

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215015	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/13/2024
NAME OF PROVIDER OR SUPPLIER Fairland Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2101 Fairland Road Silver Spring, MD 20904	
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)		
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41274</p> <p>Based on observations, record review, and interviews during a complaint survey the facility failed to ensure to treat each resident in a manner and in an environment that promoted the maintenance or enhancement of his or her quality of life, recognizing each resident ' s individuality for one resident (Resident #56) of three residents reviewed for resident rights. Specifically, Resident #56 was not able to wear their own clothing because the facility did not ensure their clothing was clean and available for them to wear.</p> <p>The findings include:</p> <p>Review of the policy and procedure titled, Resident Rights Under Federal Law, last revised 2/1/23, read in pertinent part that residents had the right to self-determination and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>Resident #56 was admitted to the facility with diagnosis which included hemiplegia and hemiparesis affecting the right dominant side (paralysis impacting one side of the body) and heart disease. The Minimum Data Set, dated dated [DATE] documented the resident was dependent on staff to complete activities of daily living.</p> <p>On 12/5/24 at 11:15 AM, Resident #56 was lying in bed dressed in a hospital gown. The resident ' s name was not listed/assigned outside of the room. Geriatric Nurse Aide (GNA) #22 was present in the resident ' s room and stated they were assigned to the resident ' s care that day but did not know the resident ' s name.</p> <p>On 12/9/24 at 12:40 PM, during an observation and interview, Resident #56 was lying in bed dressed in a hospital gown. The resident stated they would prefer to wear their own clothing, but they did not think they had any of their own clothing at the facility. Beneath a chair, in the corner of the resident ' s room, there were two transparent plastic bags with clothing and a plastic basin in them.</p> <p>During an interview on 12/9/24 at 12:45 PM, GNA #21 stated Resident #56 had been at the facility for approximately three months and they were unsure whether the resident had clothing.</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 215015	If continuation sheet Page 1 of 19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215015	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/13/2024
NAME OF PROVIDER OR SUPPLIER Fairland Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2101 Fairland Road Silver Spring, MD 20904	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and interview on 12/9/24 at 12:50 PM, the Director of Nursing (DON) entered Resident #56 's room, donned surgical gloves and opened the bags of clothing. They pulled out pieces of clothing from the bags which were balled up and wrinkled and revealed the clothing was labeled with Resident #56 's name. They stated they did not know if the clothing was clean or dirty but would have it sent out to the laundry.</p> <p>On 12/11/24 at 10:34 AM, during an interview with the Director of Housekeeping (DOH), they stated GNA ' s were responsible for placing soiled laundry in transparent plastic bags, labeling the bag with the resident ' s name and placing it in the soiled linen closet. The DOH stated the facility ' s laundry procedure was to wash and return soiled clothing within the same day. The DOH stated laundry staff should return the clean clothing to the unit and then the GNAs should put the clean clothing away for the residents. The DOH stated some residents at the facility did not come in with clothing or have clothing brought in for them, however nursing staff could then select clothing from a donated clothing area located in the laundry room if a resident had no clothing. The DOH stated nursing staff should identify which residents needed clothing.</p> <p>During an interview on 12/11/24 at 10:40 AM, the Nursing Home Administrator (NHA) stated residents should be gotten out of bed and dressed per their preference. The NHA stated it was a resident's right to wear their own clothing and be assisted with dressing. The NHA stated soiled clothing should not be left on the floor or other areas in the residents ' room.</p> <p>During an interview on 12/13/24 at 10:00 AM, DON stated residents had the right to wear their own clothing if they chose to. The DON stated nursing staff should routinely offer to assist residents with getting dressed and out of bed. The DON stated soiled clothing should be bagged, labeled and brought to the soiled linen rooms by GNAs. The DON stated once laundry staff cleaned the clothing, GNAs should put the clean clothing away for the residents.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215015	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/13/2024
NAME OF PROVIDER OR SUPPLIER Fairland Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2101 Fairland Road Silver Spring, MD 20904	
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)		
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37276</p> <p>Based on record review and interview with facility staff, it was determined that the facility failed to ensure that physicians were notified when a resident had a significant medication error. This was evident for 1 (#3) of 42 residents reviewed for a complaint during a complaint survey.</p> <p>The findings include:</p> <p>On 12/12/24 at 9:50 AM, a review of complaint #MD0020957 was conducted. In the complaint, the complainant reported that from 11/19/23 to 11/23/24, Resident #3 was administered the wrong dose of Trileptal (Oxcarbazepine) (anti-seizure medication).</p> <p>Review of Resident #3's medical record revealed resident was initially admitted to the facility in mid-November 2023 following an acute hospitalization , with diagnosis which included cerebral palsy and seizures.