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	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairland Center	2101 Fairland Road Silver Spring, MD 20904

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 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. The findings include: On 4/8/25 at 8:47AM the surveyor observed Resident #70 did not have their call device to call for staff assistance. 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. 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. 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.

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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	215015	A. Building B. Wing	04/16/2025

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on resident interview, staff interview, and clinical record review, it was determined that the facility staff failed to ensure residents received showers twice a week. This was evident for 3 (#30, #38, and #57) out of 3 residents reviewed for choices during the recertification/complaint survey. The findings include: 1. This surveyor interviewed Resident #30 on 4/8/25 at 8:06 AM. The resident stated that they have received only one shower each week. A review of the resident's clinical record revealed that from February 1 to April 11, 2025, the resident had only received 17 showers out of a possible 20. 2. This surveyor interviewed Resident #38 on 4/8/25 at 9:01 AM. The resident stated that they have not received two showers each week. A review of the resident's clinical record revealed that from February 1 to April 11, 2025, the resident had only received 17 showers out of a possible 20. 3. This surveyor interviewed Resident #57's spouse on 4/8/25 at 8:06 AM. The spouse said the resident had only received one shower each week. A review of the resident's clinical record revealed that from February 1 to April 11, 2025, the resident had only received 12 showers out of a possible 20. The Director of Nursing was interviewed on 4/11/25 at 7:00 AM and she confirmed that the shower logs provided reflected the number of showers received.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on interview and record review it was determined the facility failed to ensure a resident representative was provided with written information and the offered the opportunity to formulate an advanced directive. This was evident for one (Resident #56) out of four residents reviewed for advanced directives during the facility's recertification/complaint survey. The findings include: On 4/8/25 at 9:40AM the surveyor observed the medical record of Resident #56 and noted that a surrogate was selected on the resident's Maryland Orders for Life Sustaining Treatment Form located within the hard chart at the nurse's station. Further reveiew of the hard chart revealed two certifications of incapacity were present for Resident #56. On 4/8/25 at 10:20AM the surveyor conducted a review of the medical record for Resident #56 at which time no documentation upon their admission to the facility could be found of the resident representative having been offered the opportunity to formulate an advanced directive, having been provided with information to formulate an advanced directive, or any documentation regarding any existing advanced directive. On 4/15/25 at 11:20AM the surveyor shared the concern with the facility's Director of Nursing (DON) and provided opportunity for any documentation of advanced directives, documentation of them having been offered or provided to the resident representative, to be provided to the surveyor. On 4/16/25 at 7:34AM the surveyor conducted an interview of the DON at which time they reported to the surveyor that they could not find any documentation of advanced directives having been offered upon the resident's admission to the facility. The DON further reported that they would be reaching out and addressing it. After surveyor intervention, the surveyor observed on 4/16/25 at 12:21PM that a note was drafted in the resident's medical record dated 4/16/25 at 8:08AM which indicated a voicemail was left for the resident's representative offering the opportunity for them to create an advanced directive.

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	215015	A. Building B. Wing	04/16/2025

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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. The findings include: 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. On 4/7/25 at 6:58AM the surveyor observed dirty carpeting with numerous dark circular stains present in the A wing resident hallway. 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. 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. On 4/7/25 at 8:28AM the surveyor shared concerns with the facility Director of Nursing who acknowledged understanding of the concerns. 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. On 4/8/25 at 2:48PM the surveyor observed the furniture drawers of Resident #56 to be missing 3 out of 4 knobs. 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. (continued on next page)

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	215015	A. Building B. Wing	04/16/2025

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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. 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. 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. On 4/15/25 at 11:20AM the surveyor shared concerns with the facility's Director of Nursing who acknowledged understanding of the concerns. 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. 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 ¼ 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. 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.

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	215015	A. Building B. Wing	04/16/2025

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Deficiency Text Not Available

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	215015	A. Building B. Wing	04/16/2025

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and 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. The findings include: 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. 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. 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. 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. 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.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Deficiency Text Not Available

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	215015	A. Building B. Wing	04/16/2025

