

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 04/16/2025
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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>47200</p> <p>Based on observation and interview it was determined the facility failed to ensure a resident (#70) had access to their call device. This was evident for one out of two residents reviewed for call devices during the facility's recertification/complaint survey.</p> <p>The findings include:</p> <p>On 4/8/25 at 8:47AM the surveyor observed Resident #70 did not have their call device to call for staff assistance.</p> <p>Upon further surveyor observation on 4/8/25 at 8:47AM the surveyor observed Resident #70's call device resting behind a cardboard box situated on a nightstand table several feet away from the resident, out of their reach.</p> <p>On 4/8/25 at 8:47AM the surveyor conducted an interview with Resident #70 who reported to the surveyor that they could not reach their call device from their bed.</p> <p>On 4/8/25 at 8:51AM the surveyor requested a dual observation of the concern with the Assistant Director of Nursing (ADON) #3 who observed the concern and stated to Resident #70: Of course it needs to be next to you. ADON #3 was observed obtaining the resident's assigned nurse to observe the concern and asked Licensed Practical Nurse (LPN) #11 where the resident's call bell was located. LPN #11 was observed to be unable to find where the resident's call device was. ADON #3 was observed by the surveyor showing LPN #11 where the call device was, and ADON #3 asked LPN #11 to place it in reach of the resident, to which LPN #11 replied to them: S/he always calls me. At this time, the surveyor observed ADON #3 providing education to LPN #11 and instructed them again, to place the call device within the resident's reach.</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
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<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>47200</p> <p>Based on observation and interview it was determined the facility 1) failed to ensure a safe, clean, and comfortable environment, and 2) failed to provide maintenance services necessary to maintain a sanitary and comfortable environment. This was evident for 1) 1 floor (second floor) out of 2 floors and 2) 1 of 3 nursing units on the 2nd floor during the facility's recertification/complaint survey.</p> <p>The findings include:</p> <p>1) On 4/7/25 at 6:57AM surveyors smelled a strong, unpleasant odor in the A wing hallway at which time the closet door was opened and surveyors observed a trash can with bagged trash which was overflowing with several trash bags on top of cardboard trash on the floor of the closet. The trash can was observed to be dirty condition with drip marks down the side of it, and the walls of the closet had a layer of black matter present and drip marks. A piece of covered respiratory equipment was observed sitting on the floor in the hallway against the wall next to the closet, approximately one foot away from the garbage on the floor.</p> <p>On 4/7/25 at 6:58AM the surveyor observed dirty carpeting with numerous dark circular stains present in the A wing resident hallway.</p> <p>On 4/7/25 at 7:32AM the surveyor observed multiple areas of damaged spots of laminate flooring within the main area on the second floor leading to the resident dining area and the nursing station.</p> <p>On 4/7/25 at 7:33AM the surveyor observed one resident motorized wheel chair and one motorized scooter-type of mobility equipment in unclean condition with areas of staining and debris present on them in the C wing hallway.</p> <p>On 4/7/25 at 8:28AM the surveyor shared concerns with the facility Director of Nursing who acknowledged understanding of the concerns.</p> <p>On 4/8/25 at 8:22AM the surveyor observed various carpet staining with pieces of trash present on the floor of the B wing resident hallway near where the med cart was located, brown staining and brown drip marks were observed on the wall and hand rail adjacent to the medication cart.</p> <p>On 4/8/25 at 2:48PM the surveyor observed the furniture drawers of Resident #56 to be missing 3 out of 4 knobs.</p> <p>On 4/14/25 at 8:07AM the surveyor smelled a strong, unpleasant odor in the A wing resident hallway. Upon surveyor's opening of the closet door near to the area of odor, the trash can was observed to be overflowing. At this time, the surveyor shared the concern with Director of Maintenance #20 who observed and acknowledged the concern.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/14/25 at 8:13AM the surveyor observed the shower room located on the facility's second floor on the A wing which revealed signage present on one of two shower stalls which read the following information: Shower is temporary out of order no hot water. At this time, the surveyor turned on the shower water, allowed it to run, and felt that the water was cold to the touch, and did not become warm or hot.</p> <p>On 4/14/25 at 8:18AM the surveyor conducted an interview with Director of Maintenance #20 who stated the following information regarding the shower stall which had no hot water: One and a half years ago, before I left, I put those signs up, and no, it doesn't have hot water. At this time, the surveyor shared concerns with Director of Maintenance #20 who acknowledged understanding of the concerns.</p> <p>On 4/14/25 at 8:19AM the surveyor conducted a dual observation of the various carpet staining on the second floor of the resident hallways with Director of Maintenance #20 and Regional Director of Nursing (RDON) #4 who observed and acknowledged understanding of the concerns.</p> <p>On 4/14/25 at 9:25AM the surveyor was approached by RDON #4 who reported to the surveyor that they would be addressing the carpet staining concerns of the surveyor by observing the carpeting and obtaining quotes for carpet replacement for the facility's second floor.</p> <p>On 4/15/25 at 11:20AM the surveyor shared concerns with the facility's Director of Nursing who acknowledged understanding of the concerns.</p> <p>On 4/16/25 at 7:41AM a dark stained area of carpet approximately 4 ft long by 3ft wide was observed to be present outside of room A12.</p> <p>51213</p> <p>2) On 4/7/25 at 7:57 AM the Director of Maintenance, Staff # 20, was asked to open the 2nd floor shower room. Staff #20 was asked how long they had worked here, and Staff # 20 replied, I have worked here for 3 years, I left, and I have been back for 2 months. Staff #20 was shown the black substance all over both vents in the 2nd floor shower room, that the door to the shower room was warped 1/4 of the way up from the floor, white paint was chipped off the door and the corner of the door had wood missing which exposed a rough edge. Broken tiles on the base of the floor and on the corner wall of the shower stall were observed to be broken, and the radiator was rusty, and the front cover was touching the floor. Staff #20 attempted to lift the front cover of the radiator to prevent it from touching the floor but was unable to. Staff # 20 was also shown the ceiling which had large pieces of paint peeling off around both light fixtures and brown marks were also observed on the ceiling around each light fixture. Staff # 20 was asked if the shower room is currently being used to bathe residents. Staff # 20 replied yes, we use this shower room to bathe the residents. Staff #20 was then asked if they agreed that these are issues that need to be fixed. Staff # 20 said yes, this shower room needs to be remodeled and repaired.