</p> <p>Review of Resident #3's hospital discharge summary with a discharge date of [DATE] documented Resident #3 had a history of epilepsy (seizure disorder), that there was no recommendation at this time to escalate antiseizure medications, and to resume Oxcarbazepine 900 mg BID. Included in the discharge summary was a list of the medications that Resident #3 was to continue in the facility including an order for Oxcarbazepine 900 MG (milligrams) by mouth two times a day.</p> <p>Review of Resident #3's November 2023 Medication Administration Record (MAR), revealed two orders for Oxcarbazepine (Trileptal) that documented the resident was given the wrong dose of oxcarbazepine on 10 administration times between 11/17/23 and 11/23/23.</p> <p>In the MAR, there was (a) an 11/17/23 order for oxcarbazepine oral tablet, 300 milligrams (MG), give 3 tablets [equals 900 MG) by mouth two times a day for seizure disorder, that documented the oxcarbazepine was administered as ordered twice a day, every day, from 11/17/23 through 11/23/23, and (b) an 11/18/24 order for Trileptal oral tablet 600 MG, give 1 tablet by mouth two times a day for seizure disorder; give with the 300 MG dose for a total of 900 MG, that was documented as given once on 11/18/23 at 9:00 PM, given twice a day on 11/18, 11/19, and 11/21, given one time on 11/22 at 9:00 AM, given twice on 11/23. On 11/22 at 9:00 PM, and 11/24 at 9:00 AM, the Trileptal order was documented as refused then discontinued on 11/24/23.</p> <p>No associated order for Oxcarbazepine 300 MG was found in the MAR.</p> <p>A continued review of the medical record failed to find evidence that the physician was notified that Resident #3's order for oxcarbazepine had been transcribed twice in his/her MAR resulting in Resident #3 being given the wrong dose of the medication on 10 administration times in November 2023.</p> <p>During an interview on 12/12/24 at 11:28 AM, Staff #36, Medical Director, stated that whenever a resident received the wrong dose of medication, the physician should be notified, and if a resident received the wrong dose of medication for multiple days, the physician may want to hold the medication or check the labs.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215015	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/13/2024
NAME OF PROVIDER OR SUPPLIER Fairland Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2101 Fairland Road Silver Spring, MD 20904	
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)		
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The above concerns were discussed with the Director of Nurses on 12/12/24 at 2:51 PM. The DON acknowledged the concerns at that time.</p> <p>On 12/12/24 at 2:51 PM, the Director of Nurses (DON) was made aware of the above concerns, and acknowledged the concerns at that time.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215015	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/13/2024
NAME OF PROVIDER OR SUPPLIER Fairland Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2101 Fairland Road Silver Spring, MD 20904	
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)		
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>31145</p> <p>Based on review of a complaint, record review, observation, and staff interview, it was determined the facility staff failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable environment. This was evident on 3 of 4 nursing units observed.</p> <p>The findings include:</p> <p>On 12/3/24 at 11:30 AM a review of complaint MD00211814 alleged that there was black mold in the ceiling of resident rooms.</p> <p>On 12/3/24 at 11:45 AM an environmental tour was conducted, and the following observations were made:</p> <p>In room Dogwood Vent D2-B 3 Bed in the bathroom in the shower, there was water dripping through the ceiling light in the shower. There were towels on the floor. There was an out of order sign on the bathroom door. There was a musty odor in the bathroom. The wall behind both beds in the bedroom was spackled without paint.</p> <p>In the adjacent room, which was the Rehab gym, the ceiling in the bathroom was spackled approximately 3 ft. by 3 ft. The Director of Rehab was there and was asked about water leaking through the ceiling. He stated not as much recently since the spring. The Director of Rehab stated it had resolved and was due to the housekeeping closet upstairs. Observation was made of an overhead fluorescent light in the gym that had residual brown stains on the light.</p> <p>Room D1 was unoccupied as the resident was at the hospital. In the corner of the room was a pole with a bottle of tube feeding, Jevity with 780 cc in the bottle along with a small piggyback back of Normal Saline Solution and an IV antibiotic Piperillin in a 4.5 gm/vial. The items were not disposed of when the resident was sent out to the hospital on 12/1/24 at 12:15 PM. In the bathroom was a toilet filled with feces and there were dead bugs along with other debris on the floor. The ceiling tiles in the room did not fit in the ceiling tile grids.</p> <p>The ceiling tiles in the hallway on the Dogwood unit had brown stains outside of room D2 (2) tiles, a tile by the emergency door, and (2) tiles by the entrance to the rehab gym. There was 1 ceiling tile that was missing a chunk of material which was located outside of the clean utility room. The ceiling tiles in the hallway were lopsided and did not fit in the ceiling tile grids.</p> <p>In room D3 the vinyl floor tile was missing in front of the bathroom door. There were (5) other vinyl floor tiles that were missing pieces of the tile and not covering the floor. The ceiling in the bathroom in the shower had plaster that was peeling. There was also peeling plaster on the wall by the toilet.</p> <p>In room D7 the closet door was missing laminate, the nightstand was missing a drawer handle, and the drawer was crooked.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215015	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/13/2024
NAME OF PROVIDER OR SUPPLIER Fairland Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2101 Fairland Road Silver Spring, MD 20904	
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)		
