STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215348	A. Building B. Wing	07/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lorien Taneytown, Inc	100 Antrim Blvd Taneytown, MD 21787

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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 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. 30428 Based on interview and medical record review, it was determined that the facility failed to thoroughly investigate and report to the state agency when a resident eloped from the facility. This was evident during the review of 1 of 4 residents (#20) reviewed for accidents. The findings include: During the tour of the facility on 7/11/2022 and interview with facility staff, Unit manager LPN #3, Surveyor was alerted when staff reported there was an 'incident' regarding a resident that was identified as a wanderer/elopement risk. At 12:53 PM on 7/11/2022 the Surveyor requested from the DON any facility policy on elopement or wandering that the facility followed and any information regarding the alleged incident occurring with Resident #20. Review on 7/12/2022 at 8:38 AM of Resident #20's medical record review revealed diagnoses including dementia and a history of falls. According to the social work admission note completed in March of 2021, s/he was admitted to the Long Term Care (LTC) from the Assisted Living Facility (ALF) in March of 2021 with a wander guard bracelet in place secondary to the potential risk of elopement. At 9:00 AM on 7/12/2022 an Incident/Accident form was provided to the survey team from an incident occurring on 5/21/2022. The incident type was labeled as an elopement, and stated that Resident #20 was placed on 15-minute checks as an intervention. The DON on 7/12/2022 was asked if there was any other documentation the facility can provide to the survey team regarding this incident including the facility report, however she stated that it was not reported to the state. The DON was able to provide email correspondence between facility staff regarding the incident. There was an email from the receptionist staff #8 on 5/21/2022, the day of the incident at 10:29 AM, to the Administrator stating that a Resident exited the building and they were not sure how the resident got out. Staff #8 was alerted that the resident was out of the building, she stated by another 'employee' and later reviewed the cameras to determine how Resident #20 was able to leave the building. There were no interviews, witnesses or investigation provided to the survey team regarding Resident #20's documented elopement from the LTC unit. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review on 7/12/2022 revealed that on 6/27/2022, Resident #20 was found on the ALF unit. The DON was asked on 7/12/2022 how s/he ended up on the ALF unit. As of 7/14/2022, there has been no follow-up from the DON.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 30428 Based on medical record reviews, interviews, and observations, it was determined that the facility failed to thoroughly investigate and implement interventions related to an elopement documented for Resident #20. This was found to be evident for 1 out 7 (Resident #20) residents reviewed for accidents. The findings include: A wander guard is a device worn by residents with dangerous wandering behaviors to alert staff with an alarm if the vulnerable resident attempts to elope (leave the facility unsupervised). The device is detected by sensors at alarmed exits or other dangerous areas that cause the system to alarm when the resident approaches or walks past the monitored areas. Activities of Daily Living (ADLs) assessment provides indicators of where residents lie on a spectrum between completely independent and completely dependent. ADLs include but are not limited to bed mobility, transfers, eating, locomotion on and off the unit, and personal hygiene. Periodically (at least quarterly) facilities conduct assessments of residents to track status and identify if the residents have experienced significant decline or improvement. If there has been change in at least two categories assessed, facilities are required to conduct a comprehensive Significant Change in Status Assessment (SCSA) to drive any needed revisions to care plans. This facility is a long-term care facility that is in a building with an attached assisted living facility (ALF). An ALF is a housing facility for people with disabilities or for adults who cannot or who choose not to live independently. The brief cognitive screening (BIMS) is a tool that assists in assessment of resident cognition and can identify need for additional assessment and for care planning. According to this facility (LTC) policy provided on 7/11/2022, noted from 2007, titled; Wandering Resident, The safety and wellbeing of all residents with a potential for wandering is ensured at all times. The policy further stated that all residents who were at risk for harm because of wandering behavior would have a Resident Care Plan that addressed the issue. Facility policy also provided that if a resident repeatedly wanders off a unit, the resident care plan should reflect a monitoring schedule to ensure resident safety. Review on 7/12/22 of the medical record for Resident #20 revealed that he/she was admitted to long term care in March of 2021. At the time of admission Resident #20 had known risk for elopement. Review on 7/12/2022 at 8:38 AM of a social work admission note, revealed that Resident #20 was admitted to the LTC from the assisted living facility (ALF) in March of 2021 with a wander guard bracelet in place secondary to the potential risk of elopement. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the care plan addressing Resident #20's elopement risk revealed that it was first opened on 3/1/21. Interventions established in March 2021 included that the resident would not exit the building unaccompanied for the following 90 days. Further review of the care plan on 7/12/2022 revealed an intervention associated with the elopement risk assessment (also initiated in March 2021) indicated that staff was to be aware of residents whereabouts at all times. In October 2021, interventions were added that addressed wandering behavior(s) which were still evident. The resident eloped from the building on 5/21/22. Three months later, on 5/21/2022, the elopement risk care plan first opened during 2019 was still active. According to multiple staff (including the DON, staff #8, and staff #18), Resident #20 had exited the building and was observed in the parking lot ambulating with his/her walker alone. When Resident #20 was brought back inside through the front entrance, the wander guard alarm sounded. Although the care plan required that staff be aware of Resident #20's whereabouts at all times, interviews revealed that staff was not aware when Resident #20 exited the building and only learned of it in passing. Interview at on 7/24/22 at 9:07 AM with activities staff #18 from the ALF, revealed that while she was passing newspapers on the assisted living unit, she saw the resident outside waking, thought that it was too hot out, and went out to bring him/her in. (Review of weather temperatures for 5/21/2022 revealed the high temperature for that location on that date was 93 degrees.) Staff #18 was further asked if she had any familiarity with the resident or anyone that wanders or has the potential to elope from the facility. She stated she only knew Resident #20 from when s/he lived on the ALF unit, however, as far as anyone wandering or eloping, including Resident #20, she had no knowledge or concerns. In an interview on 7/13/2022, staff #8 indicated that she was alerted to Resident #20's 5/21/22 exit from the building by staff #18. Staff #8 stated she did not see Resident #20 leave, but she later reviewed the cameras and saw that Resident #20 had left out of the south door exit, turned left, and walked down the sidewalk towards the front entrance. Review of the medical record for Resident #20 on 7/12/2022 at 7:13 AM revealed Resident #20 was placed on checks every 15 minutes after the 5/21/2022 elopement and then stepped down to checks every one hour on 6/2/2022. Although planned, paperwork provided to the survey team failed to provide documentation of any checks performed for Resident #20 from 5/26/22 through 6/2/2022. According to documentation in the resident's chart and on the unit, there were multiple days with blocks of hours that were incomplete with no documentation of staff supervision of the resident, including for example, from 1:00-8:00 PM on 7/12/2022. The facility failed to report the elopement to the Office of Health Care Quality (OHCQ) as required and failed to document a thorough investigation after the elopement. On 7/12/2022 surveyor requested the investigation into the 5/21/2022 documented elopement for Resident #20. At 9:00 AM an Incident/Accident form was provided to the survey team from the 5/21/2022 incident that documented that Resident #20 had been placed on 15-minute checks. There was no formal investigation completed for the 5/21/2022 incident and at the time of the surveyor's investigation, the DON was not able to state who brought the resident back into the facility when questioned. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Throughout the day on 7/12/22, the DON intermittently provided email correspondence between facility staff regarding the incident. This included a 5/21/22 email from the receptionist staff #8 at 10:29 AM, to the Administrator documenting that a Resident exited the building; it was not through the main door; and they were not sure how the resident got out. Staff #8 indicated that s/he was alerted that the resident was out of the building by another employee and later reviewed the cameras to determine how Resident #20 was able to leave the building. According to a 5/21/22 email from the Maintenance Director #7, there was a screw loose on the south exit door that was fixed, tested , and would be followed-up on. On 7/13/2022 at 3:49 PM, surveyors toured the south hallway with maintenance director #7 where Resident #20 had been captured on security footage exiting the building. Upon exiting the door with staff #17, there were two routes observed that the resident could have taken. Straight forward there were concrete steps that lead to the parking lot; and to the left, there was a slight decline in the sidewalk with a handicap ramp that also led to the parking lot which Resident #20 traveled. Resident #20 was 73 feet from the curb of the main road had s/he walked straight instead of turning towards the main entryway to the facility. After 5/21/22 elopement the facility still failed to develop or follow effective care planning for Resident #20 After the 5/21/22 elopement, the care plan was updated again on 6/6/22 for staff to increase supervision with resident regularly. On 6/27/2022, Resident #20 was found on the ALF unit. On 7/14/22, after surveyor intervention, the facility developed a plan that included Resident #20 would not be left alone pending placement to a facility that could safely meet his/her needs. However, the following morning, on 7/15/2022 staff were still not clear on the plan for Resident #20's safety. During tour of the facility on 7/15/2022 at 7:42 AM, Resident #20's was observed alone in his/her bed with a completed breakfast tray at the bedside. The surveyor was approached by UM #3 in Resident #20's room. The surveyor asked who was assigned to the resident and she replied that she would have to find out. The surveyor continued to observe the resident. At 7:56 AM Geriatric Nursing Assistant (GNA) #28 came into the room and stated that she