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/16/25 at 12:35 PM the surveyor observed the 2nd floor shower room and noted that the shower door remained warped, the vents in the shower room still had a black substance all over them, the ceiling still had paint peeling around both light fixtures, the tiles at the base of the floor and on the wall of the shower stall remain broken, the radiator heater remained rusted and was still touching the floor. No changes were observed since the first observation of the 2nd floor shower room on 4/7/25, the day the survey started.</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14894</p> <p>Based on a review of intake #MD00212446, observation, and staff interview it was determined that the facility staff failed to ensure residents are free of abuse. This was evident for 1(#70) out of 3 residents reviewed for abuse during the recertification/complaint survey.</p> <p>The findings include:</p> <p>A review of the facility investigation on 4/14/25 at 12:29 PM revealed that on Thursday [DATE], a state surveyor observed Staff #22 pointing at a resident who was in bed and calling the resident crazy. Staff #22 was observed to have repeated the sentence multiple times. According to the surveyor, Staff #22 told the resident that the resident was crazy, and the resident was the reason why she was behind in her work. The surveyor tried to intervene by asking the employee her name, but she refused to identify herself. Staff #22 was working at the nursing home that day but was an agency employee. Staff #22 was asked to leave the facility by the facility administrative staff. The incident was then reported to the state agency.</p> <p>The State Surveyor wrote a statement for the investigation: State Surveyor observed the GNA [Geriatric Nursing Assistant] call the resident crazy. [Name of GNA] was complaining that [name of resident], on the second bed, made her fall behind in her work, that was why she could not change the resident in the first bed. [Name of GNA] refused to identify herself as she was not wearing a name tag. The surveyor said she approached [name of resident] and the GNA followed her. [Name of GNA] then started to point at [name of resident] and continued to call [name of resident] crazy. The surveyor wrote that she identified herself but that did not seem to have registered with the GNA.</p> <p>A review of Staff #22's statement revealed that she stated she came in to assist the resident on incontinence care and there was no mention in her statement of her calling the resident crazy.</p> <p>The Administrator was interviewed on 04/16/25 at 11:27 AM. The Administrator acknowledged the abuse and said the Maryland Board of Nursing (MBON) was notified. He then suggested that upon their interview with the agency staff she stated that she had a thick accent and may not have been understood. Staff #22 was so upset by the facility's questions that she left mid-interview.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>47200</p> <p>Based on interview and observation it was determined the facility failed to ensure the reporting of an allegation of abuse. This was evident for one resident, (Resident #56) during the surveyor's investigation of MD#00213104 during the recertification/complaint survey.</p> <p>The findings include:</p> <p>On 4/8/25 at 1:07PM the surveyor conducted an interview of a family member of Resident #56 who reported to surveyors that they had found a red mark on Resident #56's forehead upon visiting the resident, and when they had brought this to the attention of facility staff, they were informed that it was not reportable. At this time, surveyors observed a photo dated from March 2025 in which an elongated red mark appeared to be present on the resident's forehead.</p> <p>On 4/10/25 at 10:37AM the surveyor conducted an interview of Unit Manager #26 who confirmed the Director of Nursing and the Assistant Director of Nursing had inquired to them about the red mark on the resident's forehead, at which time they had first observed it to be present. Unit Manager #26 further reported they had observed the resident earlier in the day and had not seen the red mark to be present at that time, and they recalled being perplexed as to how it occurred.</p> <p>On 4/10/25 at 11:50AM the surveyor conducted an interview with Licensed Practical Nurse (LPN) #11 who reported to the surveyor that a Geriatric Nursing Assistant (GNA) had informed him/her of the red mark on the resident's forehead at which time they (LPN#11) had asked the resident abuse related questions. LPN #11 further reported that the GNA then reported their concern to the DON.</p> <p>On 4/10/25 at 12:03PM the surveyor conducted an interview with the DON who confirmed that it was assumed that the tv remote caused the red mark on the resident's forehead, however, no one saw the remote on the resident.</p> <p>On 4/10/25 at 1:06PM the surveyor conducted an interview with the facility's Administrator who stated to the surveyor: S/he (Resident #56's family member) alleged someone hit him/her (Resident #56). At this time the surveyor shared their concern and the Administrator acknowledged and confirmed understanding of the concern and confirmed the allegation was reportable and had not been reported. After surveyor intervention, the allegation of abuse was observed to have been reported to the Office of Health Care Quality on 4/10/25.</p>		

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<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>47200</p> <p>Based on observation and interview it was determined the facility failed to ensure a thorough investigation of an allegation of abuse was performed. This was evident for one resident, (Resident#56) during the surveyor's investigation of MD#00213104 during the recertification/complaint survey.</p> <p>The findings include:</p> <p>On 4/8/25 at 1:07PM the surveyor conducted an interview of a family member of Resident #56 who reported to surveyors that they had found a red mark on Resident #56's forehead upon visiting the resident, and when they had brought this to the attention of facility staff, they were informed that it was not reportable. At this time, surveyors observed a photo dated March 2025 in which an elongated red mark appeared to be present on the resident's forehead.</p> <p>On 4/9/25 at 7:33AM the surveyor made a request to Regional Clinical Resource Nurse #5 for all facility reported incidents regarding Resident #56 to be provided to the surveyor.