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In room D8 there were (2) brown circles on ceiling tiles and the door handle on the closet door was broke. There was a water puddle on the floor in the bathroom and the white tray table in the shower had black material covering the tray. The bathroom had a funky odor.</p> <p>In room D9 there were several ceiling tiles that were missing chunks of material in the corners of the tile.</p> <p>In room D10 the closet doors were missing handles, the floor was dirty with debris and the nightstand door was hanging crocked off the nightstand.</p> <p>In the medical supply room, the entire corner ceiling tile was covered with a brown stain.</p> <p>In room B12, which was directly above room D1, there was no janitor's closet and no dripping water. On the windowsill in the bathroom there was an opened enema. The front cover of the wallboard heater was missing. There were 2 pillows on the bed that had rips in the blue covering. The ceiling over the bed by the entrance door had silver tape which held brown paper in place.</p> <p>There were stains in the carpet in the hallway outside of rooms B11 - B9.</p> <p>The ceiling in the hall by C5 had an area that was brown and spackled.</p> <p>On 12/3/24 at 1:00 PM the regulatory compliance advisor took a tour of all of the rooms and areas above with the surveyor. She confirmed all of the findings.</p> <p>On 12/3/24 at 1:15 PM the maintenance assistant stated that the Maintenance Director had resigned this past Friday. When asked about the water dripping in the shower, the maintenance assistant stated it had been like that. The regulatory compliance advisor was present during the interview.</p> <p>41274</p> <p>Review of the policy and procedure titled, Resident Rights Under Federal Law, last revised 2/1/23, read in pertinent part that it was the policy of the facility to provide a safe, clean, comfortable homelike environment. This included ensuring the resident can receive care and services safely and that the physical layout of the facility maximized resident independence and did not pose a safety risk. Housekeeping and maintenance services were to be provided to maintain a sanitary and comfortable interior. Residents were to be provided with clean bed and bath linens that were in good condition.</p> <p>On 12/5/24 at 10:15 AM, an observational tour of Unit A revealed Room # ' s A3, A4, A5, A14 and A15 had cracked/broken doorframes.</p> <p>On 12/5/24 at 10:24 AM, Resident #36 was lying on their bed on top of bedding with large yellowish/brown colored stains that were dried on the blanket.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215015	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/13/2024
NAME OF PROVIDER OR SUPPLIER Fairland Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2101 Fairland Road Silver Spring, MD 20904	
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)		
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 12/5/24 at 12:11 PM, in Room #C2, there were soiled hospital gowns piled on a chair next to bed #1. On a bedside table there was a cup filled with dirty napkins. Soiled clothing was piled in a corner of the room. The pillows on bed one did not have pillowcases, and both pillows had a ripped plastic exterior. In the adjoining bathroom between Rooms # 's C2 and C4 there was black mold/mildew around the caulking of the bathtub. The interior of the bathtub was stained and had areas where the porcelain had chipped away. There was a shower bench in the bathtub which had a plastic basin on top filled with soiled clothing. The toilet had feces stuck to the side of the interior toilet and urine on the seat of the toilet. There were broken tiles at the base of the toilet. The radiator cover had fallen off and was resting on the floor with exposed interior radiator coiling. The door to bathroom leading into Room #C4 had deep scrapes along the bottom of the door with areas of paint peeled back.</p> <p>On 12/5/24 at 12:41 PM, in the bathroom in Room #A1, the caulking around the base of the toilet was missing and there was water on the floor around the toilet. When the toilet was flushed, water leaked from the base of the toilet. The toilet seat was chipped away in portions and had dark brown stains. The windowsill had broken tiles and the cover for the radiator was disconnected and on the floor.</p> <p>On 12/5/24 at 12:48 PM, there were large stains, which were approximately two to three feet in length and a foot in width on the carpeting in the hallway between Room #s C3 and C5.</p> <p>On 12/5/24 at 1:00 PM, in Room #C12 there were two holes, that were approximately four to five inches wide in the drywall behind bed two. The radiator cover was on the floor with exposed interior coils. The bathroom between Room #s C12 and C10 had black dirt/debris throughout the bathtub. The bathtub had stains and areas where the porcelain was worn away. There was no caulking around the toilet and cracked tiling at the base of the toilet. There was a hole in the window screen which was stuffed with paper towels.</p> <p>On 12/6/24 at 11:57 AM, in Room #C2, on bed #1, the two ripped plastic pillows remained on the bed without pillowcases. On the floor next to the bed, there was an empty soda can and spilled soda which had dried on the floor and was sticky when stepped on. There was garbage and debris on the floor and in corners of the room.</p> <p>On 12/10/24 at 1:43 PM, during an environmental tour and interview with the Regional Director of Maintenance (RDM), they observed areas of the facility which required repair/maintenance and stated they had noted several of the issues when they had been in the facility a few days prior. The RDM stated they were unaware of current projects/work orders to address the needed repairs. The RDM stated radiator covers being off the radiators and door frames with jagged edges could present safety risks to the residents. The RDM observed the bathtub in the adjoining bathroom between Room #s C12 and C10; which still had black debris throughout the bathtub, and they described it as crud. The RDM stated some of the bathtubs in the facility would not drain and should not be used to discard dirty water after mopping or cleaning. The RDM stated several bathrooms had bathtubs which were not functional and in need of repair/ replacement and faucets and toilets which would leak. The RDM stated there were multiple areas in the resident environment in need of repair which should be addressed.</p> <p>During an interview on 12/10/24 at 2:17 PM, the Nursing Home Administrator (NHA) stated they were aware that the building needed repairs.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215015	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/13/2024
