STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215060	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Care of Silver Spring, LLC	9101 Second Avenue Silver Spring, MD 20910

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2) On [DATE] a review of Resident #8's medical record revealed the resident was admitted to the facility in [DATE]. A review of the resident's paper chart revealed a Maryland Order for Life Sustaining Treatment (MOLST) dated [DATE] which indicated Attempt CPR and a certificate of capacity that revealed the resident was capable of making his/her own decisions. However, there was no Advance Directives document found in both the paper chart and electronic medical record. Review of Minimum Data Set (MDS) assessment with Assessment Reference Date (ARD) of [DATE] revealed Resident #8 had a BIMS (Brief Interview for Mental Status) of 13/15 indicating the resident was cognitively intact. Further review of the medical record failed to reveal documentation of advanced directives or that a discussion about advance directives had occurred with the resident. On [DATE] at 9:47 AM, surveyor reviewed the concern with the Director of Social Services (DSS), Staff #8, regarding the lack of documentation about advance directives in the medical record. Staff #8 stated she had a discussion with the resident and the resident's brother regarding the formulation of advance directives and referred the surveyor to the resident's admission notes. On [DATE] at 10:39 AM, a review of admission assessment dated [DATE] had nothing checked under Advanced Directives. A review of social services progress notes on [DATE] at 10:50 AM failed to reveal documentation that advance directives were discussed with the resident and/or RP. On [DATE] at 11:09 AM, in a follow up interview with the Director of Social Services (Staff #8), surveyor reviewed resident's admission assessment dated [DATE] and social services progress notes that did not reveal any documentation that advance directives was addressed with the resident. Staff #8 verified and confirmed surveyor's findings. The concerns regarding the failure to ensure advance directives was discussed with the resident/responsible was addressed with the Director of Nursing on [DATE] at 8:34 AM. No further documentation was provided. On [DATE] at 11:59 AM, additional review of social services progress notes revealed the following documentation on [DATE] at 9:32 AM: (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Note Text: DSS, followed back up with resident and provided resident with information on advance directives. DSS will continue to follow up with resident. Social Services. However, This was done after surveyor's intervention. Based on medical record review and interview, it was determined that the facility failed to ensure that advance directives were discussed with and/or information regarding advance directives was provided to residents and/or their responsible representatives (RP). This was evident for 2 (Resident #8 and #41) of 4 selected residents reviewed for advance directives during the recertification/complaint survey. Findings included: 1) On [DATE] at 11:40 AM, a review of Resident's #41 record revealed that the resident had capacity to make one's own decision, however, there was no documented evidence to support that the facility provided education and/or obtained Resident #41's advance directive. On [DATE] at 08:52 AM, in an interview conducted with the Director of social services (Staff #8), She stated that residents were evaluated on admission and if capable, they were asked about their ADs and copies requested to be placed in their paper chart. If a resident was deemed incapable and incapacity certification signed by the doctor, then Social Services will reach out to RP and ask for a copy that is kept in the resident's paper chart. Those residents that are deemed capable but do not have ADs are offered the opportunity to formulate one. On [DATE] at 01:33 PM, in an interview with Staff #8, she was asked about Resident #41's Advance Directive, and she stated that she will need to check and get back to the surveyor. She also stated that based on the previous surveyor interview, she was aware that a plan of correction will be required to address the missing AD documentation moving forward. The surveyor requested that Staff #8 provided any AD documentation for Resident #41, if available. On [DATE] at 01:55 PM, Staff #8 stated that there were no AD found for this Resident #41.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Deficiency Text Not Available

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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. 2) On 4/14/25 at 11:38 AM, a review of the Facility Reported Incident (FRI) #:MD00212896 revealed Resident #18 was observed by an ancillary staff member exposing their private area to Resident #38 in the resident's room. On 4/14/25 at 11:45 AM, a review of the facility investigation file revealed that the facility administrator was notified of the allegation on 12/19/24 at 4:45 PM; however, the allegation was reported to the Office of Healthcare Quality (OHCQ) on 12/19/24 at 7:38 PM, which was more than the 2-hour timeframe required. 04/14/25 at 02:24 PM, in an interview with the Director of Nursing (DON), the DON acknowledge the late reporting time after reviewing the documentation provided and confirmed that it was reported late, she stated she was not present in the facility at the time of the incident. Based on record review and interviews, it was determined the facility failed to ensure timely reporting of abuse allegations. This was evident for 2 (Resident #18 and #58) out of 6 residents reviewed for allegations of abuse during the complaint/recertification survey. Findings Included: 1) On 4/10/2025 at approximately 11:15 AM the surveyor notified Unit Manager Staff #16 that Resident #58 stated that a Geriatric Nursing Assistant (GNA), white lady with yellow big hair was very rough with him/her during care. The Resident added that when the GNA asked him/her to turn over, the GNA does not give him/her time to turn, and the GNA turns him/her very roughly. By 4/15/2025 at 2:00 PM the surveyor did not get any notification that this alleged incident was reported to the DON, the Administrator, or Office of Healthcare Quality (OHCQ). On 4/16/2025 at approximately 1:40 PM, the surveyor asked the DON if Staff #16 notified her of an alleged abuse incident. The DON stated that she did not get any information concerning this incident. The surveyor and the DON went to Resident #58's room and the Resident again stated that the GNA was rough with her, and she considered it abuse. On 4/17/25 at 2:00 PM before exiting the facility, the DON did not provide the surveyor with any evidence that this incident was reported to OHCQ within the 2 hours of hearing about the incident of an alleged abuse.