he expected injury of unknown source concerns to be reported within two hours, regardless of the time of day or week. He said that by the time the facility submits the five-day summary he hoped to have the cause identified. He confirmed that this was a delay in reporting. 2.Review of R35's Admission Record, located in the electronic medical record (EMR) under the Profile tab, revealed R35 was admitted to the facility on [DATE]. Diagnoses included paraplegia, pressure ulcers, major depressive disorder, muscle weakness, psychoactive substance use, and neuromuscular dysfunction of the bladder. Review of R35's quarterly MDS with an ARD of 07/29/24 found in the EMR under the MDS tab revealed a BIMS, score of 15 out of 15 which indicated that R35 was cognitively intact. (continued on next page)

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	215346	A. Building B. Wing	08/26/2024

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R35's Progress Note dated 12/02/23 indicated The change in Condition's reported on this CIC (Change in Condition) Evaluation were: altered mental status. Review of R35's Progress Note dated 12/03/23 indicated Late Entry: R35 was noted hard to arouse with altered mental status. Review of the Initial Facility Investigation Report, dated 12/02/23 revealed on 12/02/23 at 9:20 PM, R35 was noted to be short of breath, unresponsive, and not able to be aroused. R35 received two doses of Naloxone HCl nasal liquid (a medication used to treat known or suspected opioid overdose) 8 mg (milligrams)/0.1 ML (milliliter) one spray in nostril as needed for opioid overdose and may repeat every two-three minutes until patient responds. R35 became more alert and was transported to the hospital on 12/02/23 at 10:12 PM. Review of the initial investigation report revealed a submission date of 12/02/23 at 11:35 PM to the state agency. Documentation of the facility's submission of the five-day final completed investigation for R35 on 12/02/23 was requested by the survey team on 08/21/24 at 6:00 PM. During an interview on 08/22/24 at 4:09 PM the Administrator stated that documentation that the completed investigation had been submitted to the state could not be found. Review of the facility's policy titled, Occurrence Reporting, dated 04/04/24, revealed, It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. Safety is a primary concern for our residents, staff and visitors. Occurrences or incidents will be investigated using the Risk protocol for tier reporting and investigation. Occurrences are entered, reported, tracked, and investigated using the electronic or online program with reference to specific types of incidents .The administrator is responsible for the oversight of timely reporting to Federal, State, and Local authorities as appropriate. 31982 Based on record review and interview it was determined the facility staff 1) failed to report an incident of resident-to-resident abuse to the state agency and 2) failed to report an injury of unknown origin timely. This was evident for 2 (#20 and #14) of 50 residents reviewed during the survey. The findings include: 1) Complaint #MD00173898 was reviewed on 8/20/24 at 3:45 PM. The complaint indicated Resident #20, and a staff person were attacked by another resident in the banking area on 11/3/21. Resident #20's medical record was reviewed at that time. No documentation was found in the record related to an incident involving Resident #20 on or around that date. Licensed Practical Nurse 3(LPN3) who is a Unit Manager, was interviewed on 8/21/23 at 12:25 PM. She was asked about an incident occurring on or about 11/3/21 in which Resident #20 and a staff member were assaulted by a resident in the banking area. She was unable to find documentation of the incident. In an interview on 8/22/24 at 1:43 PM the complainant identified the staff person who was involved in the incident, as the Activities Director (AD). (continued on next page)

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	215346	A. Building B. Wing	08/26/2024