would be assigned all day to Resident #20. Surveyor then left Resident #20's room and interviewed the nurse (LPN #20) who was assigned to Resident #20. She was asked what she was told in report from the 11-7 AM shift regarding Resident #20. She stated that the MDS coordinator #20, had worked the prior night and had given her report indicating that Resident #20 was only supposed to be on 1:1 through the 11-7 AM shift and she noted that there had been a miscommunication. A review of Resident #20's medical record on 7/15/2022 at 8:38 AM did not yet reveal any orders for the 1:1 and revealed that a care plan intervention for 1:1 was initiated on 7/15/2022 by the facility social worker #17. Thus, the facility had failed to conduct the required comprehensive assessment in February 2022, failed to develop an effective care plan based on that assessment, failed to report and investigate the 5/21/22 elopement after it occurred, failed to ensure a clear and effective care plan was developed after the 5/21/22 elopement, failed to ensure staff understood and followed the care plan both before and after the elopement, and failed to follow the facility's own policy to ensure resident safety. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	42783 37585

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 44369 Based on observation, interview with staff, and medical record review, the facility failed to meet the requirement to provide a system to account for the reconciliation of all controlled medications and ensure that an account of all the controlled drugs was completed with two licensed nurses at the change of each shift. This was evident for 3 of 3 available narcotic count logs. Findings Include: Tour of the unit on 07/14/22 at 1:28 PM to check for compliance of Medication Storage and Labeling revealed the Controlled Drug Count Verification Sheets. Several empty spaces for signatures were observed in the shift to shift verification log noted from March 2022 through the present day July 2022. On 07/14/22 at 2:30 PM, Surveyor requested the schedule for specific days from March to June of 2022 that were noted on the narcotic log where there were missing signatures over multiple shifts to verify if staff worked over multiple shifts in a row. According to the schedules provided to the survey team, no staff worked multiple shifts on the days noted with missing signatures on the log. During completion of medication storage task, 07/15/22 10:45 AM, Surveyor interviewed Nurse Manager LPN# 25 about what processes are in place to comply with the requirement of narcotic verification. The Nurse Manager, LPN # 25 was unable to show the Surveyor the process. However, LPN #25 verbalized that for the Inventory of Control and Controlled Substances; nurses should ensure that the incoming and offgoing nurses count all Schedule II controlled substances and other medications at the change of each shift or at least once daily and document the results on the Controlled Drug Count Verification Log. This concern was reviewed with the Nurse manager and the DON throughout the survey and again during exit.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 30428 Based on medical record review and interview with facility staff, it was determined that the facility contracted pharmacist failed to identify recommendations were followed up on. This was evident for 1 of 5 residents reviewed for unnecessary medications. Pharmacy reviews are to occur monthly at a minimum to determine any irregularities in a resident drug regimen and report to the physician. The findings include: Review of the medical record for Resident #20 on 7/12/2022 at 2:04 PM for unnecessary medications, specifically regarding the use of a psychotropic medication, trazadone an antidepressant and sleep aide, revealed a recommendation from the pharmacist completed on 2/26/2022 to change the medication from AM to PM secondary to the risk of falls. The consult was signed by the resident's attending physician # 27 and the change was notated as agreed upon. Further review of Resident #20's medication administration records (MAR) for March through June 2022, revealed Trazadone was ordered and administered with the morning medications. The medication was not ordered to be changed to 'bedtime' until 6/13/2022. Resident #20's medical record failed to reveal any other pharmacy recommendations from February to July 2022. The pharmacist failed to identify the failure of the facility to implement the agreed upon recommendation to change the Trazadone from AM to PM from March 2022 to June 2022. This concern was reviewed with the DON throughout the survey and again during exit. Cross reference with F758

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 30428 Based on medical record reviews and interviews with facility staff, it was determined that the facility failed to 1) implement pharmacy recommendations that were agreed upon by the physician and ensure that they were followed up on (#20) and 2) ensure that orders for as-needed psychotropic medications were limited to 14 days for residents #25 and #56. This was evident for 3 out of 6 residents reviewed for unnecessary medications. The findings include: 1) Review of the medical record for Resident #20 on 7/12/2022 at 2:04 PM regarding the use of a psychotropic medication, Trazadone an antidepressant and sleep aide, revealed a recommendation from the pharmacist completed on 2/26/2022 to change the medication from AM to PM secondary to the risk of falls. The consult was signed by the resident's attending physician # 27 and the change was notated as agreed upon. Further review of Resident #20's medication administration records (MAR) for March through June 2022, revealed Trazadone was ordered and administered with the morning medications. The medication was not ordered to be changed to 'bedtime' until 