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **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 provide the bed hold policy on transfer out of the facility and/or mail it to the resident's responsible representative. This was found to be evident for 1(Resident #58) out of 2 residents selected for the recertification/complaint survey. The findings include: On 4/14/2025 at 10:31 AM review of Resident #58's medical record revealed that the Resident was admitted on [DATE] and transferred out to the hospital on multiple occasions with the most recent transfer to hospital with return anticipation on 4/4/2025 and a re-admission to facility on 4/8/2025. On 04/14/25 at 10:54 AM further medical record review revealed that Resident #58 had a change in condition which was documented on 4/4/25 at 1840, that the Resident had a fall and was transferred out of the facility via 911. On 04/14/25 11:20 AM surveyor conducted an interview with Nurse #23 and asked about the process for when a resident is sent to the hospital. Nurse #23 said a packet is sent with the Resident, but she/he did not mention the bed hold policy as an item in the package. When the surveyor asked if the Resident was given a copy of the bed hold policy, Nurse #23 reported that she did not know what a bed hold policy was. An interview was conducted on 4/14/25 at 11:20 AM with Nurse #12, who stated that a bed hold policy was given to the Resident on transfer, but did not know if a copy was mailed to the resident's responsible representative. On 4/14/25 at 12:18 PM an interview was conducted with the Admissions Director, Staff #4. When the surveyor asked who mailed a copy of the bed hold policy to the responsible representative, Staff #4 stated that nursing is responsible for ensuring the Resident or responsible representative get a copy of the bed hold policy on transfer out. Staff #4 also added that the Resident signed a bed hold policy on admission and that is the copy on file. On 4/14/25 at approximately 1:00 PM, Staff #4 provided the Surveyor with a copy of the Bed hold policy and procedure that was Electronically signed on 3/12/2025 by Resident #58 as an acknowledgement of receipt of bed hold policy. There was no evidence that a copy was mailed to the responsible representative when Resident #58 was transferred to the hospital. An interview was conducted with the DON on 04/14/25 at 01:58 PM concerning the bed hold policy. DON stated that he/she was not aware that a copy had to be mailed to the responsible representative when Residents are transferred out of the facility. Surveyor stated that this was a concern and DON stated ok.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on medical record review and staff interview, it was determined the facility staff failed to ensure Minimum Data Set (MDS) assessments were accurately coded. This was evident for 1 (Resident #53) of 5 residents reviewed for antibiotic use during the recertification/complaint survey. The findings include: The Minimum Data Set (MDS) is a federally mandated assessment tool used by nursing home staff to gather information on each Resident's strengths and needs. The information collected drives resident care planning decisions. MDS assessments must be accurate to ensure that each Resident receives the care they need. During an interview with Resident#53 on 04/10/25 09:51 AM, the resident denied having a UTI and was unsure if he/she was taking antibiotics (ABX). A review of the Facility 30-day admissions Matrix on 4/10/25 at 11:02 AM indicated that Resident #53 is taking an ABX for a Urinary Tract Infection. On 4/13/2025 at 1:30 PM, the surveyor completed a record review for Resident #53. The review revealed an MDS assessment, dated March 23, 2025, at 12:12 PM in Section N0415. High-Risk Drug Classes: Use and Indication, F. Antibiotic checked yes. However, further record review for pharmacy orders for Antibiotic, and Medication Administration Records for Antibiotics failed to show evidence that the resident had been ordered or given antibiotics. 04/14/25 at 08:45 AM an Interview was conducted with the MDS Coordinator, staff #34. The surveyor asked the MDS coordinator how the MDS assessment is completed on admission. MDS coordinator stated that she/he opens the schedule assessment and goes to the Resident's hospital records, choose the Activities of Daily Living (ADLs) within the first 8 days and look back 7 days at the hospital records. MDS coordinator added that in the 7 days look back, the Resident is not assessed for medications that are not ordered on admission. On 04/14/25 at 08:51 AM, the MDS coordinator reviewed Resident 53's record for current and discontinued medication and stated that there were no ABX found. The surveyor asked MDS coordinator why was the MDS assessment coded for ABX. The MDS coordinator stated that it was a weekend MDS coordinated that completed the assessment and she/he could not provide an answer but agreed that the MDS assessment for ABX was coded incorrectly. On 04/14/2025 at 11:10 AM, Surveyor shared concern with DON who agreed that the MDS assessment for ABX was incorrectly coded.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, it was determined the facility staff failed to ensure that a PASARR screening (Preadmission Screening for Individuals with a Mental disorder and Individuals with Intellectual Disability) was re-evaluated as required. This was evident for 3 (Resident #9, #19, and #41) of 9 residents reviewed for PASARR screening during a recertification/complaint survey. The findings include: 1) Preadmission Screening and Resident Review (PASARR) is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care. Everyone who applies for admission to a nursing facility must be screened for evidence of serious mental illness (MI) and/or intellectual disabilities (ID), developmental disabilities (DD), or related conditions. The program assists in the placement and provision of services for individuals with severe mental illness and/or intellectual disability. The screening form only needs to be partly completed if a resident is expected to remain in a nursing facility for fewer than 30 days, but if the resident remains longer than 30 days, a new level 1 screen must be completed within 40 days of admission. A brief review of Resident #9's medical record on 4/9/2025 at 11:52 AM, revealed the resident was initially admitted to the facility on [DATE] and re-admitted on [DATE]. During the review, surveyor found a completed PASARR Level 1 form dated 11/25/2019 that revealed the resident needed to be referred to AERS (Adult Evaluation and Review Services) for further evaluation (level II PASARR screen). According to the screening instructions, the form was required to be completed again if the resident was not discharged from the facility within 30 days; it should have been completed within 40 days. However, there was no evidence in the clinical record that the PASARR screening form was completed within the required 40 days and/or that a Level II PASARR screen was done. Although Resident #9 was identified as a positive PASARR level 1 on admission, there was no evidence that the resident was sent to the appropriate agencies for further evaluation (PASARR level II screen). In an interview with the Director of Social Services (Staff #8) on 4/10/2025 at 8:57 AM, she stated that Level I PASARRs came from the hospital. If the resident did not have one filled out in the hospital, then Social services will complete the form in the facility. If a resident had a positive level 1 PASARR screen, i.e., meets criteria for Level II screening, Social services will contact AERS for a PASARR level II screen to be done. Surveyor requested from Staff #8 copies of Resident #9's PASARR screens. On 4/10/2025 at 9:46 AM, Staff #8 presented surveyor with a copy of Resident #9's PASARR level 1 screen dated 11/25/2019 and stated she did not find any other PASARRs in the resident's records. Staff #8 further confirmed that she did not find a PASARR level II screen in the resident's records and was going to follow up. On 4/11/2025 at 8:30 AM, In an interview with the Director of Nursing (DON), surveyor shared concerns regarding Resident #9's level 1 PASARR screen and no follow up Level II PASARR evaluation as identified on the level 1 screen dated 11/25/2019. No additional information was provided to surveyor. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) Review of the medical records for Resident #19 on 4/9/2025 at 12:35 PM revealed a completed PASARR form dated 12/14/2018 that indicated if the stay extended for 30 days or more, a new screen and resident review must be performed within 40 days of admission. The answers to section D (Categorical Advance Group Determinations) of the form indicated that Resident #19 needed to be referred to AERS for a level II PASARR evaluation. However, there was no evidence in the clinical record that the PASARR screening form was completed within the required 40 days and/or that a Level II PASARR screen was done for Resident #19. On 4/10/2025 at 9:44 AM, in an interview with the Director of Social Services (Staff #8), surveyor reviewed resident's PASARR level I screen dated 12/14/2018. Staff #8 reviewed and acknowledged that based on the screen, Resident #19 needed to be re-evaluated and/or referred to AERS for a follow evaluation (PASARR level II screen). Staff #8 confirmed that she did not find any other PASARRs and/or a PASARR level II screen in the resident's records. On 4/11/2025 at 8:30 AM, in an interview with the Director of Nursing (DON), surveyor shared concerns regarding Resident #19's level 1 PASARR screen and no follow up Level II PASARR evaluation as identified on the level 1 screen dated 12/14/2018. No additional information was provided. 3) On 04/10/25 at 10:59 AM, a review of Resident #41 chart revealed that the PASARR form, level I dated 4/22/2024 was completed; however, a review of section D of the PASARR level I form revealed that all answers were No and the form stated that if all answers to part D were No the resident should be referred to AERS for level II evaluation. On 04/10/25 at 11:11 AM, in an interview conducted with Director of social services (Staff #8), was asked about Resident #41's level II evaluation and she stated that the resident's PASARR didn't show a positive indication for a level II assessment but after speaking with another surveyor, they notice that based on the section D of the level I form, a level II PASARR was required. She stated that it was not completed but it will be addressed.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews with facility staff, it was determined that the facility failed to 1) Initiate a wound care plan for a resident with wounds, 2) initiate a care plan for a resident who was receiving hospice care, and 3) failed to develop a comprehensive care plan that included psychotropic and antidepressant medications. This was evident for 3 (Resident #6, #11 and #65) out of 19 residents reviewed for care plans during the Medicare/Medicaid recertification and complaint survey. The findings include: A care plan is an outline of nursing care showing all the residents' needs and the ways of meeting the needs. It is a dynamic document initiated at admission and subject to continuous reassessment and change by the nursing staff caring for the resident. Terminal prognosis means a disease is expected to lead to death and is not expected to be cured or adequately treated. In essence, it indicates a life-limiting condition where death is anticipated, regardless of medical interventions. 1) On 04/10/2025 at 08:44 AM, review of Resident #6's electronic health record showed that he/she was admitted into the facility on [DATE] and had diagnosis of epilepsy, hemiplegia and hemiparesis following cerebral infarction affecting left dominant side amidst other diagnosis and was also noted to have right lateral (buttocks) wound upon admission. On 01/28/2025, the resident was seen by the facility's wound team and documented stage 2 pressure wound of the right ischium partial thickness caused by pressure and on 03/25/2025, the wound team documented a venous wound of the left calf of the resident. On 04/10/2025 at 9:18 AM, further review of the resident's care plans revealed the facility staff failed to develop and implement a care plan with specific interventions and approaches to manage the resident's wounds. On 04/10/2025 at 09:23 AM, in an interview with the Long-Term Care Unit Manager, RN #14, she was asked who was responsible for initiating and updating care plans. She stated that the Unit Manager was in charge and that the Director of Nursing (DON) also assisted. When asked if wounds were care planned, she stated that a care plan was created for any open areas on residents, along with the necessary interventions. When she was asked if Resident #6 had a wound care plan in place, she stated that she did not see any care plan addressing the wound and that the resident should have had one. On 04/10/2025 at 09:52 AM, in an interview with the Director of Nursing (DON), while the administrator was present, she was asked about the process of initiating a care plan. She stated that care plans were initiated upon admission, when changes were noted, and generally as needed. When asked who initiated the care plans, she responded that the nurses and the Unit Managers (UM) were responsible, and that she assisted as well. When asked if Resident #6 had any wounds, she replied that she would need to review the chart. After reviewing the chart in the presence of the surveyor, she confirmed that the resident had been admitted with a pressure wound and currently had a venous wound. When asked whether there was a care plan for the wounds, she confirmed that there were no wound care plans in place and acknowledged that there should have been one. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) On 04/10/2025 at 12:00 PM, review of Resident #11's record showed that he/she had a terminal prognosis and was admitted to hospice care on 03/24/2025. On 04/11/2025 at 12:23 PM, in an interview with the Long-Term Care Unit Manager, RN #14, she was asked who oversaw the care plans. She stated that it was her responsibility and that the Director of Nursing (DON) also assisted. When she was asked if there was a hospice care plan for Resident #11, she stated that she did not find one. On 04/11/2025 at 12:25 PM, in an interview with the DON, when she was asked if there was a hospice care plan for Resident #11. She stated that the resident did not have a care plan for hospice admission and that she had planned on training the new Unit Manager on how to put in a care plan in the facility's electronic health record (EHR). 3) 04/15/25 at 12:59 PM, Resident #65's medical record review for unnecessary medications, psychotropic medications, and Medication Regimen Review (MRR) revealed that the resident was taking an antipsychotic and antidepressant medication for depression and bipolar disorder. Review of the care plan on 4/15/2025 at 1:15 PM indicated no antipsychotic or antidepressant medication were found on the medications and evaluation portion of the care plan. Therefore, there was no focus, goals or interventions outlined to meet the Resident's medical, nursing, mental, and psychosocial needs while taking these medications. Interview with the Director of Nursing on 04/16/25 at 09:26 AM confirmed the facility staff failed to develop and implement a comprehensive care plan to manage the medications of Resident #65, who is taking antipsychotic and antidepressant medications.