NAME OF PROVIDER OR SUPPLIER Fairland Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2101 Fairland Road Silver Spring, MD 20904	
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)		
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 12/11/24 at 10:34 AM, the Director of Housekeeping (DOH) stated soiled laundry should be bagged and placed in individual clothing hampers or in designated laundry rooms on the units. The DOH stated soiled laundry should never be stored in the resident 's room. The DOH stated many of the bathtubs in the facility would not drain so if anything was poured into them, the substance would stay in the bathtub. The DOH stated the bathtubs could appear unclean because of stains even after mopping them. The DOH stated resident rooms should be thoroughly cleaned and sanitized daily.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215015	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/13/2024
NAME OF PROVIDER OR SUPPLIER Fairland Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2101 Fairland Road Silver Spring, MD 20904	
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)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31145</p> <p>Based on review of facility administrative records, facility investigations, and staff interview, it was determined the facility failed to thoroughly investigate incidents of alleged abuse, neglect, and missappropriation of property. This was evident for 4 (#11, #35, #36, #37) of 23 residents reviewed for facility reported incidents during a complaint survey.</p> <p>The findings include:</p> <p>1) On 12/3/24 at 10:16 AM a review of facility reported incident MD00207461 alleged that Resident #11 did not receive adequate care at the facility. The allegation was reported through the facility's compliance line. The facility became aware of the concern on 7/8/24.</p> <p>Review of the facility's investigation revealed 25 staff members were interviewed for care provided between 5/31/24 and 6/7/24.</p> <p>Review of the actual worked nursing schedule for that time period revealed out of the 25 staff members that were interviewed and answered the questions, only 3 took care of the resident during that time period of 8 days. The other staff members that were assigned to and took care of the resident during that time period were not interviewed.</p> <p>The facility's investigation consisted of only 1 resident that was interviewed. The resident that was interviewed answered that they did not feel that the staff provided care to the resident while living at the facility and the resident responded yes, that the call bell stays on for long periods of time without response. There was no follow-up after that revelation. The facility's investigation was incomplete.</p> <p>On 12/5/24 at 1:15 PM a discussion was held with the Director of Nursing and Nursing Home Administrator who confirmed the findings.</p> <p>37276</p> <p>Upon entry to the facility on [DATE] a list of facility reported incidents was provided to administration. At that time the request was for all investigations to be provided to the surveyors.</p> <p>2) On 12/3/24, a review of facility reported incident MD00182148 revealed the facility reported Resident #36 was observed outside of the facility without and escort and unattended on 8/12/22.</p> <p>On 12/03/24 at 2:01 PM, the Director of Nurses (DON) reported she could not find the investigation for facility reported incident MD00182148 and she would continue to look for the investigation.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215015	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/13/2024
NAME OF PROVIDER OR SUPPLIER Fairland Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2101 Fairland Road Silver Spring, MD 20904	
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)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/4/24 at 2:10 PM, the DON reported the facility's investigation, including interviews of residents and staff, could not be found, that some of the documents were able to be reproduced, and provided the surveyor with elopement drill forms dated 8/12/22 and 8/16/22, documentation that elopement evaluations were completed on all residents, and that window stops were ordered to be installed on facility windows. The DON confirmed at that time that the facility was unable to provide evidence that the facility had completed a thorough investigation when Resident #36 eloped from the facility.</p> <p>Cross Reference F 689</p> <p>34484</p> <p>3) On 12/3/24 review of facility reported incident MD00182186 revealed Resident #37 reported on 3/18/22 he/she was assaulted by Staff #16.</p> <p>On 12/5/24 at 9:05 AM the Director of Nursing (DON) stated she could not find the investigation for facility reported incident MD00182186.</p> <p>Interview with the DON and Administrator on 12/5/24 at 1:15 PM confirmed the facility does not have the investigation including interviews of Resident #37, Staff #16 and other staff and residents. The DON confirmed at that time the facility staff failed to complete a thorough investigation of alleged abuse of Resident #37 on 3/18/22.</p> <p>41274</p> <p>4) The facility failed to ensure a thorough investigation was conducted when mistreatment was alleged by Resident #35.</p> <p>Review of the policy and procedure titled, Abuse Prohibition last revised 10/24/22, documented in pertinent part the facility would initiate an investigation within 24 hours of an allegation of abuse being made. The investigation was to document whether abuse or neglect occurred and to what extent, clinical examination for signs of injuries if indicated, causative factors and interventions to prevent further injury. The investigation was to be thoroughly documented within the Risk Management Portal and staff completing the investigation were to ensure documentation of witness interviews was included.</p> <p>Resident #35 was admitted to the facility with diagnosis which included arthropathy (disease of the joints), and muscle weakness. The Minimum Data Set, dated dated [DATE] documented the resident was assessed with a Brief Interview for Mental Status (BIMS) score of 15/15 which was indicative of intact cognition.