| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 215026 | A. Building<br>B. Wing | 03/25/2025 |

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| Potomac Valley Rehabilitation and Healthcare | 1235 Potomac Valley Road<br>Rockville, MD 20850 |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48259<br><br>Based on observation, medical record review, and interviews, it was determined that the facility failed to ensure that Minimum Data Set (MDS) assessments were accurately coded. This was evident for 1 (Resident #32) of 3 residents reviewed for communication and sensory, 1 (Resident #119) of 2 residents reviewed for limited range of motion (ROM) and 1 (Resident #145) of 2 residents reviewed for Preadmission Screening and Resident Review (PASRR).<br><br>The findings include:<br><br>The MDS (Minimum Data Set) is a complete assessment of the resident which provides the facility information necessary to develop a plan of care, provide the appropriate care and services to the resident, and to modify the care plan based on the resident's status. MDS assessments must be accurate to ensure that each Resident receives the care they need.<br><br>Preadmission Screening and Resident Review (PASRR) is a federal requirement to help ensure that individuals are not inappropriately placed in nursing facilities for long-term care. The PASRR process requires all applicants to Medicaid-certified nursing facilities (NFs) to be given a preliminary assessment to determine whether they might have serious mental illness or intellectual disability. This is called Level I Screen. Those individuals who test positive at Level I are referred to the local health department (LHD), receiving an in-depth Level II PASRR evaluation.<br><br>1) During an initial tour of the A wing on 3/17/25 at 12:56 PM, an observation was made of Resident #32's right eye to be partially closed and unable to open. The Resident was asked if s/he had any visual or hearing problems and responded yes and added that s/he was unable to read fine details including newspaper prints.<br><br>A record review on 3/20/25 at 5:10 PM included a nursing admission assessment completed on 1/24/25 that had recorded that Resident #32 had poor vision and that Per hospital nurse report [pt- patient] is blind on right eye.<br><br>A continued review of a trauma informed screen assessment completed on 1/24/25 contained a notation that Resident #32 had a Lack of sight conjoined with a recent hip surgery causes concerns for the resident that she might fall.<br><br>A review of Resident #32's admission MDS dated [DATE] showed a documentation that Resident # 32 had adequate vision.<br><br>(continued on next page) |

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

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

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 3/25/25 at 9:06 AM, MDS nurse (Staff #27), reported that her process for documenting vision on the MDS assessment was to get the data from the nursing admission assessment. However earlier review of the nursing admission assessment showed that Resident #32 had poor vision and the MDS failed to capture the Resident's impaired visual status.<br><br>2) In an interview on 3/17/25 at 2:58 PM, Resident #119's representative mentioned that the resident is unable to move his/her left side due to history of stroke.<br><br>A record review on 3/24/25 at 1:19 PM, for Resident #119 showed that he/she had been residing in the facility since March 2023 with diagnoses including history of stroke.<br><br>The review also revealed MDS assessments dated 8/13/24, 11/13/24, 3/17/25. The MDSs had recorded in section GG that Resident #119 had no functional limitations in ROM. However, further review of occupational therapy evaluation noted that Resident #119 had a left-hand contracture.<br><br>In an interview on 3/24/25 at 1:34 PM, MDS nurse (Staff #27) confirmed that Resident #119's MDS' dated 8/13/24, 11/13/24, and 3/17/25 were documented in error.<br><br>3) A medical record review on 3/18/25 at 9:58 AM, noted that Resident #145 had been living in the facility since September 2024 with diagnoses including mental illness.<br><br>Further review showed a positive Level 2 PASSR evaluation report completed by a physician on 11/26/24 for Resident #145 due to mental illness.<br><br>The review also contained an MDS assessment for Resident #145 dated 2/18/25. The MDS documented a no to the question: Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition in section A.<br><br>In an interview on 3/24/25 at 1:41 PM, MDS nurse (Staff #27) confirmed that Resident #145's MDS dated [DATE] was recorded inaccurately. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>48259<br><br>Based on interviews and medical record review, it was determined that the facility staff failed to ensure interdisciplinary team (IDT) care plan meetings were conducted and failed to update a care plan after a change in status. This was found to be evident for five (Residents #90, 100, 104, 125 and 40) out of five residents reviewed for care planning specifically, and an additional three (Residents #111, #145 and #3) out of 32 other residents reviewed during the survey.<br><br>The findings include:<br><br>A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care. They are required to be developed within 7 days of completion of a resident's admission comprehensive Minimum Data Set (MDS) assessment and revised at least every quarter (or more often as needed).