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The AD was interviewed on 8/22/24 at 3:23 PM. She indicated she recalled the incident. When asked to describe the incident she stated He/She struck us, I got in front, between the two residents, (Resident #912) was hitting (Resident #20) and kicking out at (Resident #20), I tried to stop him/her, and he/she kicked me in the stomach. I told the (former) Administrator, but he didn't think it was serious, so I called the regional, he immediately called the Administrator. The AD added that she wrote a statement and gave it to the (former) Administrator. At 12:00 PM on 8/22/24 LPN3 reported that after rechecking for a resident-to-resident abuse incident on 11/3/21 and the entire year, she was unable to find documentation of an incident. There was no evidence that a report of resident-to-resident abuse was sent to the state agency as required. 2) A facility reported incident pertaining to Resident #14 was reviewed on 8/22/24 at 4:00 PM. A Change in Condition evaluation dated 8/14/23 19:12 indicated that the resident had discoloration to the left lower eye. The facility failed to submit a report of an injury of unknown origin to the state agency until 8/18/23, 4 days after the injury was identified. These concerns were reviewed with the Administrator and Mobile Director of Nursing (MDON) on 8/26/24 at 2:55 PM.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31982 Based on record review and staff interview it was determined the facility staff failed to thoroughly investigate allegations of abuse. This was evident for 5 (R48, #901,#20, #14, and #913) of 75 residents reviewed during the survey. The findings include: 1) Review of a facility reported incident on 8/19/24 at 11:00 AM revealed Resident #901 was observed on 9/5/23 at 8:55 AM with a large cut above his/her right eye. The facility initiated an investigation. The facility investigation documentation revealed a Witness Statement from a Geriatric Nursing Assistant (GNA) who indicated she observed the injury upon entering the resident's room and notified the nurse. Another statement from the Nurse indicated she assessed the resident and followed facility precautions. 6 Witness statements asked, Did you see any resident fall or sustain a injury? all indicated no. 3 statements indicated they did not know anything about resident #901, and 1 statement indicated the staff member only worked with the residents they were assigned to. The facility's investigation did not demonstrate an attempt to rule out resident abuse or identify the circumstances as to how the resident's injury occurred. 2) Complaint #MD00173898 was reviewed on 8/20/24 at 3:45 PM. The complaint indicated Resident #20, and a staff person were attacked by another resident in the banking area on 11/3/21. The Unit Manager Licensed Practical Nurse (LPN3) was interviewed on 8/21/23 at 12:25 PM. She was unable to find documentation of an incident on or around 11/3/21. The Activities Director (AD) was interviewed on 8/22/24 at 3:23 PM. She confirmed that Resident #912 struck and kicked at Resident #20 and herself. She indicated that she reported the incident to the (former) Administrator, but he didn't think it was serious, so I called the regional, he immediately called the Administrator. The AD added that she wrote a statement and gave it to the (former) Administrator. There was no record that the report of resident-to-resident abuse was investigated by the facility. 3a.) A facility reported incident pertaining to Resident #14 was reviewed on 8/22/24 at 4:00 PM. A Change in Condition Evaluation dated 8/14/23 19:12 indicated that the resident had discoloration to the left lower eye. The facility investigative documents included statements from several staff which indicated that they either observed Resident #14 with or without a black eye or didn't observe him/her at all. The staff were not interviewed to determine when or how the injury occurred. There were no interviews with other residents. The facility's investigation was not thorough and failed to rule out resident abuse or identify the circumstances as to how the injury occurred. (continued on next page)

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	215346	A. Building B. Wing	08/26/2024

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b.) Another facility reported incident pertaining to Resident #14 was reviewed on 8/23/24 at 4:30 PM. The report indicated the resident was noticed to have a bruise to his/her left eye at approximately 3:15 PM on 9/4/23. The facility investigative documentation revealed 4 staff statements. 3 indicated the staff members did not see the resident with an injury. The 4th statement by a Licensed Practical Nurse (LPN7) indicated the resident was observed in the hallway after lunch with no injury and that the resident propelled themselves to their room at approximately 2:50 PM. The statement then stated The nurse on the next shift observed the resident with a bruise to the left eyebrow. The resident indicated that (he/she) bumped his/her left eyebrow on the wall. There was no evidence that the facility thoroughly investigated to rule out abuse or identify the circumstances as to how the injury occurred including but not limited to interviews with Resident #14 and other residents, and a statement from the oncoming nurse who discovered the injury. c.) A third facility reported incident pertaining to Resident #14 was reviewed on 8/26/24 at 10:10 AM. The report indicated that on 6/15/23 at 6:40 AM Resident #910 reported being hit on the left side of his/her face with a walking cane by Resident #14. The investigative documentation consisted of 2 staff statements. The first indicated that the writer, a staff member, looked in the room and observed Resident #910 bleeding from his/her face and that Resident #910 reported Resident #14 hit him/her with a cane. The other statement by Registered Nurse (RN1) indicated Resident #910 had a skin tear to the lip below the left nostril, the provider was notified, and a message was left for the Resident Representative. The investigation documentation did not include interviews with Resident #14 or #910 nor other potential witnesses. The final report indicated the residents were separated and assessed and Incident has been substantiated after an in depth investigation. However, there was no evidence that the facility thoroughly investigated, or how they substantiated the allegation. 42886 4) Review of administrative records on 8/20/24 at 9:54 AM which revealed a facility reported incident (MD00196696) which alleged that a staff member was verbally and physically abusive to the resident. The facility investigated the allegations of abuse on 9/7/23. The facility investigation did not an investigation of the events, witness statements or other documents to show that the facility investigated the abuse allegation. During an interview with the Executive Director on 8/20/24 at 1:00 PM, the surveyor pointed out the lack of documentation showing the facility attempted to investigate resident #914's allegation of abuse. The Executive Director attempted to locate the investigative documentation but was unable to find the documents. 30347 Findings include: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215346	A. Building B. Wing	08/26/2024