</p> <p>Review of the facility investigation of cases #MD00184076 and MD00183920 revealed on 9/28/22 at approximately 8:39 PM, two police officers responded to the facility to do a welfare check on Resident #35 who had called to report that they had been calling for help and no one had responded. The resident also alleged Geriatric Nurse Aide (GNA) #19 had been rough with them during care. The facility investigation included interviews conducted with other residents on the unit and statements were obtained from GNA #19 and other staff working during the time the allegation was made; however, the investigation did not include a direct statement from Resident #35. Upon request, the facility could not produce documentation that a direct statement was obtained from Resident #35.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215015	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/13/2024
NAME OF PROVIDER OR SUPPLIER Fairland Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2101 Fairland Road Silver Spring, MD 20904	
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)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/9/24 at 9:57 AM, during an interview with the Director of Nursing (DON), they stated the facility could not locate/provide a statement from Resident #35. They stated any alert and oriented resident who alleged the abuse/mistreatment should be interviewed and a statement obtained. They stated the resident who alleged the abuse/mistreatment should be interviewed and statement documented to know their side of story and to provide reassurance that abuse was not tolerated by the facility.</p> <p>During an interview on 12/9/24 at 11:02 AM, the Nursing Home Administrator (NHA) stated any resident who alleged abuse/mistreatment should be interviewed and a statement obtained to gather details of the alleged incident, to clearly identify the perpetrator, and provide specific the time at which the allegation occurred.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215015	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/13/2024
NAME OF PROVIDER OR SUPPLIER Fairland Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2101 Fairland Road Silver Spring, MD 20904	
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)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52124</p> <p>Based on observations and interviews, the facility failed to assist two Residents (R)9 and R58 who were dependent upon staff for assistance with activities of daily living (ADLs). Specifically, staff served R9 breakfast while the resident ' s brief was soiled with feces and waited several hours after breakfast to be assisted with toileting needs. The sample size was three. The census was 75.</p> <p>Findings include:</p> <p>Record review of the facility policy titled Activities of Daily Living last revised 5/1/2023 documented, based on comprehensive assessment of a resident and consistent with residents' needs and choices the facility, must provide the necessary care and services to ensure a Residents ADLs are maintained or improved and do not diminish unless circumstances of the Residents clinical condition demonstrate that a change was unavoidable. ADLs include Hygiene, Bathing, Dressing, Grooming, Toileting and Oral Care. A Resident who is unable to carry out ADLs will receive the necessary level of ADL assistance to maintain good personal hygiene, grooming and oral hygiene. ADL care will be documented in real time as close to the time that care was provided.</p> <p>1. Record review of R9 ' s Face sheet showed an admitted [DATE], with diagnoses which included cerebral infarction and pulmonary embolism.</p> <p>Review of the quarterly Minimum Data Set (MDS) dated [DATE], revealed R9 had a BIMS score of 15/15, which indicated the resident was cognitively intact. This MDS further revealed that R9 was dependent on staff for toileting.</p> <p>Review of R9 ' s Care Plan created on 7/03/2024 documented R9 was at risk for decreased ability to perform ADLs which included toileting.</p> <p>During an interview and observation on 12/3/2024 at 8:25 AM, R9 was observed in her bed, with a foul smell of urine and feces noted from the hallway, coming from R9 ' s room. R9 stated they turned on their call light at approximately 3:30 AM that morning due to having a bowel movement. R9 stated during that time, a staff member entered his/her room, turned off the call light and stated that they would return to assist them. R9 stated they had been waiting since then. R9 stated staff served his/her breakfast at approximately 7:15 AM and stated they were unable to eat the breakfast while they sat on BM.</p> <p>During an additional observation and interview on 12/3/2024 at 9:30 AM, R9 stated staff had not assisted him/her with toileting needs and stated they felt that staff did not care. R9 remained soiled at this time.</p> <p>During an observation on 12/3/2024 at 12:44 PM, R9 spoke with another surveyor and revealed they had yet to be assisted with incontinent care since their last bowel movement earlier, before breakfast. The surveyor noted a strong urine odor in the R9 ' s room. R9 pulled her sheet down and pointed to the yellow and brown substance and stated that it was urine and bowel movement.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215015	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/13/2024
NAME OF PROVIDER OR SUPPLIER Fairland Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2101 Fairland Road Silver Spring, MD 20904	