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interviews, it was determined that the facility failed to notify the resident/resident representative in writing about the bed hold policy when the resident was transferred/discharged from the facility to an acute care facility. This was evident for 1 (resident #42) of 1 Residents reviewed who were transferred to an acute care facility during the recertification/complaint survey. The findings include: On 04/10/25 at 11:30 am, medical review of Resident # 42 revealed that the Resident was admitted to the facility on [DATE] and was receiving long-term care. The resident was sent to the hospital due to a change in condition on 07/25/23. Review of the facility policy title AR102 - Bed - Holds revealed; When it is known that a resident will be temporarily transferred out of the service location, staff involved with the resident's transfer out (example; Nursing, admissions, and social services, etc.) will provide the bed hold notice of policy & authorization form to the resident and representative, if applicable. Further review of Resident #42's medical record revealed that the progress notes, SBAR communication form, and INTERACT change in condition did not reflect the documentation on the offering of the bed hold policy to the family. On 04/10/25 at 12:06 PM, an Interview with Licensed Practical Nurse (LPN) Staff #38 revealed that she/he may not always remember to offer the bed hold policy when rushing the Resident to the Hospital. On 04/10/25 at 2 PM, an Interview with Registered Nurse (RN) staff # 6 revealed that the facility communicates with the Resident and/or family regarding the bed hold policy when the resident was sent to the Hospital. RN staff # 6, added, that when Resident #42 was transferred to the hospital on [DATE], a copy of the Bed Hold policy was sent with the Resident to the hospital; one copy was filed in the Resident's medical record, one copy was sent to the business office and one copy went to the reception, and the receptionist sent the copy to the Resident's family. On 04/10/25 at 2:15 PM, the surveyor requested RN staff # 6, a copy of the bed hold policy offered to Resident #42 for hospitalization on 07/25/23. At 4:10 PM, she/he told the surveyor that she/he had checked everywhere, including the medical records, and she didn't find a copy of the Bed Hold Policy or documentation that the facility would have offered the bed hold policy.

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	215015	A. Building B. Wing	04/16/2025

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of medical records and interview with facility staff, it was determined that the facility failed 1) to ensure that residents and/or residents' representatives were provided with summaries of their baseline care plans including a list of their medications and 2) to complete a baseline care plan within the required timeframe. This was evident for 2 (#44, #55) of 24 residents reviewed during the recertification/complaint survey. The findings include: A baseline care plan (BLCP) must be completed within 48 hours of a resident's admission to the facility and include the initial goals based on admission orders, physician orders, dietary orders, therapy services, and social services. A summary of the BLCP and medication list must be given to each resident and/or his/her representative. Completion and implementation of the BLCP is intended to promote continuity of care and communication among staff, increase resident safety, and safeguard against adverse events (undesirable outcomes) that can occur right after admission. 1) The Director of Nursing (DON) was interviewed on 4/10/25 at 11:58 AM. During the interview when asked who initiates and completes the BLCP she stated, the admitting nurse initiates it, and then the Social Worker (SW) completes it within 24-48 hours. The Regional Director of Social Services (RDSS #8) was interviewed on 4/14/25 at 10:45 AM. During the interview when asked to describe the facility's BLCP process she stated she is conferenced in via phone or video with the Unit Manager (UM) and we ensure the care plan team (she verbalized to include the UM, GNA if one is present and able to, activities/recreation, SW, the resident and/or family, and rehab) is present during the BLCP meeting. When asked who was ultimately responsible for the completion of BLCPs, she stated she was the one responsible and that there was an agency SW but that is no longer the case, so she has been the one trying to keep up with it. When asked if the BLCP process was documented, she stated yes, it is documented in the resident's medical record under Post admission Patient Family Conference, at the bottom of the assessment it says a copy was provided to the resident/family, and the UM prints a copy and takes it to them. On 4/15/25 at 12:14 PM, Resident #44's medical record was reviewed. The review revealed the resident was admitted to the facility on [DATE] but failed to reveal any evidence that Resident #44 had been provided with a summary of his/her BLCP along with a summary of his/her medications. Continued review of the medical record revealed a Post admission Patient-Family Conference dated 2/24/25 however in the section where the RDSS #8 stated the information would be documented, Copy given to resident and/or resident representative, the box was left unchecked. Additionally, the assessment was completed after 48 hours. On 4/15/25 at 12:13 PM the DON was asked to provide evidence that Resident #44 received a BLCP summary including a list of his/her medications. On 4/15/25 at 12:33 PM the DON verified and confirmed there is no documentation that Resident #44 was provided with a written summary of his/her BLCP including medication list within 48 hours of their admission. (continued on next page)

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	215015	A. Building B. Wing	04/16/2025

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) On 4/14/25 at 10:38 AM review of Resident #55's medical record revealed the resident was admitted on [DATE]. Further review of the medical record revealed a Post admission Patient-Family Conference, however it was dated 10/17/24, after the 48 hour required time frame for completion. In an interview with RDSS #8 on 4/14/25 at11:09 AM when asked if Resident #55 had a BLCP completed timely within 48 hours, she stated she did see a BLCP from 10/17/24, but that no, it was not completed timely. During the interview she stated she was the one who completed that assessment. When asked why it was not completed within the required time frame, she stated she did not have that answer.