<br><br>The Minimum Data Set (MDS) assessment is a federally mandated assessment tool that nursing home staff use to gather information on each Resident's strengths and needs. The information collected is used in the Resident's care planning decisions.<br><br>The facility must 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).<br><br>1) In an interview on 3/17/25 at 11:03 AM, Resident #100 was asked if s/he participated in his/her care plan meeting. The Resident responded that s/he had been in the facility for 3 weeks but had not been to any meetings yet.<br><br>A record review on 3/19/25 at 2:27 PM showed that Resident #100 was admitted to the facility in February 2025.<br><br>The review also contained an attending provider's note dated 2/24/25 that stated that Resident #100 was alert, oriented, and able to make his/her own decisions.<br><br>A review of Resident #100's admission MDS assessment showed that it was completed on 2/27/25; however, the review failed to show that a care plan meeting occurred following the Resident's admission to the facility and completion of the Resident's admission MDS assessment.<br><br>In an interview on 3/20/25 at 1:46 PM, the director of nursing confirmed that there was no documentation in Resident #100's record to show that an IDT care plan meeting had occurred for the Resident.<br><br>2) A review of a facility self-report MD00214031 and a complaint MD00214173 on 3/18/25 at 3:32 PM for Resident #145 indicated that the Resident eloped (unauthorized exit) from the facility on 1/27/25.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Review of the medical record revealed an MDS with an assessment date of 12/23/24. No documentation was found to indicate a care plan meeting occurred in December 2024 or January 2025.<br><br>The continued review revealed a care plan initiated on 9/18/24 and revised on 2/12/25, indicating that Resident #145 remained at risk for elopement due to exit-seeking behaviors. One of the interventions on the plan of care stated that the wander guard removed as resident is now deemed competent.<br><br>Wander guard is a system that uses bracelets and sensors to alert caregivers when a resident at risk of wandering approaches a monitored door or area, potentially triggering alarms or automatic door locks.<br><br>In an interview with the Director of Nursing (DON) on 3/19/25 at 1:12 PM, she reported that Resident #145 was assessed and certified by 2 attending providers as having the capacity to make his/her decisions after s/he was returned from the elopement and therefore was no longer at risk for elopement.<br><br>However, an earlier review of the Resident's care plan for elopement, revised on 2/12/25, failed to show an update to the care plan to reflect that s/he was no longer at risk.<br><br>In a subsequent interview on 3/20/25 at 9:49 AM, the DON confirmed the concern that the care plan was not revised to reflect Resident #145's current elopement risk.<br><br>48470<br><br>3) Resident #90 was admitted to the facility in late 2023. On 3/17/25 at 11:04 AM, the resident was interviewed and reported that s/he had not attended a care plan meeting.<br><br>A review of Resident #90's medical record was conducted on 3/20/25 at 8:51 AM. The review revealed comprehensive assessments were completed on 8/15/24, 10/18/24, 10/28/24, 1/24/25 and 2/3/25.<br><br>Further review of Resident #90's medical record on 3/20/25 at 9:28 AM, revealed care plan meeting progress notes. The progress notes indicated that a care plan meeting took place on 8/15/24 and 2/21/25. No other documentation was found to indicate that a care plan meeting was conducted between 8/15/24 and 2/21/25.<br><br>On 3/20/25 at 1:09 PM, the Director of Social Services (Staff #9) was interviewed. During the interview, Staff #9 reported the facility's process with care plan meetings and that the responsibility of scheduling them was divided among him and the 2 other staff members of the social services department.<br><br>The medical record of Resident #90 was reviewed with Staff #9 on 3/20/25 at 2:02 PM. Staff #9 indicated that a care plan meeting should have been conducted after the completion of the October 2024 comprehensive assessment. Staff #9 confirmed that there was no documentation to indicate that a care plan meeting was conducted between 8/15/24 and 2/21/25.<br><br>On 3/25/25 at 1:08 PM, the concern was discussed with the Director of Nursing (DON) that a care plan meeting was missed after completing the comprehensive assessment for Resident #90. The DON verbalized understanding and acknowledged the concern.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 51900<br><br>4) On 3/19/25 at 11:38 AM, the record review for Resident #3 showed Minimum Data Set assessments on 10/15/24 and 1/15/25, but no documentation was found to indicate a care plan meeting occurred after either of these assessments.<br><br>On 3/19/25 at 1:30 PM, the Director of Nursing (DON) provided documentation of a care plan meeting on 8/22/24 but confirmed that Resident #3 had no care plan meetings after the October or January assessments. For Resident #3, she provided a care plan meeting note from 8/22/24 and confirmed no meetings had occurred since that date.<br><br>5) On 3/19/25 review of Resident #104's medical record revealed two quarterly MDS assessments were completed in January 2025 (1/24/25 and 1/29/25). No documentation was found to indicate a care plan meeting was scheduled or held after the January MDS assessments.