6/13/2022. The Director of Nursing (DON) was interviewed on 7/13/2022 at 1:39 PM regarding the concern and the facility process of receiving pharmacy recommendations and implementation. She stated that the Physician will put the recommendations in a stack and the nurses take care of it and she is not sure how it was missed. The DON followed up at 2:30 PM on 7/13/2022 after review with the unit manager # 3 and they were not able to determine how this recommendation was missed. The concern that there were agreed upon pharmacy recommendation that were not implemented from 4 months was reviewed with the DON through the survey and again during exit. Cross reference F756 37585 2) Anti anxiety medications fall under the category of psychotropics and include the medication Lorazepam. On 7/11/2022 at 2:05 PM, the surveyor conducted a record review for resident #25 that included a review of the resident's active as-needed orders. The list revealed an as-needed order for Lorazepam. The Lorazepam order was noted to have a duration of 30 days. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Regulation requires that as-needed orders for psychotropic drugs be limited to 14 days. If the attending physician or prescribing practitioner believes that it is appropriate for the as-needed order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the as-needed order. On 7/13/2022 at 2:35 PM, the surveyor conducted an interview with the Director of Nursing (DON). When asked why the duration of resident #25's Lorzepam order was 30 days rather than 14, the DON indicated that she did not know why, confirming her understanding that regulation requires as-needed psychotropics to be limited to 14-day orders. The DON stated that she would investigate the order and provide the survey team with any additional information that she could find. On 7/15/2022 at 11:12 AM, the surveyor reviewed resident #56's medical record. The review revealed that resident #56 also had an order for Lorazepam as-needed with a duration of 30 days. On 7/15/2022 at 1:30 PM, the surveyor conducted a follow up interview with the DON. During the interview, the surveyor asked the DON if there was any additional information regarding the lorazepam orders with 30 day duration and the DON stated there was not. The facility did not provide any additional documentation to the survey team prior to exit.

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F 0803 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 37585 Based on observation and interview with facility staff, it was determined that the facility failed to ensure that the weekly menus displayed in the corridor outside the nursing unit accurately reflected the menu being served. This practice had the potential to affect all residents in the facility. The findings include: During an observation on 7/11/2022 at 9:30 AM, it was noted that there were two weekly menus placed prominently in the entry hallway of the facility's only nursing unit. The weekly menus were labeled This Week's Menu and Next Week's Menu. The menu under This Week's Menu was noted to be the Week 4 Menu and the menu under Next Week's Menu was the Week 1 Menu. Tour of the unit at that time failed to reveal any other location where the weekly menu was displayed. Based on menus given to the survey team during the entrance conference on 7/11/2022 at 9:45 AM, it was determined that the facility followed a 4 week rotating menu schedule in which the Week 1 menu follows the Week 4 menu. The surveyor observed the nursing unit's lunch service on 7/11/2022 around 12:00 PM. During the meal service, it was noted that the meal being served did not match the meal identified on the Week 4 calendar. Instead, it matched the meal identified on the Week 2 calendar. Food service observed on 7/12/2022 and 7/13/2022 also matched meals identified on Week 2 rather than Week 4. On 7/12/2022 at 8:40 AM, the surveyor observed a daily menu near the weekly menu. The daily menu matched the meal being prepared for the day but did not match the displayed weekly menu (Week 4). It matched the menu for Week 2. On 7/13/2022 at 1:15 PM, the surveyor observed Kitchen Staff #30. During the interview, the staff member confirmed that the facility was currently serving the week 2 menu. The staff member was informed that the current published menus available in the nursing hallway reflected that the current menu was Week 4 and next week's menu was Week 1.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 37585 Based on observation and interview of staff, it was determined that the facility failed to ensure that the kitchen stored and prepared food in accordance with professional standards for food service safety. This practice had the potential to affect all residents. The findings include: During a tour of the kitchen that took place on 7/11/2022 at 9:15 AM, the surveyor observed ice buildup at the back of the dessert walk-in freezer. The ice was built up around the base of the overhead condenser and had formed a stalactite that came in contact with two containers of ice cream. The temperature of the freezer was appropriate. The Food Service Director (FSD) was present for the tour and stated that she would have the freezer inspected by maintenance. During a follow up tour that took place on 7/12/2022 at 11:49 AM, the surveyor reviewed the July temperature logs with the FSD. These temperatures logs documented the highest cooking temperature obtained by kitchen staff during the preparation of potentially hazardous foods (foods that should reach a certain temperature for a certain length of time to minimize the risk of foodborne illness). The temperature log for 7/8/2022 was noted to have no temperatures documented for any lunch or dinner item cooked that day. Otherwise, the temperature logs had multiple temperature entries for all meals.