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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. Based on record review and interviews, it was determined that the facility failed to: 1) conduct an interdisciplinary care plan meeting as required, 2) revise or update the care plan to reflect the needs of the resident, and 3) failed to review and revise the interdisciplinary care plan for discontinuation of Physical Therapy (PT) and Occupational Therapy (OT). This was evident for 2 (Resident #18 and #60) of 19 resident care plans reviewed during the recertification/complaint survey. Findings included: The Minimum Data Set (MDS) is a standardized comprehensive assessment tool that measures health status in nursing home residents and is usually completed with on admission, quarterly, annually and with significant change of condition. A care plan is a tool used to summarize the resident's healthcare needs, treatments, and care goals. This tool is to be developed within 7 days after completion of the comprehensive assessment (MDS) and prepared by an interdisciplinary team. A care plan meeting is where healthcare professionals, residents and/or their family members come together to discuss and review a person's individual care plan and healthcare needs, treatment and care goals to ensure the best possible outcome for the resident. 1) On 04/09/25 at 09:19 AM, in an interview with Resident #18 during the initial screening process, the resident stated that he/she was not included or invited to attend care planning meetings to discuss the care and services provided and neither was the family representative. On 04/10/25 at 11:53 AM, a review of Resident #18's record revealed that on 8/24/24, 11/22/24 and 2/22/25, MDS assessments were completed; however, there was no documentation to support that the care plan meetings were conducted after each MDS assessment. There was no documented evidence to support that the care plan meeting including the resident and/or family was conducted to discuss the plan of care in 8/2024 and 2/2025. On 04/10/25 01:26 PM, in an interview with the Director of social services (Staff #8), when asked about the care plan meeting process, she stated that every three months the family was contacted to update them with any changes in the resident status, and the residents were usually in attendance if they choose to be involved in their care plan meetings. The families were notified via email and/or phone with voicemail. However, she admitted that they were not documenting when the unsuccessful attempt to contact families were made. She stated that Resident #18 chose not to participate in the care plan meetings even when he/she is in attendance. Therefore, the resident's representatives usually attend the care meetings at their earliest convenience, if available. When asked Staff #8 confirmed that there was no documented evidence that attempts were made by the facility to inform the resident representatives of any upcoming care plan meeting. Staff #8 also stated that in February 2025 the electronic health record (EHR) server went down, and they were not able to document in the EHR but the care plan meeting was conducted on 2/26/25 and both the resident and the resident representatives were in attendance. She stated moving forward they will put in place a system to document services on paper if the EHR server was not available. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) On 04/14/25 at 11:38 AM, a review of a Facility Reported Incident (FRI) MD00212896 revealed that on 12/19/24 a report was made to the Office of Healthcare Quality (OHCQ) regarding an allegation that Resident #18 wandered into female resident's room and exposed themselves to a female resident on 12/19/2024 at 4:45 PM. On 04/15/25 08:53 AM, a review of the Resident #18 cognitive status at the time of the event showed that the resident had an episode of cognitive impairment. A review of the resident's Brief Interview for Mental Status (BIMS) assessment revealed that the resident was deemed cognitively intact on 11/22/24; however, on 12/19/24 the resident's cognitive status was deemed severely impaired after the event and the subsequent brief interview for mental status assessments indicated that the resident returned to the baseline, which was cognitively intact. On 04/14/25 at 11:45 AM, a review of the facility investigative report for MD00212896 revealed that on 12/19/24 at 3:00 PM to 12/27/24 at 07:00 AM the facility initiated one-to-one monitoring by staff and behavioral assessments of Resident #18 were completed every 15 minutes. On 04/15/25 at 09:06 AM, a review of Resident #18's care plan revealed that on 02/03/22 a care plan for elopement/wandering was initiated and Resident #18 was identified to have an impaired safety awareness. Interventions initiated on 02/03/2022 were to include but not limited to; check for wander guard placement every shift, check for functioning every day; distract the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, and books. However, the review of the care plan revealed no evidence to support that the interventions were recently reviewed, revised or resolved, if applicable. The above-mentioned interventions were last revised on 04/23/22. Also, the last elopement assessment for Resident #18 was completed on 04/10/24. During the survey process observations of the environment revealed no concerns for elopement in the facility. On 04/16/25 at 03:23 PM, in an interview with the Director of Nursing, she acknowledged that the interventions documented were not updated and she also added that the resident was not a risk for elopement at this point. 3) On 04/10/25 at 09:32 AM the surveyor observed Resident #60 lying in bed with son at bedside. The son stated that he has not seen the resident getting Physical Therapy (PT) or Occupational Therapy (OT). On 04/10/25 at 10:45 AM during the medical record review there was an order written by the physician on 2/11/2025 for PT, OT, and Speech to evaluate and treat as indicated. The Care Plan review on 4/10/2025 at 10:50 noted PT/OT evaluation and treatment as per MD orders, which was created on 2/18/2025, Initiated on 2/18/2025, revision on 2/28/2025, with a target date of 5/13/2025. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Rehab Director, staff #5 on 4/10/25 12:52 PM, revealed that Resident #60 was discharged from PT and OT on 2/20/2025 because Resident #60 was not able to follow directions, was not progressing and was not fully participating in PT and OT. The Rehab Director also stated the Resident's daughter, who is the responsible party, was made aware and agreed to the discontinuation of PT/OT. The surveyor asked the Rehab Director how does discharge from rehab services got communicated to the nursing staff. The Rehab Director stated that information is passed on in morning meetings or during care plan meetings. Upon further record review on 4/10/25 at 1:02 PM, it was noted that the nursing staff was documenting on the skill notes that Resident #60 received PT, and or OT on the following days 2/21/25, 2/22/25, 2/27/25, 3/7/25, 3/10/25, 3/11/25, 3/15/25, 3/25/25, 3/26/25, 3/27/25 - 3/30/25, 4/1/25, 4/4/25, and 4/7/25, after PT/OT was discontinued on 2/20/25; and, the care plan had not been updated with the discontinuation of PT/OT. On 4/11/2025 at 08:00 AM The DON stated that unit managers are responsible for updating the care plans. The DON agreed that the care plan should have updated when PT/OT services were discontinued, and staff should not have documented on services that were not provided.