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)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/3/2024 at 12:50 Registered Nurse (RN) 32 revealed it was confirmed R9 had soiled her pad, brief and draw sheet, she stated she was not sure when the last time R9 had been assisted with incontinent care.</p> <p>During an interview on 12/5/2024 at 02:30 PM, General Nursing Assistant (GNA) 21 stated GNA 21 explained she was aware R9 had raised concerns regarding her quality of care in the past. GNA 21 explained on 12/3/2024 at approximately 1:30 PM she was called to assist R9 with ADLs and stated R9 had a bowel movement. According to GNA 21, she observed R9 ' s bowel movement was dry. R9 stated they had been seated on their BM all night long. GNA 21 stated the night shift did not assist R9 when he/she had a BM. GNA 21 stated it was never appropriate for any resident to stay seated in their bowel movement for long periods and concluded staff served R9 breakfast while R9 was seated in his/her BM.</p> <p>During an interview on 12/9/2024 at 9:10 AM, the Director of Nursing (DON) revealed, Residents who required assistance with ADLs should be checked every two hours or as needed for their toileting needs. DON stated, it was never acceptable for any Resident to be seated in their BM for over six hours.</p> <p>During an interview on 12/12/2024 at 11:24 AM the facility Medical Director (MD)36 stated staff were required to be checking on Residents every two hours stated it was never appropriate for any resident to be served a meal while they required assistance with Bowel/Bladder incontinent care.</p> <p>2. Record review of R58 ' s Face sheet showed an admitted [DATE], diagnoses included, Intracerebral Hemorrhage in Hemisphere Subcortical, Aphasia following Cerebral Infarction and Dysarthria (Motor Speech disorder) following Cerebral Infarction and Sequelae following Cerebral Infarction.</p> <p>Record Review of the admission Minimum Data Set assessment (MDS) dated [DATE], revealed R58 had a BIMS score of 5/15. R58 was impaired on one side and was dependent on staff for toileting, including personal hygiene and dressing.</p> <p>During an observation and interview on 12/3/2024 at 10:30 AM. R58 ' s nails were observed to be three to six inches long and had dark brown substances under the nail bed. R58 nodded when asked if he/she expected staff to trim his/her nails.</p> <p>During observation and interview on 12/9/2024 at 11:55 PM, R58 representative wheeled R58 along the hallway. R58 nails were not trimmed and had brown substances under the nail bed. R58 was asked if his/her nails had been trimmed and his/her representative stated shehe was not aware staff were supposed to trim the resident ' s nails and stated she/he thought it was up to the family to provide nail care due to asking the staff on several occasions to trim R9 ' s and it had not been done. R58s Representative stated she/he would prefer staff to trim R58's nails.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215015	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/13/2024
NAME OF PROVIDER OR SUPPLIER Fairland Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2101 Fairland Road Silver Spring, MD 20904	
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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37276</p> <p>Based on medical record review and staff interview, it was determined that the facility failed to provide adequate supervision to prevent a vulnerable resident who was assessed, and care planned as an elopement risk, from leaving the facility unattended. This was evident for 1 (#36) of 3 residents reviewed for elopement.</p> <p>The findings include:</p> <p>Elopement occurs when residents who are incapable of protecting themselves from harm are able to successfully leave the facility unsupervised and unnoticed and possibly enter into harm's way.</p> <p>Upon entry to the facility on [DATE] a list of facility reported incidents was provided to administration. At that time the request was for all investigations to be provided to the surveyors.</p> <p>1) On 12/3/24, a review of facility reported incident, MD00182148 documented that Resident #36 was admitted to the facility in December 2022 with diagnoses that included Alzheimer's Dementia with behavioral disturbance, that s/he was able to walk independently, and wore a wanderguard to alert staff of unaided exit attempts. The facility reported that on 8/11/22, a dining service staff member observed Resident #36 outside of the facility without an escort and went to be with the resident. The staff member, along with the supervisor, and together accompanied Resident #36 back into the facility. The self-report documented that when Resident #36 left the facility, s/he was wearing a wanderguard that was functioning when resident re-entered the facility. There was no documentation in the self-report to indicate how Resident #36 exited the facility unnoticed, however, measures implemented following the elopement included, updating the wanderguard unit at the patio door and securing the gate leading from the patio .</p> <p>On 12/3/24 at 10:43 AM, a review of Resident #36's medical record revealed the resident was admitted to the facility in December 2021 with diagnoses that included Alzheimer's disease and Dementia, and following his/her admission, determined to be an elopement risk. An Elopement Evaluation, with an effective date of 1/27/22 at 5:17 PM, documented Resident #36 had a history of actual or attempted elopement, a history of wandering that placed the resident at significant risk of getting to a potentially dangerous place, and s/he had expressed a desire to leave. An Elopement Evaluation, with an effective date of 4/12/22 at 10:00 AM, documented Resident #36 had a history of wandering and expressed a desire to leave. In addition, the resident had a care plan, [Resident #36]is at risk for elopement related to: Cognitive Loss/Dementia and Alzheimer's Disease, that was initiated on 1/27/22.</p> <p>Review of Resident #36's progress notes revealed on 12/27/2021 at 5:19 AM, the nurse wrote that Resident #36 was alert to self only and attempted to elope 3 times during the night shift. On 1/29/22 at 10:25 AM, in a progress note, the nurse wrote that Resident #36 was observed walking towards the door, carrying his/her bag and a wanderguard was placed on the resident for safety per nursing protocol.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215015	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/13/2024
NAME OF PROVIDER OR SUPPLIER Fairland Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2101 Fairland Road Silver Spring, MD 20904	
