

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215065	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/02/2024
NAME OF PROVIDER OR SUPPLIER  Bel Pre Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2601 Bel Pre Road Silver Spring, MD 20906	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 30428</p> <p>Based on medical record review and interview, it was determined that the facility failed to accurately and appropriately identify a residents health status and representative in order to change a resident's code status. This was evident during the review of 1 of 3 (#16) residents reviewed during a complaint survey.</p> <p>The findings include:</p> <p>The Maryland Orders for Life Sustaining Treatment (MOLST) form is a portable and enduring medical order form covering options for CPR (on the front page) and other life-sustaining treatments (on the back page). The medical orders are based on a patient's wishes about medical treatments.</p> <p>Review of the medical record for Resident #16 on [DATE] at 9:37 AM revealed diagnosis to include chronic obstructive pulmonary disease and rheumatoid arthritis. Resident #16, who was admitted back in 2022 was transferred to this facility with a MOLST documenting that s/he was full code according to the patients' health care agent as named in their advanced directive.</p> <p>According to this ongoing review in [DATE], Resident #16's MOLST was changed from full-code status to DNI-A-2 do not intubate. According to this new MOLST it was per the resident's surrogate decision maker. Then in [DATE], Resident #16 was placed in hospice and his/her MOLST was changed to DNR-B per the residents' surrogate decision maker. Noted on the MOLST's the surrogate decision maker was noted as the resident's child, however, a comprehensive review of the residents' medical record failed to reveal any advanced directive documentation or documentation in the record of Resident #16's end of life wishes.</p> <p>Further review on [DATE] at 10:00 AM failed to reveal any certifications on the medical record of medical ineffectiveness that would then allow a surrogate decision maker to change the MOLST. Further there were no advanced directives available on the chart to determine what the resident's wishes were or who s/he wanted to represent him/her to make decisions related to life sustaining treatment.</p> <p>The attending physician, staff #1, was interviewed on [DATE] at 12:15 PM. She acknowledged changing the MOLST in April. She also acknowledged not being fully aware of the policies and procedures and laws that go along with changing a MOLST and who has the legal authority when it comes to residents, surrogates, guardians and healthcare agents in relation to who has the authority and when to make changes to a resident's MOLST.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The concern that the surrogate that was allowed to change Resident #16's MOLST did not have the proper authority in October and again in April was reviewed with physician, staff #1 at this time.</p> <p>The collaborative concerns that were identified were reviewed with the facility NHA and regional nurse on [DATE] at 7:30 AM.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 31982</p> <p>Based on observation and interview with staff it was determined the facility failed to provide services to maintain a clean, safe, comfortable and homelike environment. This was evident for 2 of 2 units in the facility and in the kitchen.</p> <p>The findings include:</p> <p>During observational rounds of the facility on 9/23/24:</p> <p>The surveyor observed on the 2nd floor at 10:15 AM-</p> <p>room [ROOM NUMBER] - A hand sink was located in a small alcove within the room on the wall to the left of the bathroom door. Three 4 inch by 4 inch (4x4) ceramic wall tiles, missing from the wall below and to the right of the sink, were stacked on the floor below the sink.</p> <p>A 1x1 hole was observed completely through the wallboard along the top of the rubber shoe molding, located between the bathroom door and the alcove.</p> <p>Numerous cracked floor tiles were observed throughout the room. The cracks and gaps in the seams between the tiles were black.</p> <p>The shared bathroom between rooms [ROOM NUMBERS] - A wall panel covered the long shower wall and extended from the floor approximately 3 feet up the wall. A hole approximately 2 tall x 4 long extended along the top edge of the panel.</p> <p>The shower head bracket was broken, and the handheld shower head was hanging by its hose.</p> <p>The shoe molding behind and to the left of the toilet was pushed into the wall creating a 1/2 gap approximately 1 foot long along the floor.</p> <p>The wall above the molding was crumbled, a few patches of spackling were observed on the wall. Spackling is an unfinished porous surface and cannot be cleaned and sanitized.</p> <p>The metal framework of the drop ceiling was hanging down in areas and had rust colored patches. The ceiling panels were not fitted securely into the framework and gaps approximately 1/4-1/2 wide were visible.</p> <p>A toilet plunger was on the floor and uncovered in the corner to the right of the toilet.</p> <p>The threshold was missing in the doorway between the bathroom and room [ROOM NUMBER] with exposed subfloor, the edge of the bathroom floor vinyl was curling upward.</p> <p>A piece of floor tile approximately 6x12 was missing from the bedroom side of the doorway.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In the short hallway located to the left of the elevator the surveyor observed the shoe molding pulled away from the wall leaving a 1 gap approximately 1.5 feet long.</p> <p>On 9/23/24 at 10:40 AM The surveyor observed:</p> <p>The hallway left of the door to room [ROOM NUMBER] shoe molding was coming away from the wall creating a gap 1/2 by 12 long.</p> <p>On the wall to the right of room [ROOM NUMBER] were several scrapes in the lower part of the wall exposing the underlying wallboard.</p> <p>A scrape measuring 2x1x3 was observed in the wall to the right of the door labeled Doctor's and Therapy office on the 2nd floor.