</p> <p>On 4/10/25 at 10:37AM the surveyor conducted an interview of Unit Manager #26 who confirmed the Director of Nursing and the Assistant Director of Nursing had inquired to them about the red mark on the resident's forehead, at which time they first observed it to be present. Unit Manager #26 further reported they had observed the resident earlier in the day and had not seen the red mark to be present at that time, and they recalled being perplexed as to how it occurred.</p> <p>On 4/10/25 at 11:15AM the surveyor conducted an interview of Licensed Practical Nurse (LPN) #11 who confirmed with the surveyor that Resident #56 was unable to operate a remote.</p> <p>On 4/10/25 at 11:50AM the surveyor conducted an interview with LPN #11 who reported to the surveyor that a Geriatric Nursing Assistant (GNA) had informed him/her of the red mark on the resident's forehead at which time they (LPN#11) had asked the resident abuse related questions. LPN #11 further reported that the GNA then reported their concern to the DON. When the surveyor inquired to LPN #11 if any facility staff had asked them to provide a written statement, they responded: I don't think so.</p> <p>On 4/10/25 at 11:56AM the surveyor conducted another interview of Unit Manager #26 and inquired if facility staff had asked them to provide a written statement to which they replied: No, I did not have to write a statement.</p> <p>On 4/10/25 at 12:03PM the surveyor conducted an interview with the DON who confirmed that it was assumed that the tv remote caused the red mark on the resident's forehead, however, no one saw the remote on the resident.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/10/25 at 1:06PM the surveyor conducted an interview with the facility's Administrator who stated to the surveyor: S/he (Resident #56's family member) alleged someone hit him/her (Resident #56). At this time the surveyor shared their concern and the Administrator acknowledged and confirmed understanding of the concern and confirmed the allegation was reportable and had not been reported. After surveyor intervention, the allegation of abuse was observed to have been reported to the Office of Health Care Quality on 4/10/25, and at that time, a facility investigation for the allegation of abuse began.</p>		

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<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>47200</p> <p>Based on observation, interview, and record review it was determined the facility failed to ensure a resident received necessary oral care. This was evident for one resident (Resident #56) during the surveyor's investigation of MD#00213104 during the recertification/complaint survey.</p> <p>The findings include:</p> <p>On 4/8/25 at 1:07PM the surveyor conducted an interview of Resident #56's family member who expressed concern for the resident's oral care.</p> <p>On 4/8/25 at 2:50PM the surveyor observed the resident's tongue to have a yellow, dry, crusty appearance, and their front upper teeth to have a thick, creamy film present.</p> <p>On 4/8/25 at 3:02PM the surveyor conducted a dual observation of the resident's oral condition described above with Unit Manager #26 and conducted an interview with them at the conclusion of the observation. The surveyor shared their concern with Unit Manager #26 who acknowledged and confirmed understanding of the concern and reported to the surveyor that the Respiratory Therapist (RT) was responsible for performing the resident's oral care and that oral care was performed 1 or 2 times per shift according to the recommendations made by respiratory therapy.</p> <p>On 4/14/25 at 1:50PM the surveyor conducted an interview with RT #27 who reported to the surveyor that they perform suctioning, but that nurses were responsible for oral care of the resident.</p> <p>On 4/14/25 at 1:59PM the surveyor conducted an interview with RT #28 who reported that they are responsible to suction the mouth of residents, but were not trained to provide oral care otherwise.</p> <p>On 4/14/25 at approximately 2:15PM the surveyor conducted an interview with Licensed Practical Nurse #29 who stated to the surveyor that nurses are responsible for oral care which the nurse documents on the MAR/TAR (medication and treatment administration record) and there is also a medical order for oral care.</p> <p>On 4/14/25 at 2:22PM the surveyor reviewed the medical record for Resident #56 and observed the following active medical order which was dated 8/20/24: Oral care every shift. Review of the February, March and April 2025 treatment administration records revealed empty boxes in which no oral care documentation was signed off for day shift on the following dates: 2/9/25, 2/10/25, and on 3/14/25.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47200</p> <p>Based on observation, interview and record review it was determined the facility failed to: ensure a resident (Resident #56) received the recommended frequency of visits for therapy care for rehabilitation, ensure consistent turning and repositioning needs were provided, and ensure medical orders were followed. This was evident for 1) one (Resident #56) out of three residents reviewed for positioning and for 2) one (Resident #44) of five residents reviewed for unnecessary medications during the facility's recertification/complaint survey.</p> <p>The findings include:</p> <p>1) On 4/8/25 at 8:28AM the surveyor observed Resident #56 laying in their bed in a back lying position with the head of the bed elevated and observed their feet in a plantarflexed position (feet pointed downwards) laying directly on the bed without any intervention instituted for support.</p> <p>On 4/8/25 at 2:48PM the surveyor observed Resident #56 laying in their bed in a back lying position with the head of the bed elevated and observed their feet in a plantarflexed position (feet pointed downwards) laying directly on the bed without any intervention instituted for support.</p> <p>On 4/10/25 at 10:28AM the surveyor observed Resident #56 laying in their bed in a back lying position with the head of the bed elevated and observed the resident's lower extremities laying directly on the surface of the mattress with no supports in place. At this time, the surveyor conducted an interview of the resident's assigned nurse, Registered Nurse (RN) #32 and inquired as to why the resident had no boots/splints in place. RN #32 was observed by the surveyor asking Nurse Practitioner #7 the following question: Does s/he have boots?</p> <p>On 4/10/25 at 2:25PM the surveyor conducted an interview with the Director of Rehab, Physical Therapist (PT) #31 who reported to the surveyor that therapy had been providing the role of application of the resident's splints and hand rolls, and the wearing schedule for them was that therapy applied them, and in the evening, the resident's family will take them off. When the surveyor inquired as to what the therapy recommendations were for the nursing staff's role in care of the resident's feet, and shared their concern, they replied: I will work with nursing on improving that process.