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5.) Review of the The 5-Day Incident Report, provided by the facility, for R29 and R48 revealed, On 05/03/24, R48 was in the hallway when R29 was displaying agitation, s/he was shoved by R29 and R48 shoved him/her back .R48 was taken to his/her room, the physician was notified, the family was notified, and the police were notified. Psychological services were called to review R29's medications. Staff are doing increased checks on R29 as s/he is refusing one on one observation .Preventative measures to prevent further incidents of similar nature, both residents had PTSD (Post Traumatic Stress Disorder) completed with no signs of trauma. No further interaction between residents. Medications were reviewed with no changes. Review of R48's undated Admission Record, located in R48's EMR under the Profile tab, revealed R48 was admitted to the facility on [DATE] with diagnoses that include schizophrenia, vascular dementia, disturbance, psychotic disturbance. Review of the quarterly MDS with an ARD of 05/05/24, located under the EMR MDS tab, revealed a BIMS score of 99 which indicated R48 was unable to complete the interview. Review of Progress Notes, dated 05/03/23 and located in the EMR Progress Note tab, revealed, .[R48] was in the hallway when another resident [R29] was displaying agitation, s/he was shoved by [R29] and [R48] shoved back. They were immediately separated, and a skin assessment was conducted to check for injuries, no injuries were noted . Review of R29's undated Admission Record, located in R29's EMR under the Profile tab, revealed R29 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that include schizophrenia, generalized anxiety. Review of the quarterly MDS with an ARD of 06/13/24, located under the EMR MDS tab, revealed a BIMS score of 7 out of 15 which indicated R61 was severely impaired. Review of Progress Notes, dated 02/08/24 and located in the EMR Progress Note tab, revealed, .[R29] presented with increased agitation and fell while ambulating his/her walker . During an interview on 08/22/24 at 9:30 AM, the Administrator stated, the incident between R48 and R29 did happen. I was not able to find any additional paperwork related to the incident investigation. The facility incident investigation failed to contain the initial report of the incident, any interviews of other residents in the facility who could be affected by the actions of R29. There were no notes regarding a Post Traumatic Stress Disorder evaluation of R29, or results of monitoring his/her for additional behaviors. Review of the facilities undated policy Maryland Abuse, Neglect & Misappropriation, revealed, .VI. Protection from Abuse: 2. When the alleged abuse involves a resident-to-resident altercation the residents will be separated by the staff and the appropriate physical assessments will be completed on each resident .VII. Reporting of Incidents and Facility Response: 1. All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 [two] hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215346	A. Building B. Wing	08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northwest Healthcare Center	4601 Pall Mall Road Baltimore, MD 21215