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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an SBAR (Situation, Background, Assessment, Recommendation) (a standard way to communicate medical information) Summary for Providers note, on 8/11/22 at 7:31 PM, Staff #46, Registered Nurse (RN) wrote that Resident #36 was observed walking towards the main road and the resident was immediately re-directed inside the facility. On 8/12/22, in encounter note, the Certified Registered Nurse Practitioner (CRNP) wrote that Resident #36 was seen for follow-up following an elopement. The CRNP documented that in the evening of 8/11/22, the resident apparently went through a side door that was left open and found outside the building. The CRNP documented this was an uncommon event, however Resident #36 wandered around the nursing units secondary to Alzheimer's disease and dementia.</p> <p>On 12/03/24 at 2:01 PM, the Director of Nurses (DON) reported she could not find the investigation for facility reported incident MD00182148. The DON stated that when Resident #36 eloped, there were different administrative personnel, and that she would continue to look for the investigation.</p> <p>On 12/4/24 at 11:26 AM, when asked for the contact information for the clinical staff (RN Supervisor, CRNP) familiar Resident #36's elopement, the DON indicated they could not be contacted and interviewed, that the RN supervisor was out of the country, and the CRNP no longer worked at the facility. On 12/4/24 at 11:35 AM, during an interview, Staff #46, Receptionist stated that when Resident #36 eloped, s/he was employed at the facility, however she was not working and unable to provide details of the resident's elopement. Staff #46 stated that to his/her knowledge, Resident #36 had made no further attempts to leave the facility unattended.</p> <p>On 12/4/24 at 12:00 PM, during an interview, the DON stated that she was unaware of any other elopement attempts by Resident #36, that she knew the resident had not attempted to elope since she had been there, which was over a year, and currently, the resident was not an elopement risk. The DON reported that for the past month or so, Resident #36 was not able to walk, though s/he would try, and the resident did not like to use a wheelchair.</p> <p>On 12/4/24 at 2:10 PM, the DON reported the facility's investigation, including interviews of residents and staff, could not be found and confirmed the facility was unable to provide evidence that the facility completed a thorough investigation when Resident #36 eloped from the facility. The DON stated that they were able to reproduce some documents from the investigation and provided the surveyor with elopement drill forms dated 8/12/22 and 8/16/22, documentation that elopement evaluations were completed on all residents, and that window stops for some facility windows were ordered. Cross Reference F610</p> <p>The Nursing Home Administer (NHA) was made aware of the concerns with the facility's failure to prevent a vulnerable resident from exiting the facility, unsupervised on 12/13/24 at approximately 1:45 PM, and the NHA acknowledged the concerns at that time, and offered no further comments.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215015	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/13/2024
NAME OF PROVIDER OR SUPPLIER Fairland Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2101 Fairland Road Silver Spring, MD 20904	
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)		
<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37276</p> <p>Based on medical record review and staff interview it was determined the facility staff failed to ensure that medication irregularities were identified during monthly drug regimen reviews. This was evident for 1 (#3) of 42 residents reviewed for a complaint.</p> <p>The findings include:</p> <p>On 12/12/24 at 9:50 AM, a review of complaint #MD0020957 alleged that Resident #3 was administered the wrong dose of Trileptal (oxcarbazepine) (anti-seizure medication) from 11/19/23 to 11/23/24.</p> <p>A review of Resident #3's medical record revealed resident was initially admitted to the facility in mid-November 2023 with diagnoses which included cerebral palsy and seizures. A hospital discharge summary with a discharge date of [DATE] documented Resident #3 had a history of epilepsy (seizure disorder) and there was no recommendation to escalate (increase) the resident's antiseizure medications at this time, and to resume oxcarbazepine 900 mg twice a day. The discharge summary listed the medications that Resident #3 was to continue to take in the facility that included an order for oxcarbazepine 900 MG (milligrams) by mouth two times a day.</p> <p>Review of Resident #3's November 2023 Medication Administration Record (MAR), revealed two orders for Oxcarbazepine (Trileptal) had been transcribed in the MAR that documented the resident was given an extra dose of Oxcarbazepine on 10 administration times between 11/17/23 and 11/23/23.</p> <p>Review of Resident #3's November 2023 Medication Administration Record (MAR), revealed that between 11/17/23 and 11/23/23, the resident had 2 orders for Oxcarbazepine, (a) an 11/17/23 order for oxcarbazepine oral tablet, 300 milligrams (MG), give 3 tablets [equals 900 MG] by mouth two times a day for seizure disorder, that was documented as administered twice a day, every day, from 11/17/23 through 11/23/23, and (b) an 11/18/24 order for Trileptal oral tablet 600 MG, give 1 tablet by mouth two times a day for seizure disorder; give with the 300 MG dose for a total of 900 MG, that documented the medication was given on 11/18/23 at 9:00 PM, given twice a day on 11/18, 11/19, and 11/21, given once on 11/22, and given twice on 11/23. The Trileptal order was documented as refused on 11/22 at 9:00 PM, and 11/24 at 9:00 AM, then discontinued on 11/24/23.</p> <p>Further review of Resident #3's medical record revealed on 11/21/23 at 10:40 AM, in a Drug Regimen Review (DDR) Documentation note, the pharmacist documented that a medication regimen review was performed with no irregularities found. The consulting pharmacist failed to identify the irregularity related to the resident having multiple oxcarbazepine orders and refer the irregularity to the physician.</p> <p>The above concerns were discussed with the Director of Nurses on 12/12/24 at 2:51 PM. The DON acknowledged the concerns at that time and indicated she would have expected the pharmacist would have identified the discrepancy with the resident's oxcarbazepine orders.</p> <p>Cross Reference F760</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215015	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/13/2024