</p> <p>On 4/10/25 at 2:50PM the surveyor conducted another interview with PT #31 who confirmed with the surveyor that the resident was to be seen at a frequency of 5 times per week beginning the week of 4/5/25 (date of their new physical therapy recertification period) and the visit weeks run from Sunday to Saturday. When the surveyor further inquired to PT #31 as to the frequency of physical therapy visits and why there was not five visits documented for Resident #56 for the week of 4/5/25, they responded: We didn't see him/her the five times. When the surveyor inquired to PT #31 what the reason was as to why the resident was not seen the five times, they stated the following information: Nothing that I can give to you, I wasn't able to schedule that.</p> <p>On 4/10/25 at 3:06PM, after surveyor intervention, PT #33 was observed applying positioning devices to the resident's feet. Resident #56 was observed laying in their bed in a back lying position with the head of the bed elevated.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/11/25 at 10:33AM the surveyor reviewed therapy documentation which documented the physical therapy recertification period of 4/5/25-5/4/25 in which the resident's plan of treatment was documented as having a frequency of 5 times a week.</p> <p>Review of the medical record on 4/15/25 at 9:00AM revealed the following active medical orders for care of the resident dated as beginning on 8/21/24: 1.) order date 8/21/24 Heel medix boots/pillows to both feet for continuous off loading of heels, may be removed for hygiene, inspection of skin or dressing changes every shift for preventative care and 2.) turn and reposition every 2 hours while in bed every shift for preventative care. Further review of the medical orders revealed a late entry physical therapy order for 4/5/25 recertification beginning on 4/12/25.</p> <p>On 4/15/25 at 11:20AM the surveyor shared concerns with the facility's Director of Nursing who confirmed and acknowledged understanding of the concerns.</p> <p>Review of the resident's medical record on 4/15/25 at 1:37PM revealed the following: 1.) inconsistent point of care documentation for the turn and reposition every 2 hours task, 2.) point of care task documentation for turning and repositioning every 2 hours was not completed on approximately 6 occasions for April 2025, 3.) point of care task documentation for floating heels in bed as tolerated was not completed on approximately 6 occasions for April 2025.</p> <p>49304</p> <p>2) The Centers for Medicare & Medicaid Services (CMS) defines a psychotropic medication in the regulations at S483.45(c)(3), as any drug that affects brain activities associated with mental processes and behavior (CMS, 2023). These drugs include, but are not limited to, drugs in the following categories: anti-psychotic, anti-depressant, anti-anxiety, and hypnotic medications. These medications can have serious potential risks, including side effects, drug interactions, and the possibility of neuroleptic malignant syndrome (a rare but potentially life-threatening condition) or tardive dyskinesia (a movement disorder that can develop if you take an antipsychotic medication) therefore requiring careful consideration and monitoring.</p> <p>On 4/14/25 at 10:40 AM review of Resident #44's medical record revealed the resident was admitted to the facility on [DATE] with a diagnosis of bipolar disorder.</p> <p>On 4/14/25 at 9:24 PM review of Resident #44's orders revealed the resident was ordered 2 psychotropic medications: Quetiapine Fumarate 400mg (milligrams) and Valproic Acid Oral Solution 250mg/ml (milligram/milliliter). Further review of the resident's orders revealed the following order: Is resident free from side effects of psychotherapeutic medications? (if no, document side effects in PN) every shift.</p> <p>Resident #44's April 2025 MAR (medication administration record) was reviewed on 4/14/25 at 10:12 PM. The review revealed No documented 38 out of 40 shifts from 4/1/25 through 4/14/25 for the order Is resident free from side effects of psychotherapeutic medications? (if no, document side effects in PN). The resident's progress notes from 4/1/25 through 4/14/25 were reviewed and failed to reveal any side effects documented in the progress notes.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Director of Nursing (DON) was interviewed on 4/15/25 at 7:53 AM. During the interview, when asked if there were certain medications that required monitoring, she stated antipsychotics, anti-depressants, and antianxiety medications, so the psychotropics. When asked if there was a physician order that read, Is resident free from side effects of psychotherapeutic medications? (if no, document side effects in PN) what was PN, and she stated, progress notes. The abovementioned concern of lack of documented side effects was shared with the DON and during the interview, the surveyor requested any progress notes with documented side effects of psychotherapeutic medications for Resident #44.</p> <p>On 4/15/25 at 9:37 AM in an interview with the DON, she verified and confirmed that there were no side effects documented for Resident #44. During the interview she stated that the nurses might have misread the order and thought that documenting no meant that the resident was not having side effects.</p>		

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<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>47200</p> <p>Based on observation and interview it was determined the facility failed to ensure a chemical was stored in a locked location. This was evident for one (A wing) out of three nursing units on the facility's second floor during the facility's recertification/complaint survey.</p> <p>The findings include:</p> <p>On 4/14/25 at 8:08AM the surveyor conducted observations which included rounding of environmental concerns with the facility's Director of Maintenance #20 and Regional Director of Nursing #4 and during rounding the surveyor was able to freely access and open one of two closet doors on the A wing located between rooms A1 and A3 and observed a container of carpet cleaning chemical. At this time, the surveyor shared their concern with Director of Maintenance #20 and Regional Director of Nursing #4 who both observed, acknowledged, and confirmed understanding of the surveyor's concern.</p> <p>On 4/14/25 at 8:10AM the surveyor observed Director of Maintenance #20 attempt to lock the closet door which contained the carpet cleaning chemical, at which time it was observed that after attempting to lock it, the door was able to be pulled right open by them. At this time, Director of Maintenance #20 was observed unlocking the closet next to it, and removing the chemical and placing it into the closet which was able to be locked which contained various other cleaning chemicals.</p>