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	215015	A. Building B. Wing	04/16/2025

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of medical records and interview with facility staff, it was determined that the facility failed to revise care plans for residents quarterly. This was evident for 1 (Resident #55) of 24 residents reviewed during the recertification/complaint survey. The findings include: Care plans are developed for residents to guide the care that residents receive in the facility. They describe residents' needs and the interventions to address them and must be reviewed and revised at least every quarter and/or as changes in the residents' conditions occur. The facility is required to have care plans developed and revised by an interdisciplinary team (IDT) including: the attending physician, a registered nurse, a nursing aide, a representative from dietary services, the resident, and the resident's representative (as practicable). On 4/14/25 at 10:39 AM Resident #55's medical record was reviewed. During the review it was noted that the resident was admitted to the facility on [DATE], however, only one care plan was observed in his/her medical record, initiated on their admission date. Additionally, in the next section, Review History (the next time(s) the care plan was/were reviewed by the facility's IDT) it was documented, No records found. The Regional Director of Social Services (RDSS #8) was interviewed on 4/14/25 at 10:45 AM. During the interview when asked how often care plans are reviewed and revised, she stated every 90 days. Residents have their first, initial care plan developed within 14 days of admission to the facility and then quarterly from there or as needed. The surveyor shared the concern that only one care plan was observed in Resident #55's medical record even though s/he was admitted on [DATE]. When asked if to date, Resident #55 should have had any care plan revisions she stated yes, s/he should have had one in January [2025] and s/he is due for one this month [April 2025]. When asked if she saw evidence in the medical record of a care plan revision for Resident #55, she stated s/he (the resident) might not have been triggered. She stated her process is to go into the electronic medical record and go into reports. When she goes into reports, it shows care plan report/task and care plan reviews that are due. Then she goes under each unit in the facility and the system tells me which residents have a care plan that needs to be completed.

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	215015	A. Building B. Wing	04/16/2025

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. Based on review of the medical record and interview with facility staff, it was determined that the facility failed to complete a discharge summary of a resident . This was evident for 1 (Resident #84) of 3 residents reviewed for closed records during a recertification/complaint survey. The findings include: Resident #84's closed medical record was reviewed on 4/16/25 at 9:01 AM. The review revealed the resident was noted to have left against medical advice on 1/16/25. Further review revealed on 4/15/25 at 2:38 PM Nurse Practitioner (NP #25) wrote, Patient desires discharge AMA (Against Medical Advice). Notified the primary care provider, Dr. [Medical Doctor #16], via voicemail regarding the patient's situation and concerns. Notified the Director of Nursing about the patient's dissatisfaction and intent to leave AMA. Additionally, the last nursing progress note documented 1/16/25 at 8:29 PM revealed, Resident left against medical advice despite education in regard to risks and benefits, but resident still insisted on leaving, resident left via stretcher accompanied by 2 paramedical transport in no pain/distress. NP made aware. However, further review of the medical record failed to reveal a completed discharge summary that included: a recapitulation of the resident's stay, a final summary of the resident's status, reconciliation of all pre-discharge medications with the post discharge medications, and a post discharge plan of care. On 4/16/25 at 9:24 AM the above concerns were discussed with the Director of Nursing (DON) and she confirmed that the expectation was that residents leaving the facility, for any reason, would require a discharge summary written by the physician. During this interview, the surveyor requested a copy of Resident #84's discharge summary. The DON was interviewed on 4/16/25 at 10:01 AM and confirmed there was no documentation from the physician regarding the resident's discharge and verified that yes, there should have been a discharge summary written for the resident.

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	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairland Center	2101 Fairland Road Silver Spring, MD 20904

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 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. The findings include: 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. 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. 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. 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. 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. 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. 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.

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	215015	A. Building B. Wing	04/16/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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. The findings include: 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. 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. 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? 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. 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. 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. (continued on next page)

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	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairland Center	2101 Fairland Road Silver Spring, MD 20904

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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. 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. 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. 2) The Centers for Medicare & Medicaid Services (CMS) defines a psychotropic medication in the regulations at §483.45(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. 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. 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. 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. (continued on next page)

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	04/16/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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.