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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. Deficiency Text Not Available

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, medical record review, and interview, it was determined the facility failed to 1) properly date label oxygen tubing when changed, 2) follow physician's orders for the administration of oxygen, and 3) develop and implement a person-centered comprehensive care plan with resident centered goals for respiratory care to include oxygen therapy. This was evident for 1 (#15) of 3 residents reviewed for respiratory care during a recertification/complaint survey. The findings include: Oxygen (O2) therapy is a treatment that provides you with extra oxygen to breathe in. It is also called supplemental oxygen. It is only available through a prescription from your health care provider. On 4/9/2025 at 9:05 AM, surveyor observed Resident #15 in bed awake, alert, and oriented to person and place. The resident was wearing a nasal cannula (a device that delivers extra oxygen through a tube and into your nose) that was connected to a humidifier (water) bottle connected to an oxygen concentrator set at 4LPM (liters per minute). The LPM oxygen flow rate of 4 indicates that 4 liters of oxygen should flow into the resident's nose in 1 minute. The humidifier bottle was almost empty and dated 4/8/2025. However, the oxygen tubing/ nasal cannula was not dated. When asked, Resident #15 could not recall when the oxygen tubing was changed. On 4/9/2025 at 9:10 AM, Resident #15's nurse, Licensed Practical Nurse (LPN #12) observed and verified that the humidifier bottle was dated 4/8/2025 and the oxygen tubing had no date/time on it. When asked, Staff #12 did not know what flow rate the resident's Oxygen was supposed to be set to and when the oxygen tubing was last changed. During a review of Resident #15's medical record conducted on 4/11/2025 at 7:56 AM, surveyor noted an active physician order dated 1/7/2025 for: Oxygen 2LPM via NC (nasal cannula) Continuous every shift. There were additional orders dated 1/14/2025 for Change Oxygen tubing weekly on Tuesday one time a day every Tues for patency. Further review of the active orders did not reveal any order for humidification/use of humidifier bottle with the administration of the Oxygen. On 4/11/2025 at 8:04 AM, review of Medication Administration Record (MAR) and Treatment Administration Record (TAR) for March and April 2025 did not reveal any staff documentation that they were applying humidification (using humidifier bottle) with the administration of the Oxygen. Further review of the MAR and TAR for April 2025 revealed staff documentation that the Oxygen tubing was changed on Tuesday 4/8/2025. However, the Oxygen tubing when observed on 4/9/2025 had no date/time on it, and it was connected to a humidifier bottle (not in the orders nor in MAR/TAR). On 4/11/2025 at 8:22 AM, a review of Resident #15's care plan did not reveal a care plan focus for Oxygen therapy with goals and interventions. The care plan was not comprehensive and resident centered. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/11/2025 at 12:04 PM, in an interview with the Director of Nursing (DON), surveyor reviewed resident's orders for Oxygen, staff documentation on the MAR/TAR, oxygen care plan, and surveyor's observations on 4/9/2025 regarding resident's Oxygen tubing not being labeled, Oxygen set at 4L instead of 2L as ordered, orders not addressing use of humidifier, and resident's care plan not having a focus on Oxygen therapy with goals and interventions. DON stated that the Oxygen tubing should be changed once a week and labeled with date/time. Regarding care plans, DON stated that she would expect to see Oxygen therapy addressed on the care plan with goals and interventions. DON added that she was aware of surveyor's observation/concerns and the corrections were made and the Oxygen tubing changed/labeled and flow rate set correctly.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on medical record review and interview with facility staff, it was determined that the facility failed to document the use of nonpharmacological methods for pain management. This was evident in the review of 2 (Resident #58 and #65) of 5 reviewed for unnecessary medications during the recertification/complaint survey. The findings include: 1.On 4/15/25 at 11:51 AM during an unnecessary medication review for Resident #58, the surveyor found a physician order dated 3/12/2025 for Roxicodone Oral Tablet 5 MG Give 1 tablet by mouth every 4 hours as needed for pain 6-10 or prior to physical therapy. The care plan review on 4/15/25 at 11:53 noted that the RN and LPN must use the nonpharmacological interventions for pain management: Turn and Reposition, music, television, low light, hot application, cold intervention, and reduce noise. On further medical record review on 4/15/25 at 11:55 AM, the surveyor noted that there was no documentation of the nonpharmacological pain interventions on the Treatment Administration Record (TAR) therefore, there was no way to validate that nonpharmacological measures were used prior to the administration of pain medication. 