NAME OF PROVIDER OR SUPPLIER Fairland Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2101 Fairland Road Silver Spring, MD 20904	
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)		
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37276</p> <p>Based on observation, medical record review and staff interview, it was determined the facility failed to keep residents free from significant medication errors. This was evident for 1 (#3) of 42 residents reviewed for a complaint during the complaint survey</p> <p>The findings include:</p> <p>On 12/12/24 at 9:50 AM, a review of complaint #MD0020957 was conducted. In the complaint, the complainant reported that from 11/19/23 to 11/23/24, Resident #3 was administered the wrong dose of Trileptal (Oxcarbazepine) (anti-seizure medication).</p> <p>Review of Resident #3's medical record revealed resident was initially admitted to the facility in mid-November 2023 following an acute hospitalization , with diagnosis which included cerebral palsy and seizures.</p> <p>Review of Resident #3's hospital discharge summary with a discharge date of [DATE] documented Resident #3 had a history of epilepsy (seizure disorder), that there was no recommendation at this time to escalate antiseizure medications, and to resume Oxcarbazepine 900 mg BID. Included in the discharge summary was a list of the medications that Resident #3 was to continue in the facility including an order for Oxcarbazepine 900 MG (milligrams) by mouth two times a day.</p> <p>Review of Resident #3's November 2023 Medication Administration Record (MAR), revealed two orders for Oxcarbazepine (Trileptal) that documented the resident was given an extra dose of Oxcarbazepine on 10 administration times between 11/17/23 and 11/23/23.</p> <p>In the MAR, there was (a) an 11/17/23 order for Oxcarbazepine oral tablet, 300 milligrams (MG), give 3 tablets [equals 900 MG) by mouth two times a day for seizure disorder, that documented the Oxcarbazepine was administered as ordered twice a day, every day, from 11/17/23 through 11/23/23, and (b) an 11/18/24 order for Trileptal oral tablet 600 MG, give 1 tablet by mouth two times a day for seizure disorder; give with the 300 MG dose for a total of 900 MG, that was documented as given once on 11/18/23 at 9:00 PM, given twice a day on 11/18, 11/19, and 11/21, given one time on 11/22 at 9:00 AM, given twice on 11/23. On 11/22 at 9:00 PM, and 11/24 at 9:00 AM, the Trileptal order was documented as refused then discontinued on 11/24/23. No associated order for Oxcarbazepine 300 MG was found in the MAR.</p> <p>A continued review of the medical record failed to find evidence that the physician had been notified when Resident #3 received the wrong dose of medication, and no documentation was found to indicate the facility investigated this medication error or added interventions after the event.</p> <p>During an interview on 12/12/24 at 11:28 AM, Staff #36, Medical Director, stated that whenever a resident received the wrong dose of medication, the physician should be notified, and if a resident received the wrong dose of medication for multiple days, the physician may want to hold the medication or check the labs.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215015	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/13/2024
NAME OF PROVIDER OR SUPPLIER Fairland Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2101 Fairland Road Silver Spring, MD 20904	
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)		
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/12/24 at 2:51 PM, during an interview, the Director of Nurses (DON) stated that if she became aware of a medication error, she would notify the resident's physician, notify the resident and/or resident representative and complete an incident report. Following the interview, the above significant medication error concerns were discussed with DON. The DON acknowledged the concerns at that time and indicated she would look to see if there was an incident report for this medication error.</p> <p>As of time of exit on 12/13/24, no additional information had been provided regarding this medication error or any interventions put in place to prevent re-occurrence.</p> <p>Cross reference F580, F610</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215015	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/13/2024
NAME OF PROVIDER OR SUPPLIER Fairland Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2101 Fairland Road Silver Spring, MD 20904	
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)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>37276</p> <p>Based on observation and staff interview, it was determined the facility staff failed to ensure treatment carts were locked and secured when unattended. This was evident on 1 of 3 nursing hallways observed.</p> <p>The findings include:</p> <p>On 12/3/24 at 1:41 PM, during an observation of C wing, 2 medication carts were observed to be parked, side by side, on the left wall of the hallway. At that time, a nurse was observed in front of the 1st medication cart and appeared to be preparing medication for a resident.</p> <p>On 12/3/24 at 1:50 PM, during an observation of the C wing hallway, 2 medication carts were observed to be unlocked and unattended. The 2 medication carts were parked, side by side, on the left wall of the hallway, in an area where they could be accessed by residents and were not within direct observation of authorized staff.</p> <p>The surveyor stood near the medication carts for at 5 minutes, then at 1:55 PM, Staff Member #12, Licensed Practical Nurse (LPN), walked up to the medication carts and the nurse was made aware of the surveyor's observations. At that time, Staff #12 observed the unlocked medication carts and confirmed the medication carts were unlocked with no explanation given at that time.</p> <p>On 12/3/24 at 2:15 PM, Staff #10 (Regulatory Compliance Advisor) was made aware of the observation of unlocked med carts. Staff #10 acknowledged the concerns and offered no further comments at that time.</p>		