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	215015	A. Building B. Wing	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairland Center	2101 Fairland Road Silver Spring, MD 20904

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 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. The findings include: 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. 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.

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	215015	A. Building B. Wing	04/16/2025

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on a review of staff training and staff interview it was determined that the facility staff failed to ensure all staff received the appropriate training. This was evident for 3 (Staff #10, Staff #23, Staff #24) out of the 5 staff reviewed for training during the recertification/complaint survey. The findings include: The employee files for the five employees were reviewed on 04/11/25 at 06:57 AM. Staff #10 was missing evidence of training for behavioral health, tracheotomy care, and ventilator care. Staff #23 was missing evidence of training for Resident rights, communication, behavioral health, ventilator care, and tracheotomy care. Staff #24 was missing evidence of training for abuse, resident rights, communication, ventilator care, and tracheotomy care. Staff #5 (Regional Clinical Resource Nurse) was interviewed on 4/11/25 at 8:27 AM. When asked what training staff must complete prior to working on the units she stated: safety- fire, electrical; infection control; dementia; skills- basic skills such as Range of Motion (ROM), Activities of Daily Living (ADLs), turning and repositioning, skin prevention, and handwashing. Stated that these trainings are to be completed prior to starting on the unit in orientation. The Director of Nursing was interviewed on 4/15/25 at 11:45 AM. She informed this surveyor of the missing trainings/competencies. She said they searched for them and looked through their files and could not find them anywhere.

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	215015	A. Building B. Wing	04/16/2025

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 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. The findings include: 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. 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.

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	215015	A. Building B. Wing	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairland Center	2101 Fairland Road Silver Spring, MD 20904

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. Based on clinical record review and staff interview, it was determined that the facility staff failed to ensure facility staff documented monitoring of behavioral symptoms. This was evident for 1(#38) out 24 residents reviewed during the recertification/complaint survey. The findings include: A review of Resident #38's clinical record revealed that the behavior monitoring that was ordered for the monitoring of the resident's depression symptoms for the month of April could not be found. The Director of Nursing (DON) was interviewed on 4/15/25 at 8:14 AM. The DON reviewed the electronic health record with the surveyor. She showed the surveyor that the button for who was responsible for the monitoring was clicked to Ancillary staff instead of nursing. The provider should have clicked nursing so that it would show up on the Medication Administration Record for nursing to document. She said she would change it.

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	215015	A. Building B. Wing	04/16/2025

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on record reviews and interviews with facility staff, it was determined that the facility failed to respond to recommendations made by consulting pharmacists in a timely manner. This was evident for 1 (Resident #44) of 5 residents reviewed for unnecessary medications during the recertification/complaint survey. The findings include: The Medication Regimen Review (MRR) is a review of the medication regimen (plan) of each resident with the goal of promoting positive outcomes and minimizing adverse (negative) consequences and potential risks associated with medications. The MRR must be completed at least once a month by a licensed pharmacist and includes a review of the medical record to identify, report, and resolve medication-related problems, errors, and/or other irregularities. On 4/14/25 at 1:33 PM the DON provided the survey team the 3 most recent (January - March 2025) months of the facility's Consultant Pharmacist's MRR: Listing of Residents Reviewed with No Recommendations lists. Review of the February 2025 list failed to reveal Resident #44's name. On 4/15/25 at 9:50 AM the surveyor requested a copy of Resident #44's February 2025 recommendation from the consulting pharmacist. On 4/15/25 at 10:40 AM in an interview with the Director of Nursing (DON), she provided the surveyor with Resident #44's February 2025 recommendation that revealed the following pharmacist recommendation dated 2/18/25, DC (discharge summary) lists order for Lidocaine 4% patch (PCC order is Lidocaine 4% gel). Please ensure correct item is active for the resident. During the interview, she verified and confirmed that the resident's February 2025 MRR was not addressed by the physician. Resident #44's physician orders were reviewed on 4/15/25 at 10:45 AM. The review revealed the resident still has an active order for Lidocaine External Gel 4 %.