2. A record review conducted on 04/15/25 12:59 PM for Resident #65 revealed a physician order for tramadol 50 mg, 1 tab every 12 hours for pain. On 04/16/25 09:26 AM, review of the care plan initiated on 03/23/2025 stated that the LPN and RN should use nonpharmacological interventions for pain management: Turn and Reposition, music, television, low light, hot application, cold intervention, and reduce noise. On further medical record review on 4/16/25 at 09:55 AM, the surveyor noted that there was no documentation of the nonpharmacological pain interventions on the Treatment Administration Record (TAR) therefore, there was no way to validate that nonpharmacological measures were used prior to the administration of pain medication. An interview on 04/16/25 at 09:58 AM with the Director of Nursing revealed that the interventions from the care plan should be added to the TAR by nursing. The DON agreed that there were no documentation to validate that the nonpharmacological means were being implemented and that they would be added to the TAR template.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. Based on medical record review and interview with facility staff, it was determined that the facility attending failed to follow up with the hospital discharge recommendations and her own physician notes related to a cardiac consult for a resident with a diagnosed cardiac condition. This was evident during the review of 1 (Resident #52) of 3 residents regarding coordination of care during a recertification/complaint survey. The findings include: Left ventricular thrombus is a blood clot (thrombus) in the left ventricle of the heart After meeting with Resident #52 in his/her room on 4/9/25 after an initial tour of the facility, his/her medical record was reviewed at 11:25 AM. Resident #52 was admitted to the facility in February of 2024 after a hospital admission related to increased confusion. During that hospitalization, Resident #52 was identified as having a cardiac ejection fraction of 20-25% (A normal ejection fraction (EF), which measures how much blood your heart pumps out with each beat, typically ranges from 55% to 70%), prior stroke, ischemia cardiomyopathy, coronary artery disease status post percutaneous coronary interventions (balloon to open a blocked artery) and recently diagnosed with a left ventricular thrombus. Resident #52 was discharged from the hospital with recommendations to follow up with a cardiologist within 3 months and continue an anticoagulant for minimally 3 months secondary to his/her cardiac status. Attending #17 was interviewed on 4/10/25 at 11:06 AM and she acknowledged caring for Resident #52 since his/her admission. She was interviewed regarding Resident #52's hospital discharge recommendations and consult to see a cardiologist. She stated that 'you have to ask the facility.' The surveyor clarified with Attending staff #17 that the recommendation from the hospital was to see a cardiologist within 3 months and to be on the anticoagulant for 3 months. This surveyor also reviewed Resident #52's medical record concurrently with Attending #17 and noted that Resident #52's anticoagulant was stopped between 4/19 and 5/16/24. Attending staff #17 stated well it was restarted, referring to the anticoagulant. She then stated that 'the point of the 3 months for the anticoagulant was for him to follow up with the cardiologist, not to stop it. With the thrombus that he had you can't be off the anticoagulant.' This surveyor continued to clarify with Attending #17, that Resident #52 was off the anticoagulant within 2 months of admission to the facility for 1 month. She stated to the survey team that 'Resident #52 needed and needs to see a cardiologist and it's on the facility.' This surveyor asked if the resident ever saw a cardiologist and she stated she didn't know. This surveyor asked if she had written out an order for Resident #52 to see a cardiologist and she stated that she could have just said it verbally. This surveyor reviewed with Attending #17 that there was no consultation in the chart. Attending #17 said that the surveyors need to check with the facility about the consultation. She then stated that on July 28, 2024, she wrote a note that Resident #52 needed to see a cardiologist and the fact Resident #52 didn't need to follow up with the facility as it's on them not her. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON was interviewed on 4/10/25 at 11:16 AM, in the presence of Attending #17. The identified concern related to Attending #17's failure to monitor and follow up on Resident #52's plan of care was reviewed at this time. Specifically, the concern that Resident #52's Attending #17 was aware of the residents need to see a cardiologist timely based on his/her cardiac diagnosis of the LV thrombus as reported from the hospital discharge summary in 2024 and failed to follow through with the resident's needs. The DON followed up with the survey team on 4/10/25 at 12:00 PM, the Resident is scheduled to see a cardiologist today. On 4/10/25 Resident #52 saw a cardiologist who ordered him/her to have an Echo (ultrasound test that provides a detailed view of the heart's structure and function) which was subsequently scheduled for 4/15/25.

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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 interviews with the staff, it was determined that the facility failed to post all of the required staffing information on a daily basis. This was evident in the facilities main entrance and common areas observed during the recertification/complaint survey. The findings include: On 4/9/25 at 7:45 AM, upon walking into the facility, it was noted that there was no nurse staff information posted in a prominent place and readily accessible to visitors and residents. Observations were made during the rest of the survey from 4/10/25 to 4/17/25. During these observations, there was no nurse staff information posted. On 4/15/25 at 11:15 AM, during an interview with the Director of Nursing and the Staffing Coordinator #1, they both stated that they were unaware of the need for staff information to be posted in a prominent location that is accessible for visitors and staff.