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 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. 31982 Based on record review and interview it was determined the facility staff failed to ensure residents were prepared and oriented to ensure safe and orderly transfer from the facility.This was evident for 1 (#22) of 50 resident's reviewed during the survey. The findings include: Review of Resident #22's medical record on 8/19/24 at 11:41 AM revealed a Social Services note dated 4/4/24 17:38 by the Social Services Director (SSD) indicating Resident #22 was sent to the hospital for evaluation after he/she was assaulted by another resident on 4/4/24. There was no evidence that the facility provided and documented sufficient preparation and orientation of Resident #22 to ensure his/her safe and orderly transfer from the facility. Licensed Practical Nurse (LPN3) who is the Unit Manager was interviewed on 8/19/24 at 2:29 PM. When asked where nurses were expected to document that they prepared and oriented the resident for transfer, she was unable to explain and failed to find documentation indicating Resident #22 was prepared and oriented to the situation prior to transfer to the hospital after the incident on 4/4/24. This concern was reviewed with the Administrator and Mobile Director of Nursing (MDON) on 8/26/24 at 2:55 PM.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26446 Based on observations, staff interviews, and policy review, the facility failed to ensure food was properly stored, prepared, distributed, and served in accordance with professional standards for food service safety as required for 83 census residents who received meals from the facility kitchen. These failures had the potential to lead to food-borne illness among all facility residents. Findings include: During the initial observation with [NAME] (C)1 on [DATE] from 9:33 AM until 10:00 AM: -Infection Preventionist (IP) was noted to stand inside the kitchen food preparation area without a hair net on, speaking with the dietary staff. -C1, noted to have a ,d+[DATE]-inch length beard, was observed throughout the kitchen without the use of a beard net. -A large, opened container of applesauce was observed in the reach-in refrigerator. The container had [DATE] and [DATE] written on the outside. C1 said that the first written date was the open date, and the second date was the use by date. C1 discarded the container of applesauce. -A 46-ounce (oz.) thickened apple juice opened and undated was observed in the reach-in refrigerator. The carton documented, After opening, may be kept up to 7 days under refrigeration. C1 said that there should have been an open date recorded on the carton, and it would be discarded. -There was a 28 oz. box of cream of wheat on the food counter near the stove, opened and undated. -An additional reach-in refrigerator was observed with three 46 oz. cartons of thickened drink (two lemon water and one apple juice), all opened and undated. The cartons also documented, After opening, may be kept up to 7 days under refrigeration. C1 stated these cartons should also have been tossed in the trash. -Approximately 35 4 oz. cartons of strawberry shakes were observed in the reach-in refrigerator, thawed without thaw dates. The cartons documented, Use within 14 days after thawing. C1 said the shakes should have been dated with the thaw date. -An observation of the backsplash behind the dishwasher revealed a large area of black mildew speckled along the wall extending approximately three feet on both sides of the dishwasher unit. The chlorine test strips used by the dietary staff were labeled with an expiration date of [DATE]. C1 and Culinary Aide (CA) 1 had not been aware of the expired test strips and stated they would get them replaced. -An observation of the ice machine revealed the outer sides contained dirt buildup. Inside the machine was observed a small area of pinkish buildup along the inner rim of the door. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-There were extensive areas of dark debris buildup along a broken corner of the wall near the stove. Corners of the kitchen floor were observed with dark debris buildup along edges of the tile floor, baseboards, and corners throughout the kitchen. -Geriatric Nursing Assistant (GNA) 2 was observed entering the kitchen with a snack cooler. GNA2 went to the ice machine and scooped out ice for the cooler. Her hair was not contained in a hair net. During an observation on [DATE] from 10:54 AM until 11:55 AM: -There was an opened and undated bag of frosted flake cereal on the food preparation table. -A window air conditioning unit was observed with a thick coat of dirt and debris coating the air vents. The air conditioning unit was observed blowing air onto metal bowls and colanders stored on a shelf directly in front of the window air conditioning unit. -During an interview on [DATE] at 11:55 AM, Healthcare Services Group District Manager (HSGDM) confirmed the air conditioning unit needed to be cleaned. He removed the metal bowls and colanders away from the blowing air. HSGDM stated that ensuring the floors and baseboard areas of the kitchen were the responsibility of the dietary staff, and confirmed the floors required cleaning. He confirmed that hair and beard nets were to be worn in the kitchen. He stated the backsplash area behind the dishwasher was being replaced. Review of a facility policy titled, Storage of Resident Food, dated [DATE], revealed, Unsafe foods: foods that have visible mold, mildew, foul odors .This may also include food that is expired, outdated or food that has been exposed to incorrect temperatures or other environmental contaminants .Safety for all residents is a priority for food handling .Daily monitoring for refrigerated storage duration and discard of any food items that have been stored for ? 7 days .Foods will be stored in a closed container with sealable lids .Frozen foods must be stored and kept frozen.