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	215015	A. Building B. Wing	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. Based on clinical record review and staff interview it was determined that the facility staff failed to 1) ensure residents received medication according to ordered parameters, and 2) ensure a resident was free from unnecessary pain medications. This was evident for 2 (Resident #45, Resident #55) out of 24 residents reviewed during the recertification/complaint survey. The findings include: 1) A review of Resident #45's clinical record on 4/14/25 at 7:51 AM revealed that the resident was ordered Atenolol (medication to treat hypertension) 25 mg two times a day and to hold it if the systolic (top number) blood pressure (SBP) was under 110. A review of the Medication Administration Records (MAR) for April revealed that the resident was administered the Atenolol on 4/7/25 at 9:00 PM even though the SBP was 100. A review of the February MAR revealed that the Atenolol was administered on 2/5/25 at 9:00 PM when the SBP was 107. A review of Resident #45's clinical record on 4/14/25 at 7:51 AM revealed that the resident was ordered to receive Humalog insulin 10 units, hold if blood sugar is less than 100. A review of the February MAR revealed that the resident was administered the Humalog on 2/2/25 at 11:30 AM with a blood sugar of 94, on 2/16/25 at 11:30 AM with a blood sugar of 88, on 2/16/25 at 4:30 PM with a blood sugar of 90, and on 2/25/25 at 11:30 AM with a blood sugar of 91. The Director of Nursing was interviewed on 4/14/25 at 1:03 PM. She said she understood the findings and confirmed that the first dose of Atenolol was administered outside of parameters and she stated that administering insulin outside of parameters was an ongoing issue with nursing staff. 2) The medical abbreviation PRN stands for 'pro re nata' (a Latin phrase), which means the medication is taken on an as needed basis and is not prescribed to be administered at scheduled times. The numeric rating scale (NRS) is a pain screening tool, commonly used to assess pain severity at that moment in time using a 0-10 scale, with zero meaning no pain and 10 meaning the worst pain imaginable. Oxycodone is used to relieve pain severe enough to require opioid treatment and/or when other pain medicines do not work well enough or cannot be tolerated. On 4/14/25 at 1:03 PM review of Resident #55's medical record revealed the resident was ordered oxycodone HCl (hydrochloride) Oral Tablet 5 MG *Controlled Drug* Give 1 tablet via PEG-Tube every 4 hours as needed for moderate pain 4-7. Further review of the medical record revealed the facility staff assessed and documented the resident's pain as 2 on 4/1/25 at 2:28 PM and 4/4/25 at 10:44 AM; however, documented the administration of the oxycodone. Additionally, the facility staff assessed and documented the resident's pain as 3 on 3/30/25 at 12:38 PM, 4/6/25 at 11:43 AM, 4/7/25 at 10:49 AM, 4/8/25 at 10:15 AM, and 4/8/25 at 2:19 PM; however, documented the administration of the oxycodone. (continued on next page)

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	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairland Center	2101 Fairland Road Silver Spring, MD 20904

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/14/25 at 12:59 PM in an interview and dual observation of the resident's March and April 2025 MAR (medication administration record) with the Director of Nursing, when asked if the medication was administered as ordered, the DON stated no, because they did not follow the parameters. The DON verified and confirmed that this pain medication was administered outside of the physician's ordered parameters.

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	215015	A. Building B. Wing	04/16/2025

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. Based on medical record review and interview with facility staff, it was determined that the facility failed to ensure that psychotropic medications were only used to treat a specific, diagnosed, and documented condition. This was found to be evident for 1 (Resident #44) of 5 residents reviewed for unnecessary medications during the recertification/complaint survey. The findings include: The Centers for Medicare & Medicaid Services (CMS) defines a psychotropic medication in the regulations at §483.45(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: antipsychotic, 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. Resident #44's medical record was reviewed on 4/14/25 at 9:24 PM and revealed an order for trazodone HCL (hydrochloride) oral tablet 50 mg (milligrams), give 1 tablet via gastrostomy tube at bedtime for insomnia. Further review of the resident's diagnoses in the medical record failed to reveal that the resident had a diagnosis of insomnia. On 4/15/25 at 8:02 AM in an interview with the Director of Nursing (DON), she stated there should be an indication for all medications ordered for residents. During the interview, the DON verified and confirmed there should be a corresponding diagnosis in the resident's medical record to the indication written in the order. The above mentioned concern was shared with the DON, and she was asked to provide any evidence of an insomnia diagnosis for Resident #44. On 4/15/25 at 12:15 PM in an interview with the DON she stated that there was no evidence in the medical record that Resident #44 had a diagnosis of insomnia, and she would have to talk to psychiatry about it.