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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. 2) On 4/10/2025 at 11:57 AM, a record review of Resident #19's drug regimen review from October 2024 through March 2025 was completed: Two (2) dates (10/30/2024 and 2/28/2025) had notations that irregularities were identified and recommendations made by the consultant Pharmacist. On 4/10/2025 7:39 AM, Surveyor requested from the Director of Nursing (DON) the 2 drug regimen reviews (10/30/2024 and 2/28/2025) that had identified irregularities with recommendations from the consultant Pharmacist. On 4/11/2025 at 8:26 AM, in an interview with the DON, she stated that residents' drug regimen was reviewed monthly by a consultant Pharmacist. She stated that after each review the consultant Pharmacist sends an email with consultation and recommendations attached to the DON and sometimes to the attending Physician. DON further stated that she prints copies of the report and give to Unit Managers (UM) to follow up with the physicians regarding irregularities identified and recommendations made by the consultant Pharmacist. Regarding the pharmacist reviews/recommendations for 10/30/2024 and 2/28/2025, DON stated that she could not find the pharmacy recommendation reports in Resident #19's chart. When asked what the irregularities/recommendations were and/or if they were reviewed by Resident #19's physician, DON stated that she did not know but will look through her emails to see if she could find the missing pharmacy reviews. On 4/17/2025 at 1:45 PM prior to survey exit, DON did not provide any additional information and/or documentation regarding the missing consultant Pharmacist drug regimen reviews for 10/30/2024 and 2/28/2025 that identified irregularities. Moreso, she did not know what the irregularities/recommendations were and hence, could not provide proof that those irregularities/recommendations were addressed by Resident # 19's physician. Based on medical record review and interview with facility staff, it was determined that the facility failed to provide and show documentation that the attending physician reviewed any irregularities identified by the pharmacist. This was evident for 2 (Resident #52 and #19) of 5 residents that were reviewed for drug regimen reviews during the recertification/complaint survey. The findings include: 1) On 04/10/25 at 09:24 AM, Review of Resident #52's medical record revealed 4 dates (2/28/24, 7/30/24, 10/30/24, 12/31/24) with irregularities identified during drug regimen reviews (DRR) completed by the pharmacist. On 4/10/25 at 10:15 AM, after an interview with the Director of Nursing (DON), the surveyor asked her to provide documentation of the drug regimen reviews (DRR) from the dates identified with irregularities. The DON responded back to the surveyors at 10:41 AM that she was only able to locate one (2/28/24) of the requested DRR and she was not able to locate the other dates of documentation and that they were not able to provide proof that the reviews were completed and seen by the appropriate discipline. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the facility's policy for drug regimen reviews revised in 2025, provided 4/11/25 at 10:29 AM, the facility failed to do the following: In section 5. The pharmacist shall communicate any irregularities to the facility in the following ways: b. Written communication to the attending physician, the facility's Medical Director, and the Director of Nursing In section 6. Written communications from the pharmacist shall become a permanent part of the resident's medical record. In section 7. Timelines and responsibilities for the Medication Regimen Review: b. The pharmacist shall communicate any recommendations and identified irregularities via written communication within 10 working days of the review. These concerns were reviewed with the DON on 4/11/25 and again at exit on 4/17/25.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, it was determined that the facility failed to implement behavior monitoring for residents receiving antipsychotic medications. This was evident for 1 (Resident #65) out of 5 residents reviewed for unnecessary medications during the recertification survey. The findings include: Medical record review on 4/15/25 at 12:59 PM found that Resident #65 was admitted to the facility on [DATE] with diagnoses including bipolar disorder. Further review on 4/15/25 at 1:10 PM revealed a physician order dated 3/12/25 for Risperidone Tablet 0.25 MG Give 1 tablet by mouth at bedtime for bipolar disorder, give with 0.5 mg for total dose of 0.75mg. On 4/15/25 at 1:20 PM the surveyor noted the psychiatry initial consult notes dated 3/20/25 stating that, There are no reports of disturbances in his sleep, patterns or appetite, indicating stability in these areas. He also denies any suicidal ideation (SI) or homicidal ideation (HI), suggesting he does not have thoughts of wanting to harm himself or others. Furthermore, he reports no experience of hallucinations or delusions. Throughout the visit, no signs of agitation, irritability, or aggression were noted, reflecting a calm and stable demeanor. The assessment and plan indicated that if the Resident's mood continues to be stable, the psychiatrist will consider a gradual dose reduction (GDR) and Discontinuation (D/C) of risperidone. On 4/15/25 at 1:30 PM a review of the Treatment Administration Record (TAR) did not have the behavior monitoring that are associated with antipsychotic medications. On 04/16/25 at 10:58 PM the DON was made aware that this was a concern because the behavior monitoring tool was to be used for the psychiatrist to consider GDR or D/C of the antipsychotic medication. The DON agreed.

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	215060	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Care of Silver Spring, LLC	9101 Second Avenue Silver Spring, MD 20910

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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 interviews with facility staff, it was determined the facility failed to: 1) Remove outdated nourishment from the refrigerator, 2) ensure a sanitary environment in cleaning food items, and 3) ensure the labeling, dating, and expiration of food items. This was found to be evident during the facility's recertification/complaint Medicare/Medicaid survey and has the potential to affect all residents who consume food prepared in the facility's kitchen. The findings include: During the initial tour of the kitchen conducted on 04/09/2025 08:08 AM, a quarter jar of yellow mustard with open date of 12/05/2024 was seen in the refrigerator. At 08:13 AM of the same day, a dual observation with the dietary aide staff #10 was done and he stated that the jar should have been removed from the refrigerator, and he took it out. On the same day at 8:19 AM, a tray containing celery, onions, and two green peppers was observed in the manual rinse compartment of the three-compartment dishwasher sink. When Staff #11 was asked why the vegetables were in the sink, she stated that she was planning to rinse them. Upon further questioning whether vegetables are typically rinsed in that area, she admitted that she sometimes does so but acknowledged that she should have used the designated food preparation sink instead. She further stated that the vegetables should not have been placed in the rinse compartment and promptly removed them to be rinsed in the appropriate food prep sink. On 04/09/2025 at 08:25 AM, the surveyor informed the Director of Dietary (DoD) #9 of the concerns from the kitchen tour. In response to the issue of the vegetables being in the dishwasher rinse compartment, Director of Dietary (DoD)#9 stated that they should have been in the designated vegetable rinsing area. The surveyor also brought to her attention a quarter jar of yellow mustard found in the refrigerator. Staff #9 acknowledged this and stated that the mustard should have been discarded and not stored in the refrigerator. On 04/09/2025 at 08:38 AM, During a joint observation with the Director of Dietary (DoD) #9, the surveyor observed two and a half loaves of sliced bread in the refrigerator with an expiration date of 04/08/2025. She acknowledged that the bread should have been discarded as of that date and immediately removed it from the refrigerator. On 04/09/2025 at 8:41 AM, the surveyor observed an unlabeled and undated frozen meat item in the freezer, which Director of Dietary (DoD)#9 identified as rose pork loin. She stated that the meat should have been labeled and dated immediately after being removed from its original packaging. According to her, the meat had been delivered on 04/07/2025 and that there was no way the surveyor would have know the delivery date. She proceeded to remove the item and stated she would label and date it appropriately.

