STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215344	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Residences at Vantage Point	5400 Vantage Point Road Columbia, MD 21044

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 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. Based on interview and record review it was determined the facility failed to timely report an injury of unknown origin to the Office of Health Care Quality. This was evident for 2 (#MD00200761, and #MD00162737) out of 2 facility reported incidents reviewed for injuries of unknown origin for Resident #220 during the facility's recertification/complaint survey. The findings include: 1.) On 12/6/24 at 8:22AM the surveyor requested the complete investigation file for facility self-report #MD00200761 from the facility's Administrator. On 12/6/24 at 8:42AM the surveyor received the investigative file from the Administrator who confirmed this was the complete investigation file. Review of the facility's initial self-report revealed Resident #220's hip fracture was reported as an injury of unknown source to the Office of Health Care Quality on 12/19/23 at 10:30AM. Review of the follow-up self-report revealed the following information was documented: Resident had a fall on 11/28/23 from his/her wheelchair. On 12/10/24 at 9:58 AM the surveyor conducted a review of the medical record of Resident #220 which revealed the following was documented in a nursing progress note dated 11/28/23 at 2:01PM: At 11:30AM nurse was called to resident's room, observed resident laying face down in front of w/c (wheelchair), Resident slid out of w/c, sustained hematoma to left side of forehead size of a golf ball, ice applied, Root cause determine from constant agitation, always reaching and trying to grab things around him/her, Frequent yelling at all times on going behavior, Neuro check initiated WNL (within normal limits), on routine pain management . On 12/10/24 at 10:53 AM the surveyor conducted an interview with the facility Administrator who reported the following information to surveyors regarding the root cause analysis process for Resident #220: We think through what could be done for this resident, s/he can't communicate, does s/he need a new cushion, did s/he slide out of it because of the traction? At this time, the surveyor provided opportunity to the Administrator for all documentation and actions taken by the facility regarding Resident #220's 11/28/23 incident to be provided to the surveyor for review. On 12/10/24 at 11:50AM the surveyor conducted an interview with the facility's Administrator who reported to surveyors the following information regarding the 11/28/23 incident for Resident #220: S/he slid out of his/her wheelchair, s/he was in a room by her/himself, Staff do rounds every two hours typically, a lot of staff walk by, someone was walking by and from the note s/he was found there on the floor. When the surveyor inquired as to if there was an investigation performed and an investigation file for the incident, the Administrator replied: No, we don't keep investigation files for (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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	every single fall, we don't report every single fall to your office, it's only when they have injuries, it was part of the investigation because we said the fracture was related to the fall. At this time the surveyor inquired as to how staff ruled out abuse and neglect and how staff knew that Resident #220's hematoma was from a fall sliding from the wheelchair; to which they replied: because s/he was on the floor. At this time, the surveyor shared their concerns and noted that the 11/28/23 incident resulting in an injury of unknown origin with the resident having been documented as sustaining a hematoma to the left side of their forehead the size of a golf ball in which neuro checks were instituted, was not reported to the Office of Health Care Quality. Review by the surveyor on 12/10/24 at 11:53AM of the facility's incident report dated 11/28/23 documented the following was selected on the report: alleged fall, unattended. Other options present on the incident report were: abuse investigation for unknown injury, and abuse ruled out, in which neither of these options were observed selected. On 12/10/24 at 4:47 PM the surveyor reviewed the facility's initial self-report for injury of unknown source dated 12/19/23 at 10:30AM and noted the following information was present on the self-report for the hip fracture reported on 12/19/23: Date/time/Name of when staff became aware of the incident: 12/19/23 at 8:15AM, Director of Health Services. Review of the email submittal for the initial self report was observed to be dated 12/19/23 at 10:28AM. Further review of the final report radiology results which notified the facility of the hip fracture was observed to be dated 12/19/23 at 1:56AM. 2.) On 12/6/24 at 8:22 AM the surveyor requested the complete investigation file for facility self-report #MD00162737 from the facility's Administrator. On 12/6/24 at 8:42 AM the surveyor received the investigative file from the Administrator who confirmed this was the complete investigation file. Review by the surveyor of the facility's self-report of an injury of unknown origin revealed the following information was reported to the Office of Health Care Quality dated 1/19/21 at 4:15PM: Resident complained of left hand pain, Order for x-ray was completed, X-ray was performed and found acute anterior humeral head dislocation, Resident was taken to the hospital where s/he had a successful closed reduction of dislocation. The following date and time of the incident was observed documented on the facility's initial self-report form: 1/18/2021 6:40PM. Review of the resident's final radiology report to the facility of the dislocation revealed a date of 1/18/21 at 6:40PM. Review of email documentation by the surveyor revealed the self-report was documented as sent to the Office of Health Care Quality on 1/19/21 at 5:37PM with the following information in the subject line: Self report 1/18/2021. On 12/9/24 at 12:36 PM the surveyor reviewed the medical record for Resident #220 which revealed the following documentation by Licensed Practical Nurse #22 dated 1/18/21 at 22:40PM: Results for x-rays ordered earlier this shift received, Left shoulder x-ray shows acute anterior humeral head dislocation. The surveyor noted that the Resident #220's serious injury was not reported to the Office of Health Care Quality until approximately 22 hours and 57 minutes after notification to the facility of the resident's x-ray results which revealed the acute anterior humeral head dislocation. Review of Certified Registered Nurse Practitioner's visit summary dated 1/18/21 documented the resident was being seen at the request of nursing for inability to use his/her left arm and left arm pain.