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	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairland Center	2101 Fairland Road Silver Spring, MD 20904

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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. 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. 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. 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. 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. The findings include: 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. 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# N1496810-03 [DATE] oxycodone 20mg, 12 tablets, supplied by John Hopkins at [NAME], Broadway, Baltimore, with the names of the recently admitted residents at the facility. 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. On [DATE] at 11:30 am, record review of the medication administration general guidelines provided by the facility, page # 4/6, item C stated Multi-use eye drops and ointments should be disposed of 28 days after initial use. (continued on next page)

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	215015	A. Building B. Wing	04/16/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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]. 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.

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	215015	A. Building B. Wing	04/16/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 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. The findings include: 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. 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. 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. 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. 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. 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. 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. (continued on next page)

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	215015	A. Building B. Wing	04/16/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. On 4/7/25 at 8:28AM the surveyor shared concerns with the facility Director of Nursing who acknowledged understanding of the concerns. 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. 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. 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. 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. 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. 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. 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. On 4/16/25 at 8:27AM the surveyor shared all kitchen concerns with Food Services Director #19 who acknowledged understanding of the concerns.

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	215015	A. Building B. Wing	04/16/2025

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on the review of administrative records and facility staff interviews, it was determined that the facility staff failed to demonstrate the presence of the required committee members for the Quality Assessment and Assurance committee (QAA), during the recertification/complaint survey. The findings include: On 4/16/25 at 8:13 AM, a review of the facility's QAA meeting required members' 12-month attendance revealed that QAA meetings had not occurred on a quarterly basis in the past 12 months, and the Nursing Home Administrator (NHA) provided 4 quarters of attendance: January, April, July, and November 2024. The October 2024 Quarterly required meeting did not occur, and minimum required members did not attend the quarterly required meetings in April 2024, July 2024, and October 2024. On 4/16/25 at 11:25, in an interview with the NHA, it was revealed that she/he has been working at the facility since September 2024, and she/he was in charge of QA meetings. Further review of QAA meeting attendance with NHA, she/he agreed with the findings.

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	215015	A. Building B. Wing	04/16/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 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. The findings include: 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. 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. 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. 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. (continued on next page)

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	215015	A. Building B. Wing	04/16/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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. 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. 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. 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. 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. 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. (continued on next page)

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	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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. On 4/15/25 at 11:20AM the surveyor shared concerns with the facility's Director of Nursing who acknowledged understanding of the concerns. 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: 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. 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. On 4/16/25 at 11:14 AM the surveyor requested any TB related documentation for GNA #23. (continued on next page)

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	215015	A. Building B. Wing	04/16/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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.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. 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. 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.

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	215015	A. Building B. Wing	04/16/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0923 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have enough outside ventilation via a window or mechanical ventilation, or both. 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. The findings include: 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. 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. 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. 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.

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	04/16/2025

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on interview and record review it was determined the facility failed to maintain a preventative pest control program. This was evident during the facility's recertification survey and during the investigation of MD#00213104. The findings include: Review of MD#00213104 revealed a concern for the presence of mouse droppings and roaches within the facility. On 4/14/25 at 6:52AM the surveyor conducted an interview of the facility's Director of Maintenance #20 who reported that they held this position previously, 13 months prior to their most recent start date in January 2025. During the interview, Director of Maintenance #20 reported to the surveyor that when they previously held their position, pest control came to the facility for preventative visits on a bi-weekly basis, however, upon their return to their position as Director of Maintenance in January of 2025, they noticed they had not seen pest control visit the facility, and when they looked for a pest control log, they didn't see any. Director of Maintenance #20 reported observations of roaches at times in the past within the facility, and described how the issue was addressed after issues had been observed, and stated: I am in the process of still putting together that program, there had been a payment issue and because of that they (pest control contractor) suspended our account. At this time the surveyor requested any and all copies of any pest control logs, copies of contracts with pest control services, and contract end and begin dates for pest control. On 4/14/25 at 1:29PM the surveyor was provided with pest control documentation which revealed the last date pest control services occurred for the building was documented as 11/6/24. Further review of an email provided to the surveyor revealed that after surveyor intervention, preventative pest control services was re-established projected to begin again on 4/15/25.

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	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairland Center	2101 Fairland Road Silver Spring, MD 20904

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 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. The findings include: 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. 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. 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. 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. 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. 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. (continued on next page)

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	04/16/2025

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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.