STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215015	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairland Center	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)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident, facility staff interviews, the facility failed to provide medication administration that meets professional standards for 2 of 4 sampled residents reviewed for medication administration. (Resident #15 and Resident #16). Findings included: 1. Resident #15 was admitted to the facility on [DATE] with a diagnosis including anoxic brain damage, diabetes, anemia and protein-calorie malnutrition. A review of the physician's orders dated 11/7/25 revealed Resident #15 was prescribed thiamine HCL oral tablet 100mg , give 1 tablet via gastrostomy tube one time a day for supplement. A medication administration observation was conducted on 11/19/25 at 11:15 am with Staff Nurse #3. Staff Nurse #3 was observed to have not administered the medication thiamine HCL oral table 100mg to Resident #15 as per physician orders. Review of Medication administration record documentation for 11/19/25, indicated that thiamine HCL oral tablet 100mg medication was administered to Resident #15 on 11/19/25 at 9 am. During interview with Staff Nurse #3 on 11/19/25 at 12.17 pm, it was revealed that Resident #15 did not have any thiamine HCL oral tablet 100mg available. Staff Nurse #3 confirmed that Resident #15 did not receive thiamine HCL oral tablet 100mg at 9 am. Staff Nurse #3 indicated that she should have not documented to have administered medication. Staff Nurse #3 confirmed that she should have documented that medication was not administered. 2. Resident #16 was admitted to the facility on [DATE] with a diagnosis including protein-calorie malnutrition, and diabetes. A review of the physician's orders dated 10/28/25 revealed Resident #16 was prescribed ferrous sulfate elixir 220(44 Fe) mg/5ml , give 7ml by mouth one time a day for supplementation. A medication administration observation was conducted on 11/19/25 at 11:18 am with Staff Nurse #3. Staff Nurse #3 was observed to have not administered ferrous sulfate elixir 7ml to Resident #16 per physician orders. Review of Medication administration record documentation for 11/19/25, indicated that ferrous sulfate elixir 220(44 Fe) mg/5ml medication was administered to Resident #16 on 11/19/25 at 9 am. During interview with Staff Nurse #3 on 11/19/25 at 12.17 pm, it was revealed that Resident #16 did not have ferrous sulfate elixir 220 (44 Fe)mg/5ml. Staff Nurse #3 confirmed that Resident #16 did not receive ferrous sulfate elixir 220 (44 Fe)mg/5ml at 9 am. Staff Nurse #3 indicated that she should have not documented to have administered medication. Staff Nurse #3 confirmed that she should have documented that medication was not administered.During an interview with the Director of Nursing (DON) on 11/19/25 at 12:05 pm, she revealed that Resident #15 and Resident #16 should have received medications as per physician orders. DON further stated, that documentation should accurate on the medication administration record. DON confirmed that if medication is not administered, it should be documented as such on the medical record.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident, facility and pharmacy staff interviews, the facility failed to administer medication as ordered by the physician to meet the resident's need of 2 of 4 sampled residents reviewed for pharmacy services. (Resident #15 and Resident #16). Findings included: a. Resident #15 was admitted to the facility on [DATE] with a diagnosis including anoxic brain damage, diabetes, anemia and protein-calorie malnutrition. The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #15 was cognitively impaired. A review of the physician's orders dated 11/7/25 revealed Resident #15 was prescribed thiamine HCL oral tablet 100mg , give 1 tablet via gastrostomy tube one time a day for supplement. A medication administration observation was conducted on 11/19/25 at 10:09 am with Staff Nurse #3. Staff Nurse #3 was observed to not have administered the medication thiamine HCL oral table 100mg to Resident #15 as per physician orders. During interview with Staff Nurse #3 on 11/19/25 at 10:09 am, it was revealed that Resident #15 did not have any thiamine HCL oral tablet 100mg available. Staff Nurse #3 indicated that she would have to get the medication from the over the counter stock in the facility. Staff Nurse #15 did not administer or get the medication from facility over the counter stock . b. Resident #16 was admitted to the facility on [DATE] with a diagnosis including protein-calorie malnutrition, and diabetes. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #16 was cognitively impaired. A review of the physician's orders dated 10/28/25 revealed Resident #16 was prescribed ferrous sulfate elixir 220(44 Fe) mg/5ml , give 7ml by mouth one time a day for supplementation. A medication administration observation was conducted on 11/19/25 at 11:18 am with Staff Nurse #3. Staff Nurse #3 was observed to not have administered ferrous sulfate elixir 7ml to Resident #16 per physician orders. During interview with Staff Nurse #3 on 11/19/25 at 11:18 am, it was revealed that Resident #16 did not have ferrous sulfate elixir 220 (44 Fe)mg/5ml. Staff Nurse #3 indicated that she would have to reorder medication from pharmacy. Staff Nurse #3 confirmed that she had reordered Ferrous sulfate elixir 220 (44 Fe) mg/5ml on 11/19/25 with an anticipation to be delivered by pharmacy. During an interview with the Pharmacy Consultant on 11/19/25 at 4:09 pm, he revealed that Resident #15 and Resident #16 should have received their medications as per physician orders. During an interview with the Director of Nursing (DON) on 11/19/25 at 12:05 pm, she revealed that Resident #15 and Resident #16 should have received medications as per physician orders. She further stated that all nurses will be retrained on reordering medication timely.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observations, record review , staff and pharmacist interviews, the facility failed to maintain a medication error rate of less than 5% as evidenced by 4 errors out of 31 opportunities observed. The medication error rate was 12%. Findings include: 1. A review of the physician's orders dated 11/7/25 revealed Resident #15 was prescribed thiamine HCL oral tablet 100mg , give 1 tablet via gastrostomy tube one time a day for supplement. A medication administration observation was conducted on 11/19/25 at 10:09 am with Staff Nurse #3. Staff Nurse #3 was observed to not have administered the medication thiamine HCL oral table 100mg to Resident #15 as per physician orders. During interview with Staff Nurse #3 on 11/19/25 at 10:09 am, it was revealed that Resident #15 did not have any thiamine HCL oral tablet 100mg available. Staff Nurse #3 indicated that she would have to get the medication from the over the counter stock in the facility. Staff Nurse #15 did not administer or get the medication from facility over the counter stock . 2. A review of the physician's orders dated 11/7/25 revealed Resident #15 was prescribed insulin lispro injection solution 100 unit/ml, inject 18 unit subcutaneously every 4 hours for diabetes. Facility provided policy and procedures on insulin pens on 11/19/25. Policy indicated that insulin pens are to be primed to each use to prevent the collection of air in the insulin reservoir. A medication administration observation was conducted on 11/19/25 at 10:09 am with Staff Nurse #3. Staff Nurse #3 was observed to not have primed the new insulin pen of insulin lispro 100unit/ml, prior to use. During interview with Staff Nurse #3 on 11/19/25 at 10:09 am, she stated that she had primed insulin lispro by ensuring to select a dose higher at than ordered (19 units and not the ordered 18units) to ensure that Resident #15 received his/her ordered dose. Staff Nurse #3 did not prime insulin pen. 3. A review of the physician's orders dated 11/7/25 revealed Resident #15 was prescribed vancomycin HCL oral suspension 50mg/ml , give 2.5 ml via gastrostomy tube one time a day for antibiotic prophylaxis. A medication administration observation was conducted on 11/19/25 at 10:09 am with Staff Nurse #3. Staff Nurse #3 was observed pouring the vancomycin HCL oral suspension into a medicine cup. Staff Nurse #3 was observed pouring 5 ml of vancomycin HCL oral suspension into medicine cup. Upon getting to room threshold heading to administer medication to Resident #15, Staff Nurse #3 was asked to check dosage of vancomycin in medicine cup by surveyor. Staff Nurse #3 observed to realize that she had poured 5ml of vancomycin instead of 2.5ml per physician orders. Staff Nurse #3 was observed getting a new syringe from the supply room, and using it to draw 2.5ml from the medicine cup. Medicine cup noted to have medication , and Staff nurse #3, observed discarding excess medication. During interview with Staff Nurse #3 on 11/19/25 at 10:09 am, she stated that she should have used a syringe to measure the 2.5ml of vancomycin hcl oral suspension, to ensure an accurate dosage. 