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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. Based on record review and interview it was determined the facility failed to ensure a thorough investigation was performed for an injury of unknown origin. This was evident during the surveyor's review of facility reported incident #MD00200761 reviewed by the surveyor during the facility's recertification/complaint survey. The findings include: On 12/6/24 at 8:22AM the surveyor requested the complete investigation file for facility self-report #MD00200761 from the facility's Administrator. On 12/6/24 at 8:42AM the surveyor received the investigative file from the Administrator who confirmed this was the complete investigation file. Review of the facility's initial self-report revealed Resident #220's hip fracture was reported as an injury of unknown source to the Office of Health Care Quality on 12/19/23 at 10:30AM. Review of the follow up self-report revealed the following information was documented: Resident had a fall on 11/28/23 from his/her wheelchair. On 12/10/24 at 9:58AM the surveyor conducted a review of the medical record of Resident #220 which revealed the following was documented in a nursing progress note dated 11/28/23 at 2:01PM: At 11:30AM nurse was called to resident's room, observed resident laying face down in front of w/c (wheelchair), Resident slid out of w/c, sustained hematoma to left side of forehead size of a golf ball, ice applied, Root cause determine from constant agitation, always reaching and trying to grab things around him/her, Frequent yelling at all times on going behavior, Neuro check initiated WNL (within normal limits), on routine pain management . On 12/10/24 at 10:53AM the surveyor conducted an interview with the facility Administrator who reported the following information to surveyors regarding the root cause analysis process for Resident #220: We think through what could be done for this resident, s/he can't communicate, does s/he need a new cushion, did s/he slide out of it because of the traction? At this time, the surveyor provided opportunity to the Administrator for all documentation and actions taken by the facility regarding Resident #220's 11/28/23 incident to be provided to the surveyor for review. During the interview, the Administrator reported to the surveyor that the risk meeting documentation that had been provided to the surveyor was the risk meeting minutes and there was no other documentation for the risk meetings. On 12/10/24 at 11:50AM the surveyor conducted another interview with the facility's Administrator who reported to surveyors the following information regarding the 11/28/23 incident for Resident #220: S/he slid out of his/her wheelchair, s/he was in a room by her/himself, Staff do rounds every two hours typically, a lot of staff walk by, someone was walking by and from the note s/he was found there on the floor. When the surveyor inquired as to if there was an investigation performed and an investigation file for the 11/28/23 incident, the Administrator replied: No, we don't keep investigation files for every single fall, we don't report every single fall to your office, it's only when they have injuries, it was part of the (12/19/23) investigation because we said the (12/19/23) fracture was related to the (11/28/23) fall. At this time the surveyor inquired as to how staff ruled out abuse and neglect and how staff knew that Resident #220's hematoma was from a fall sliding from the wheelchair; to which they replied: because s/he was on the floor. At this time, the surveyor shared their concerns and noted that the 11/28/23 incident resulting in an injury of unknown origin with the resident having been documented as sustaining a hematoma to the left side of their forehead the size (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of a golf ball in which neuro checks were instituted, was not reported to the Office of Health Care Quality. There was no investigation file that could be provided to the surveyor for the 11/28/23 incident. Review by the surveyor on 12/10/24 at 11:53AM of the facility's incident report dated 11/28/23 documented the following was selected on the report: alleged fall, unattended. Other options present on the incident report were: abuse investigation for unknown injury, and abuse ruled out, in which neither of these options were observed selected. On 12/10/24 at 12:53PM the surveyor reviewed the root cause analysis for the 11/28/23 incident which was risk meeting documentation that consisted of the following: On 11/28/23 before lunch resident was found on the floor in front of his/her bed, Resident slid off his/her wheelchair, Offer to lay down after breakfast, New cushion in place by rehab team. The surveyor noted that there was no documentation of a thorough investigation to support how the interdisciplinary team came to those conclusions.