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>14894</p> <p>Based on observation and staff interview, it was determined that the facility staff failed to ensure the staffing whiteboards were accurate and up to date, and to ensure staffing was posted at the facility entrance. This was evident for 2 out of 2 nursing units observed during the recertification/complaint survey.</p> <p>The findings include:</p> <p>During the tour of the facility on 4/7/25 at 6:35 AM the first-floor staffing whiteboard included staffing information from day shift 4/4/25 with no staffing ratios and on 4/7/25 at 6:40 AM the second-floor staffing whiteboard included staffing information from day shift on 4/6/25 and did not have the staffing ratios. During the tour of the facility on 4/9/25 at 9:30 AM the second-floor staffing whiteboard included staffing information regarding the day shift of 4/8/25 and it did not include the names of the Geriatric Nursing Assistants that were on duty during the day shift of 4/8/25.</p> <p>The Director of Nursing was interviewed on 04/15/25 at 11:45 AM. This surveyor informed her of the findings of the missing staff posting, the whiteboards without staffing ratios and still listing staffing information from days prior. She said she understood the significance of the findings.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49409</p> <p>Based on observations and staff interviews, it was determined that the facility staff failed to: ensure that multi dose medications were properly labeled, and medications were properly secured and stored. This was evident in 1) medication carts and 1 of 1 medication storage rooms and 2) one (B wing) out of three nursing wings on the facility's second floor reviewed during the recertification/complaint survey.</p> <p>The findings include:</p> <p>1) On [DATE] at 06:32 AM, when surveyors entered the facility, three medication carts on D wing were found unattended and unlocked. Geriatric Nursing Assistant (GNA) staff #40 validated the findings.</p> <p>On [DATE] at 05:10 PM, a Medication storage observation was conducted, accompanied by Licensed Practical Nurse (LPN) #11, and noted an unlabeled eye drops; Azelastine hcl 0.05% eye drops, prescribed for Resident #74, without labeling on the container with an open date. The surveyor also noted a plastic container in an old zip lock bag, labeled as: RX# N,d+[DATE] [DATE] oxycodone 20mg, 12 tablets, supplied by John Hopkins at [NAME], Broadway, Baltimore, with the names of the recently admitted residents at the facility.</p> <p>Nurse #11 acknowledged surveyors' findings and alerted the registered Nurse (RN) staff # 39, who retrieved the eye drops and the Narcotic medication oxycodone 20mg and discarded them.</p> <p>On [DATE] at 11:30 am, record review of the medication administration general guidelines provided by the facility, page # ,d+[DATE], item C stated Multi-use eye drops and ointments should be disposed of 28 days after initial use.</p> <p>On [DATE] at 12:15 PM, in an interview with LPN staff #11, it was revealed that once the eye drop pack is opened, it must be discarded after 28 days.</p> <p>On [DATE] at 09:27 AM, the surveyor observed an expired item in the medication storage room: Nisus NPWT Canister, supplied by Cork Medical Products, 250 ml 30' drainage tubing with clamp attached. The lot #2023112301 and expiration date were [DATE].</p> <p>On [DATE] at 12:20 pm, RN staff # 39 and the Director of Nursing (DON) acknowledged the findings of unlabeled eye drops, expired items, and narcotic storage.</p> <p>47200</p> <p>2) On [DATE] at 8:22AM the surveyor observed one round white pill in the B wing resident hallway on the second floor of the facility.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On [DATE] at 8:23AM the surveyor conducted an interview of Licensed Practical Nurse (LPN) #11 who observed the concern and stated the following: Okay, I don't know when that happened. At this time the surveyor observed LPN #11 pick the pill up and throw it away into the medication cart trash can.</p> <p>On [DATE] at 7:53AM the surveyor observed an unattended and unlocked medication cart on the B wing of the facility's second floor. The surveyor shared their concern with Regional Director of Nursing (RDON) #4 who observed the concern, acknowledged the concern, and after surveyor intervention, was observed locking the medication cart and attempted to round the floor looking for the staff member assigned to the cart.</p> <p>On [DATE] at 7:56AM the surveyor observed Registered Nurse (RN) #34 exit a resident room and return to the cart. RDON #4 was observed re-educating RN #34 on the importance of locking of the medication cart. At this time, the surveyor conducted an interview with RN #34 who acknowledged and confirmed that the facility's expectation was for the medication cart to be locked.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>47200</p> <p>Based on observation and interview it was determined the facility failed to ensure: 1) ice scoops and carts were maintained in a sanitary manner, 2) maintain the dining/food service area in a sanitary manner, 3) ensure covering of food removed from the hot cart and transported through resident hallways, 4) ensure food was labeled, 5) ensure a refrigerator seal was in good repair, 6) ensure kitchen ceiling and windows were in good repair to prevent potential for contamination of food contact surfaces, and 7) ensure the kitchen floor and ceiling was maintained in a sanitary manner. These conditions have the potential to affect all residents served by the facility's kitchen services.</p> <p>The findings include:</p> <p>On 4/7/25 at 6:55AM the surveyor observed an ice cart with an ice cooler on the top tier, and the ice scoop to serve ice for resident beverages stored within a plastic bag.</p> <p>On 4/7/25 at 6:56AM surveyors observed the dining area on the second floor which had a trash can which was filled to the top with several pieces of trash on the floor surrounding the trash can. The dining area floor was observed to be sticky upon walking on the floor surface with visible debris present and a dirty utensil was observed on the floor. One used cup was observed sitting on the dining table and open soda cans and a dirty napkin were observed next to a medical splint sitting on the window sill next to the dining table.</p> <p>On 4/7/25 at 7:04AM the surveyor opened the refrigerator in the facility's kitchen which was located near the walk-in refrigerator and observed a broken seal hanging unattached along the top surface of the refrigerator opening. The refrigerator was observed to contain ready to eat food.</p> <p>On 4/7/25 at 7:07AM the surveyor observed the facility's kitchen walk in refrigerator which revealed a metal pan labeled sausage gravy in which there was no labeling indicating date of preparation or date of expiration.</p> <p>On 4/7/25 at 7:07AM the surveyor conducted an interview and dual observation of the metal pan of sausage gravy with [NAME] #36. When the surveyor inquired to [NAME] #36 as to how they know when the product would expire, they responded: I don't know, there's no date on it. The surveyor shared the concern with [NAME] #36 who acknowledged and confirmed understanding of the concern.</p> <p>On 4/7/25 at 7:20AM the surveyor observed the kitchen window area located above the three compartment sink which was observed being utilized. The kitchen window area was observed to have a glass pane on half of the window area, and the other half had a wooden board in place of a window which was observed to have various splintered edges hanging off, with a food cutting board resting against the window sill in front of the wooden board. A second window area was observed to have a glass pane on half of it, and a piece of bent metal covering material nailed down for the remaining half of the window.