<br><br>On 3/19/25 at 1:30 PM, the DON provided evidence of a care plan meeting for Resident #104 dated 10/31/24 but could not provide documentation to indicate a meeting occurred after the January assessments.<br><br>On 3/20/25 at 1:14 PM, the surveyor interviewed the Director of Social Service (Staff #9), noting that a care plan meeting was due after Resident #104's January assessment. Staff #9 explained that no meeting had occurred since November 2024 because the family was unavailable. When asked if meetings proceed without family, he responded, We can, but why would we? He clarified that they aim to involve the family but did not provide documentation showing any attempts to contact them for a meeting after the January assessment He confirmed that the interdisciplinary team had not held the meeting.<br><br>On 3/20/25 at 2:06 PM, the surveyor interviewed the Nursing Home Administrator about the care plan meeting requirements. He stated they should occur upon admission and at least quarterly. When asked about how they handle meetings when families are unavailable, he responded, We should probably still have it. The surveyor informed him that Resident #3 hadn't had a care plan meeting since August 2024 and Resident #104 since October 2024.<br><br>On 3/25/25 at 11:10 AM, the surveyor spoke with the Director of Nursing (DON) to let her know the concerns that Residents #3 and #104 hadn't had timely care plan meetings.<br><br>48168<br><br>6). On 3/19/25 at 1:41 PM a record review of Resident #111's chart failed to reveal any care plan meeting notes after 4/26/24. In an interview with the unit manager (Staff #5), showed documentation of a care plan meeting on 1/31/25, but she could find no care plan meeting documentation between 4/26/24 and 1/31/25.<br><br>On 3/20/25 at 11:11 AM in an interview with the Director of Nursing (DON), she confirmed that the facility failed to hold the required care plan meetings for Resident #111.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 7). On 3/19/25 at 9:42 AM a review of Resident #40's medical records failed to reveal any care plan meeting documentation after 9/09/24. Further review revealed a note written by social worker (SW #17) on 11/05/24 that indicated the resident was due for a care plan meeting in December 2024, but there was no documentation for any meeting in December.<br><br>On 3/19/25 at 11:30 AM the Director of Nursing (DON) provided a copy of Resident #40's care plan meeting documentation for 9/09/24 but did not provide documentation for a December meeting.<br><br>On 3/19/25 at 1:05 PM in a follow up interview with the DON, she said that Resident #40 did not have any care plan meetings after 9/09/24 and she confirmed that all residents should have care plan meetings quarterly.<br><br>8). On 3/19/25 at 12:32 PM a review of Resident #125's medical record revealed care plan meeting documentation dated 6/12/24. No more recent care plan meeting documentation was found in the record.<br><br>On 3/19/25 at 1:05 PM an interview was conducted with the DON, and she was asked if Resident #125 had any care plan meetings after 6/12/24. She said she would check, and she also confirmed that care plan meetings should be held quarterly for all residents. No further evidence was provided by the end of the survey.<br><br>On 3/25/25 at 12:48 PM an interview was conducted with the Nursing Home Administrator to review the survey findings. He confirmed the deficiency that care plan meetings were not held as required. |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>48168<br><br>Based on observation, record review, and interview, it was determined that the facility failed to have a system in place to ensure resident's nutritional status was accurately assessed. This was evident for 1 resident (Resident #128) of 5 residents reviewed for nutrition.<br><br>The findings include:<br><br>On 3/18/25 at 10:26 AM Resident #128 was observed as he/she walked in the hallway next to his/her room. A Geriatric Nursing Assistant (GNA) walked next to the resident. The resident appeared very tall, much taller than the GNA.<br><br>On 3/18/25 at 11:01 AM a record review of Resident #128's height documentation revealed documentation dated 8/22/23 that the resident's height was 68 inches.<br><br>On 3/20/25 at 3:49 PM an interview was conducted with the facility dietitian (Staff #12) and she was asked if she assessed Resident #128 in person. Staff #12 said yes. When asked if 68 inches was an accurate height for this resident, she said she thought so. When asked how any discrepancy would be determined, she said that nursing staff measured and documented residents' height and weight. She further explained that height should be assessed at admission and annually.<br><br>On 3/20/25 at 4:06 PM an interview was conducted with the Director of Nursing (DON). She was asked what the process was to ensure that resident heights were accurately measured. She said that the facility did not have any such process.<br><br>On 3/20/25 at 5:00 PM in another interview with the DON, she brought a document that indicated the resident was re-measured on 3/20/25 and that the resident was 74.5 inches tall, not 68 inches tall. She confirmed that the resident's admission height was inaccurate, and that the facility failed to notice the discrepancy. |