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F 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ staff that are licensed, certified, or registered in accordance with state laws. Based on employee file reviews and interviews with staff, it was determined that the facility failed to ensure that nursing staff had an active license. This was evident for 1 (LPN #24) of 5 licensed health care professionals reviewed during the recertification/complaint survey. The Findings include: The Maryland Board of Nursing (MBON) is the agency charged with the regulatory oversight of the practice of nursing in the State. The MBON's mission is to preserve the field of nursing by advancing safe, quality care in Maryland through licensure, certification, education, and accountability for public protection. All licensed practical nurses must have an active license in order to work. The primary source verification of certification status is found in the Look Up A License feature of the MBON website. This secure program is updated daily. On 4/14/25 at 12:15 PM 5 employee files were reviewed. During this review the surveyor was checking that the health care professionals had an active license. The employees were entered into the Look Up A License feature on the MBON website to obtain their license status. It was found that License Practical Nurse (LPN) #24 had a license status of NON-RENEWED and an expiration date of 1/28/2025. On 4/14/25 at 1:30 PM, Human Resource/ Staff Scheduler #1 was interviewed. During the interview she was asked how she keeps track of employee licenses and expiration dates. She said that she kept a spread sheet of all employee licenses and expirations and would send out reminders to employees when their licenses were close to expiring. At this time she was made aware of the concerns related to LPN #24 working without an active license. The Director of Nursing was also made aware of the concern on 4/14/25 and again at exit on 4/17/25.

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. Based on record review and interviews with the staff, it was determined that the facility failed to provide outside services to a resident in a timely manner. This was evident for 1 (Resident # 52) out of 3 residents that were reviewed for coordination of care during the recertification/complaint survey. The Findings Include: Left ventricular (LV) thrombus is a blood clot (thrombus) in the left ventricle of the heart Resident #52's medical records were reviewed on 4/10/25 at 09:14 AM. There was a physicians note from 2/29/24 stating that the Resident was a new admission after being hospitalized for Cerebral Vascular Accident (CVA) caused by an LV thrombus, a blood clot that forms inside the left ventricle of the heart. Per the hospital's recommendations at time of discharge, resident was to continue taking an anticoagulant for 3 months minimum with reassessment for LV thrombus as outpatient with cardiology. It also stated that s/he would need repeat imaging to assess the LV thrombus in three months. All physician's notes were reviewed by the surveyor from 2/29/24 to 3/28/25. There was only one note (7/28/24) where Attending #17 addressed the need for Resident #52 to be seen by an outpatient Cardiologist. On 4/10/25 at 10:22 AM, Resident #52's orders were reviewed and revealed that Attending #17 failed to order the resident a cardiology consult at any point from admission to the current review, a year later. An interview was conducted with Attending #17 on 4/10/25 at 11:06 AM. During the interview the physician was asked about Resident #52 and the need for an outpatient cardiology appointment. Attending #17 said that the doctors only make the recommendations, which can be verbal, and if they are not followed through by the facility, then she has no control over that. When asked about following up on her recommendations in her note from 7/28/24 for the resident to see an outpatient cardiologist, she said that it was up to the facility to get the patient the cardiology appointment. On 4/10/25 at 11:10 AM in the presence of Attending #17 the DON was interviewed and notified of the concern related to Resident #52 's lack of a cardiology consult and Attending #17 relinquishing responsibility for the consultation to the facility.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Deficiency Text Not Available

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. Based on record review and interviews with facility staff, it was determined that the facility failed to obtain a hospice plan of care for resident receiving hospice services to ensure that the needs of the resident were addressed and met. This was evident for 1 resident (Resident #11) out of 1 resident reviewed for hospice plan of care notes during the Medicare/Medicaid recertification/complaint survey. The findings include: Terminal prognosis means a disease is expected to lead to death and is not expected to be cured or adequately treated. In essence, it indicates a life-limiting condition where death is anticipated, regardless of medical interventions. Hospice care is a specialized form of healthcare that provides comfort and support to terminally ill patients and their families. It focuses on managing pain, symptoms, and other physical, emotional, and spiritual needs during the end of life. On 04/10/2025 at 12:31 PM, Resident #11's paper medical record on the unit was reviewed for the hospice plan of care, communication process and related documentation, but none was found. The Electronic Health/Medical Record (EHR) was also reviewed for the hospice plan of care, but none was found there either. On 04/10/2025 at 12:42 PM, the hospice plan of care and communication process was requested from the Long-Term Care Unit Manager, RN #14. After checking the resident's paper and electronic medical records, she informed the surveyor that the documents were not present. When asked if there should be a plan of care in place for the resident, she stated that there should have been one in the resident's health records. She added that she did not understand why it was not available and that she would request the plan of care from the hospice services because that is what the facility would use to make sure the resident's needs were met. On 04/11/2025 at 7:42 AM, When the surveyor informed the Director of Nursing (DON) that she had requested a copy of the hospice plan of care for Resident #11 from Long-Term Care Unit Manager, RN #14 but had not yet received it, the DON stated that she was waiting for the plan of care and other related documents to be faxed from the hospice services. At 08:55 AM of the same day, the DON provided the documents to the surveyor and was informed that the unavailability of the plan of care was a concern. She acknowledged the concern and stated that she would work to ensure that hospice plans of care are made available moving forward.

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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 **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility documentation and staff interview, it was determined that the facility failed to have a Quality Assurance and Performance Improvement (QAPI) committee meeting at least quarterly and with enough frequency to conduct the required (QAPI) activities. This was evident during the recertification/complaint survey. The findings include: Review of the Quality Assurance Committee sign-in sheets for the last year (January 2024 to March 2025) revealed that the facility held meetings on 1/2/24, 2/27/24, 3/26/24, 4/30/24, 5/3/24, 7/24/24 and 12/24. There were no documented evidence that the Quality Assurance Committee meeting was held quarterly in June 2024 and from [DATE] to [DATE]. In an interview with the Director of Nursing (DON) on 4/17/25 at 11:22 AM, he/she stated that the facility's computer system was hacked, and she cannot provide the information. When the surveyor asked about paper documentation, the DON stated that there was none. The DON was made aware that this was a concern on 4/17/25 at 12:10 PM during the QAPI facility task investigation.