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/7/25 at 7:21AM the surveyor observed the kitchen floor surface which had various crumbs and other debris present, sticky areas, and a wet pooling area of water near the entrance door to the kitchen.</p> <p>On 4/7/25 at 7:23AM the surveyor observed the ceiling surface above the food prep line/areas which was found to have black debris present, cracked areas, and areas of peeling paint. Plastic serving pitchers were observed hanging from hooks below the area of concern. At this time the surveyor conducted a dual observation of the concern with [NAME] #36 who observed, acknowledged, and confirmed understanding of the concern.</p> <p>On 4/7/25 at 8:28AM the surveyor shared concerns with the facility Director of Nursing who acknowledged understanding of the concerns.</p> <p>On 4/7/25 at 12:14PM the surveyor observed the ice cart with the ice scoop sitting out on top of a bag in the B wing hallway.</p> <p>On 4/8/25 at 8:29AM the surveyor observed an ice cart in which a cooler of ice utilized for resident beverages was sitting on the top tier, and the ice scoop was sitting out laying on top of a bag on the second tier of the cart.</p> <p>On 4/10/25 at 3:14PM the surveyor observed the ice cart with the ice scoop sitting out on top of a bag in the B wing hallway.</p> <p>On 4/14/25 at 7:46AM the surveyor observed dirty dishes and dirty utensils sitting on the second tier of the ice cooler cart which held clean ice next to a sleeve of clean disposable drinking cups and the ice scoop which was situated sticking out of a plastic bag.</p> <p>On 4/14/25 at 7:47AM the surveyor observed the dining area trash can to be filled past the top of the trash can with trash, and pieces of trash laying on the floor surrounding the trash can. Dirty dishes were observed sitting on the counter in the dining area. At this time, the surveyor's concern was shared with the Regional Director of Nursing #4 who observed the concern and acknowledged understanding of the concern.</p> <p>On 4/16/25 at 7:50AM after surveyor intervention, the surveyor observed the previously identified concerning area of the kitchen ceiling to have spackling present.</p> <p>On 4/16/25 at 8:21AM the surveyor observed the lid covers on several plates of food during delivery were unable to consistently cover the food without falling off.</p> <p>On 4/16/25 at 8:27AM the surveyor shared all kitchen concerns with Food Services Director #19 who acknowledged understanding of the concerns.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>47200</p> <p>Based on observation and interview it was determined the facility failed to: 1) ensure a sanitary environment, ensure appropriate personal protective equipment was utilized, and ensure appropriate infection control precautions were instituted. This was evident during the surveyor's observations for one out of two floors of the facility during the recertification survey. The facility failed to 2) maintain current documentation that all employees were free from communicable tuberculosis (TB) as it relates to infection prevention and control, and was evident for 2 (Geriatric Nursing Assistant, GNA #30 and GNA #23) of 5 employees reviewed during the recertification survey. Additionally, the facility failed to 3) ensure that the environment of the resident's 2nd floor shower room was maintained in a manner that minimized the potential spread of infection as evidenced by wet soiled linen and several liquid soap containers in the 2nd floor shower room. This was evident 3 of 3 times the 2nd floor shower room was observed during the recertification survey.</p> <p>The findings include:</p> <p>1) On 4/7/25 at 6:54AM the surveyor observed the closet labeled fresh linen on the B wing hallway which was observed to hold linen, pieces of trash on the floor, two care basins, one of which was holding an covid test with open packaging, used medical gloves, drinking straws, and care products including packaged toothbrushes and deodorants. The second care basin was observed to contain handwritten notes of resident last names and covid test results with thermometer probe covers, medication administration cups and other care supplies. Incontinence care briefs were observed out of the packaging in disarray in care basins with a brief touching a wall which was observed to have visible staining/matter present on it.</p> <p>On 4/7/25 at 6:55AM the surveyor observed the storage closet located between room B5 and B7 with a rolling style chair within it with a blanket sitting on it, a care basin holding trash bags and various resident care products, an opened, uncapped tube of ointment, a personal travel beverage cup, a sleeve of drinking cups, and another care basin which had crumpled tissues and trash items in it along with packaged unused oral care swab supplies.</p> <p>On 4/8/25 at 8:31AM the surveyor observed that Resident #56 had a trach tube and tube feeding among other considerations, however, there was no signage to indicate precautions to direct personal protective equipment (PPE) use necessary for the resident.</p> <p>On 4/8/25 at 3:00PM the surveyor requested a dual observation of Resident #56 with Registered Nurse, Unit Manager (RN, UM) #26 who was observed donning PPE prior to entering the resident's room. At this time, signage for precautions was observed on the resident's door.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/8/25 at 3:02PM RN, UM #26 was observed with a gown and gloves on retrieving their personal phone case and cell phone from underneath their gown. The surveyor observed RN UM #26 touching the phone and case with their gloves on, prior to entering the room of Resident #56. After entering the room to assist in a dual observation of an oral care concern for the resident, RN UM #26 was asked by the surveyor if they were ready to assist the patient if necessary for the oral care observation, at which time they confirmed yes. At this time, the surveyor shared their concern with RN UM #26 who reported to the surveyor that they had forgotten to sanitize their hands after picking up their phone, and thanked the surveyor for the reminder and stated: I'll re-gown. After surveyor intervention, RN UM #26 was observed appropriately removing their ppe, performing hand sanitization, and donning new ppe to assist with the dual observation.</p> <p>On 4/10/25 at 10:28AM the surveyor inquired to Registered Nurse (RN) #32 during an interview as to why the resident had no boots/splints in place. RN #32 was observed holding a blood glucose monitor in their hands which they gave to another staff member, and then RN #32 entered Resident #56's room without hand sanitization, picked up the resident's bed covers to observe their lower extremities, and then exited the room with no hand hygiene observed. At this time, the surveyor shared their concern.