4 A review of the physician's orders dated 10/28/25 revealed Resident #16 was prescribed ferrous sulfate elixir 220(44 Fe) mg/5ml , give 7ml by mouth one time a day for supplementation. A medication administration observation was conducted on 11/19/25 at 11:18 am with Staff Nurse #3. Staff Nurse #3 was observed to not have administered ferrous sulfate elixir 7ml to Resident #16 per physician orders. During interview with Staff Nurse #3 on 11/19/25 at 11:18 am, it was revealed that Resident #16 did not have ferrous sulfate elixir 220 (44 Fe)mg/5ml. Staff Nurse #3 indicated that she would have to reorder medication from pharmacy. Staff Nurse #3 confirmed that she had reordered Ferrous sulfate elixir 220 (44 Fe) mg/5ml on 11/19/25 with an anticipation to be delivered by pharmacy. During an interview with the Pharmacy Consultant on 11/19/25 at 4:09 pm, he revealed that Resident #15 and Resident #16 should have received their medications as per physician orders. During an interview with the Director of Nursing (DON) on 11/19/25 at 12:05 pm, she revealed that Resident #15 and Resident #16 should have received medications as per physician orders.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observations, and staff and pharmacist interviews, the facility failed to label opened insulin pens with the patient name, physician name, date used for 4 insulin pens for 1 of 5 medication carts reviewed for medication storage (Dogwood Unit Medication Cart #1). The findings included: The medication Cart #1 on Dogwood unit was observed on 11/19/25 at 10:09 am in the presence of Staff Nurse #3. The observation revealed 3 opened and used insulin pens of Humalog and 1 opened insulin pen of Lantus insulin that were stored together with no labels indicating patient name, physician name and date opened. The facility insulin pens policy revised 5/1/25, provided by the Director of nursing , indicated that insulin pens will be clearly labeled with the patient name, physician name, date used;a new pen must be ordered from the pharmacy. An interview with Staff Nurse #3 on 11/19/25 at 12:17 pm, stated that the insulin was delivered in individual bags that were labelled but misplaced. Staff Nurse #3 confirmed that the insulin pens had been used , and had no label. Staff Nurse #3 confirmed that one of the insulin pens did not have a cap in place. Staff Nurse #3 indicated that their was no indication when the insulin pens were opened, or who they were assigned to. Staff Nurse #3 indicated that insulin pens would be discarded. An interview with Director of Nursing on 11/19/25 at 12:05 pm indicated that nursing staff should discard any unlabeled insulin pens and notify pharmacy to reorder new insulin pens that have labels. An interview with assistant director of nursing (ADON) on 11/19/25 at 1.13 pm indicated that insulin pens are delivered from pharmacy and are place in a clear labelled bag. ADON indicated that all insulin pens must be labelled with patient name, physician name and date opened. ADON confirmed that any opened, unlabeled insulin pens, should have been discarded and not used on any resident. ADON indicated that staff nurse should notify pharmacy to reorder labeled insulin pens. ADON indicated that all nurses will be retrained on insulin pens. During an interview with the Pharmacy Consultant on 11/19/25 at 4:09 pm, he revealed that all insulin pens must be labelled with the patient name, physician name and date opened. Pharmacy consultant further stated that once insulin pen is opened , it should be labelled with the date opened. Pharmacy consultant also indicated that any opened , unlabeled insulin pens should not be used, but facility should notify pharmacy and order a new insulin pen.