</p> <p>On 4/14/25 at 7:29AM the surveyor observed the closet labeled fresh linen located on the B wing, which held linens and was observed to have a sharps container lid laying on the floor next to a packaged toothbrush, open incontinence care briefs stuffed in the corner of the closet with a used crumpled napkin sitting on top of them which was overlapping onto a care basin which held personal sized care products including toothpaste.</p> <p>On 4/14/25 at 7:31AM the surveyor conducted an interview and dual observation of the concern with Licensed Practical Nurse (LPN) #37. LPN #37 observed the closet with the surveyor and when the surveyor inquired as to if they felt the condition of the closet was concerning, LPN #37 stated: very. At this time the surveyor observed LPN #37 proceed to remove the sharp container lid from the closet.</p> <p>On 4/14/25 at 7:36AM the surveyor opened the respiratory supply room closet door on the B wing and observed gauze sponge supplies, an opened box of other respiratory supplies, a covered bottle of sterile water, and a piece of respiratory equipment stored directly on the floor's surface. Trach tubing was observed stored in an open box uncovered without any packaging and other plastic tubing was observed stored uncovered without packaging sitting directly on the shelf's surface.</p> <p>On 4/14/25 at 7:38AM the surveyor observed the storage closet again on the B wing which revealed the rolling style chair with a blanket on it, a sweat suit hanging with a hanger, an IV pole with a personal hat hung on it, packages of hot cocoa mix, an open uncapped tube of ointment with a dried wipe sitting against it, a care basin holding two disposable spoons (utensils) mixed in with various tubes of creams and personal sized bath toiletries, a small box containing a packaged oral care swab and partially used and opened personal sized mouthwash and shampoo along with a pair of medical gloves and gauze sponges.</p> <p>On 4/14/25 at 7:40AM the surveyor shared the concern and conducted a dual observation with Regional Director of Nursing (RDON) #4 who observed and acknowledged understanding of the concern.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/14/25 at 8:01AM the surveyor conducted an observation of a closet located between rooms A15 and A17 with Director of Maintenance #20 and Regional Director of Nursing #4 which revealed brand new back up linens in plastic packaging stored within the closet some of which were observed on the floor which were coated in a layer of black soot-type of debris. Cob webs were additionally observed within the closet which were covered with black debris.</p> <p>On 4/14/25 at 8:13AM the surveyor observed the shower room located on the facility's second floor on the A wing which revealed used medical gloves resting on the lay down shower chair, a pair of visibly dirty socks resting on a rolling shower chair in one of two shower stalls with a dirty wash cloth on the floor below the shower chair, used linen was observed on the shower chair, a cloth material hand splint was resting on the sharps container, a personal sized bottle of shower gel was resting on top of the sharps container, the top surface of the sharps container was observed to be visibly soiled, the trash can was observed to be overflowing with both trash and hospital gowns, and a hospital gown and other bath linens were observed sitting in the handwashing sink. At this time, the surveyor conducted a dual observation of the concerns with Maintenance Director #20 and Regional Director of Nursing #4 who observed and acknowledged the concerns.</p> <p>On 4/15/25 at 11:20AM the surveyor shared concerns with the facility's Director of Nursing who acknowledged understanding of the concerns.</p> <p>49304</p> <p>2) On 4/16/25 at 9:39 AM during a portion of the infection control task, the surveyor randomly selected five employees' files to review their immunization and TB screening records. The review revealed:</p> <ol style="list-style-type: none"> 1. GNA #30 was hired on 8/28/24. Further review did not reveal any evidence that this employee was free from communicable TB. 2. GNA #23 was hired on 6/11/24. Further review revealed a chest x-ray dated 5/12/20. On the document it stated the employee has a history of a positive PPD, however, there was no further current documentation certifying this employee was free from communicable TB. <p>On 4/11/2025 at 9:56 AM in an interview with the Assistant Director of Nursing/Infection Preventionist (ADON/IP), she verified and confirmed there was no TB clearance for GNA #30.</p> <p>On 4/16/25 at 11:14 AM the surveyor requested any TB related documentation for GNA #23.</p> <p>On 4/16/25 at around 3pm, the Nursing Home Administrator provided the survey team with TB documentation for GNA #23, however, it was the same document dated 5/12/20 observed in the employee's file. No further documentation was provided to show GNA #23 was free from communicable TB.</p> <p>51213</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Fairland Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2101 Fairland Road Silver Spring, MD 20904	
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3) During the initial tour of the facility on 4/7/2025 at 7:07 AM, the 2nd floor shower room door was unlocked, and an electronic keypad was observed outside the 2n floor shower room. The surveyor observed 2 towels, a gown and 1 blanket on the floor. These items appeared to be soiled. The towels, gown and blanket were partially on top of a clear trash bag on the floor by the sink. The shower bed with a royal blue mat was wet and had a white wet washcloth on top of the blue mat at the foot of the shower bed. The shower chair with navy blue padding had a wet towel with brown marks observed lying on the shower chair seat. What appeared to be a bed sheet was observed on the floor under the window towards the back of the shower room. Toilet tissue was also observed on the floor by the toilet. Four open bottles of soap were also observed in the 2nd floor shower room, 1 on the floor under the blue shower chair, 1 on top of the sharp container and 2 on the silver handicap railing behind the mesh green shower chair.</p> <p>On 4/8/25 at 10:00 AM The DON was asked to open the 2nd floor shower room. The DON entered the code on the electronic keypad. Five open bottles of liquid soap were resting on the silver handicap railing in the first shower stall. The DON was asked should each resident have their own soap to bathe with? The DON replied yes, each resident should have their own soap to bathe with. The DON then threw the 5 bottles of liquid soap in the trash.</p> <p>On 4/16/25 at 12:35 PM Staff #21 was asked to open the 2nd floor shower room. The surveyor observed 2 bottles of liquid soap sitting on top of the sharp container and 2 wash clothes which appeared to have been used resting on the silver handicap railing in the first shower stall. Staff #21 was asked her title and replied I am the Unit Manager and a GNA. Staff #21 was then asked, should each resident have their own personal items to bathe with, such as soap and wash clothes? Staff # 21 replied, yes, each resident should have their own personal items to bathe, and residents should not share bathing items. Staff # 21 then put on gloves and removed the 2 bottles of liquid soap and the 2 wash clothes from the 2nd floor shower room.</p>		

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<p>F 0923</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>47200</p> <p>Have enough outside ventilation via a window or mechanical ventilation, or both.</p> <p>Based on observation and interview it was determined the facility failed to ensure adequate ventilation. This was evident on one (upstairs second floor) out of two floors during the facility's recertification survey and during investigation of MD#00213104 during the recertification/complaint survey.</p> <p>The findings include:</p> <p>On 4/14/25 at 7:51AM the surveyor observed a closet utilized for two containers for biohazard trash located between rooms C1 and C3. The ventilation cover was observed on the floor, and an uncovered ventilation area in the ceiling was present, and no air circulation within the room was able to be felt at that time.</p> <p>On 4/14/25 at 8:01AM the surveyor conducted an observation of a closet located between rooms A17 and A15 on the facility's second floor with the Director of Maintenance #20 and Regional Director of Nursing #4 which revealed brand new back up linens in plastic packaging stored within the closet which was observed to be coated in a layer of black soot-type of debris although the closet had no ventilation located within it. Cob webs were additionally observed within the closet which were covered with the black debris.</p> <p>On 4/14/25 at 8:01AM the surveyor conducted an interview with EVS Director #35 who observed the surveyor's concern and reported anything on this hallway is going to look like that, it's black soot. When the surveyor inquired as to how long the concern had existed, they stated: A couple of months. In response, Director of Maintenance #20 reported they would be getting the vents cleaned. At this time, the surveyor shared their concern with Director of Maintenance #20 and Regional Director of Nursing #4 who acknowledged the concern.</p> <p>On 4/14/25 at 1:06PM the surveyor conducted an interview with the facility's Director of Maintenance #20 who reported that upon their return to their job as Director of Maintenance in January of 2025, staff in the A wing of the second floor of the building had reported to them concerns on behalf of themselves as well as residents, that they were breathing black stuff in. Director of Maintenance #20 reported that in response to those concerns, they had went to the attic in order to observe the two hvac units at which time they observed that there were no filters present within the evaporator side which needed to be in place in order to filter the air that enters the resident rooms, and when they had observed the side of the hvac system in which the return air from the rooms gets pulled back through the system, there were filters which had one to two inches of dust and appeared to have not been changed/cleaned for an extended period of time. Director of Maintenance #20 explained to the surveyor that although they had ensured air filters were now present, cleaned, and in functional condition, this would not fix the problem because the debris was now present within the duct work. Director of Maintenance #20 reported to the surveyor that residents and family of residents complained because they could not leave belongings out in the resident rooms for a few days without them ending up covered again in the debris.</p>		

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<p>F 0943</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation.</p> <p>49304</p> <p>Based on review of employee files and interviews with facility staff, it was determined that the facility failed to provide evidence that all nursing staff had completed abuse training. This was evident for 1 (Geriatric Nursing Assistant #30) of 5 employee records reviewed during the facility's recertification/complaint survey.</p> <p>The findings include:</p> <p>HealthStream training is a web-based, self-paced software application of online learning and development resources designed for the healthcare industry. It helps healthcare organizations improve staff competency, enhance patient care, and ensure compliance with regulations and standards. HealthStream provides a variety of learning management systems, including e-learning courses, clinical development programs, and competency-based training.</p> <p>On 4/11/25 at 1:12 PM, the surveyor requested and was provided with Geriatric Nursing Assistant (GNA #30's) complete employee file which consisted of 3 manilla folders: an employee health folder, a training/education folder and the folder that held those 2 folders along with all other employee related documents. All documents within all 3 files were reviewed and did not reveal any evidence that GNA #30 completed abuse training.</p> <p>On 4/11/25 at 8:27 AM in an interview with the Assistant Director of Nursing (ADON)/Infection Preventionist (IP) when asked what training was required for nursing staff she stated: safety/fire, electrical, infection control, dementia, handwashing, and nursing skills such as ROM (range of motion), ADLs (activities of daily living), turning and repositioning and skin prevention. During the interview, she verified and confirmed that the training must be completed prior to staff starting on the unit and occurred during orientation. Additionally, she stated the Maryland Health Department comes and provides in-services every 3 months on MDROs (multidrug resistant organisms), handwashing, and PPE (personal protective equipment). When asked what training is completed annually, she stated safety and dementia.</p> <p>Furthermore, the ADON/IP stated that HealthStream is the platform used for staff training and the Director of Nursing (DON) stated that they print a transcript of all training that goes into the employee's file.</p> <p>During a dual observation of GNA #30's employee file with the ADON/IP, she verified and confirmed that there was no evidence of abuse training in GNA #30's employee file in the Training/Education folder or any of her other folders.</p> <p>On 4/11/25 at 9:42 AM in an interview with the ADON and DON she stated the facility used to use Vita Learn (a different healthcare training and education resource) through 2022 but now uses HealthStream. During the interview the ADON and DON stated that all prior training and education completed on Vita Learn was migrated over to HealthStream, so that any prior training or education would populate on the employee's HealthStream.</p> <p>(continued on next page)</p>		

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<p>F 0943</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/11/25 at 9:50 AM Unit Manager (UM #6) provided the surveyor GNA #30's HealthStream student and group transcript report that was generated on 4/11/25 at 9:36 AM. The report revealed 33 total training courses completed, however, failed to reveal any abuse training.</p> <p>On 4/11/25 at 12:20PM after requesting and checking for any additional evidence of abuse training for GNA #30, the ADON/IP returned to the conference room and stated she did not see evidence of abuse training.</p>		