</p> <p>At 10:44 AM the surveyors observed the 1st floor:</p> <p>In the hallway-</p> <p>The flooring across from room [ROOM NUMBER] had a 2x1 scrape.</p> <p>The handrail to the left of room [ROOM NUMBER] was observed to have a foot long area where the wood was splintered, the other side had a 2-foot area where the finish was rubbed down exposing the bare wood with the potential to cause splinters in the residents' hands.</p> <p>The handrail between the Biohazard room and another locked room, that had no sign attached, diagonal from room [ROOM NUMBER] had exposed wood that could potentially cause splinters; the corner rail had exposed wood and was splintered as well as the handrail across from room [ROOM NUMBER] that extended between the stairway door and kitchen area.</p> <p>The Shoe molding at the base of the wall across from room [ROOM NUMBER] was missing, crumbling wall plaster exposed; the trim around the corner of the wall was pulled away leaving a 1 gap over a length of approximately 1 foot.</p> <p>Approximately 6 of shoe molding at the base of the wall to the left of room [ROOM NUMBER] was pulled away from the wall about 1 leaving a gap.</p> <p>The corner of the wall across from the nurses' station was damaged at the bottom. Plaster was exposed with a hole approximately 4x1.</p> <p>The metal corner shield was loose from the wall.</p> <p>A box type outlet was mounted on the wall to the right of the housekeeper closet. The plate on the front of the outlet box was loose and the corners were bent outward.</p> <p>The wall around the outlet had exposed, unfinished spackling.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An outlet box was mounted on the wall in the hallway between rooms [ROOM NUMBERS]. Another outlet was located in the wall beside the outlet box. A nickel size hole through the wallboard was observed between the 2 outlets.</p> <p>A deep scrape was observed into the wall board between the outlets and room [ROOM NUMBER].</p> <p>Another deep scrape was located in the wall across from room [ROOM NUMBER].</p> <p>The wall to the right of room [ROOM NUMBER] had a hole approximately 2 diameter through the wall board.</p> <p>The Threshold to room [ROOM NUMBER] was loose from the floor and displaced on the right side.</p> <p>The floor tiles within room [ROOM NUMBER] were observed to be cracked in multiple places. The cracks and gaps in the seams between the tiles were black.</p> <p>Several holes were observed in the surface of the flooring in front of room [ROOM NUMBER]. 2 were approximately 1x1, 1 was 2x3 and another was approximately 1.5x14.</p> <p>The base of the left side of the metal door frame of room [ROOM NUMBER] was missing approximately 5 from the floor with jagged edges. A pile of gray crumbled sand like debris was piled in the void and under the edge of the flooring.</p> <p>The front of the heating/cooling unit located in the hallway to the right of room [ROOM NUMBER] was loose.</p> <p>room [ROOM NUMBER] A - There were no handles on the 1st and 2nd drawer of the bedside stand.</p> <p>There was a brown substance on the wall to the left of the glove dispenser.</p> <p>The same wall behind the bedside stand had a scrape that extended 3 feet horizontally. The area was patched but not painted. It appeared that the patched area had been scraped open.</p> <p>A spoon was observed on the floor at the bottom of the bed wheel, a straw wrapper was laying on the floor inside the door.</p> <p>Scrapes were observed on the wall about 3 feet up extending horizontally about 5 ft.</p> <p>A bath basin was on top of a trash can with clothes in it.</p> <p>The back of the door was scraped with white showing.</p> <p>On 9/23/2024 11:00 AM the surveyor observed a foul smell upon entering room [ROOM NUMBER].</p> <p>The bedside table was dirty.</p> <p>A scrape was observed along the wall to the left of the bathroom door.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An observation was made on 9/25/24 at 11:09 AM of room [ROOM NUMBER]. The room contained 4 beds. Residents were observed asleep in beds A and B, beds C and D were empty, and the residents were not in the room.</p> <p>A square box type light fixture approximately 2 feet square was located on the ceiling in the center of the room. 1 corner of the light cover was detached and hanging several inches below the box type frame of the fixture. several pieces of duct tape were affixed at 1 end to the light fixture frame above the hanging cover. The other ends of the tape were dangling and not attached to anything.</p> <p>Above bed A was a hole through the ceiling approximately 1x2, beside a support bracket for the hanging privacy curtain track.</p> <p>Both windows in the room were missing plastic vertical blind slats.</p> <p>Small bits of paper scraps, napkins and other small debris were observed on the floor under and around beds C and D.</p> <p>A maroon plastic bowl was on the windowsill beside bed C. The bowl contained 3 forks a very small amount of what appeared to be milk and small bits of cereal pieces.</p> <p>The same room was observed again on 9/26/24 at 11:16 AM. Residents were observed asleep in beds A, B and C. Bed D was empty and the resident was not in the room.</p> <p>Located in the center of the room was a wheelchair closest to the foot of A bed which had several blankets on its seat, a Rollator walker close to the foot of D bed had a blanket and a large thick padded elbow/heel protector on its seat. 2 large opaque trash type bags were on the floor of the room. 1 contained several tan adult briefs, the other contained blankets, hospital type gowns and other miscellaneous linens.</p> <p>2 overbed tables were also in the center of the room closest to beds C and D. Each table had a clear plastic water cup with a lid and straw. Both cups were dated 9/25/24 (the day before).</p> <p>The bottom of the bathroom door was broken on both sides with a 4x8 area of splintered wood on the inside.</p> <p>The sink in the bathroom had approximately 5 of standing cloudy water which was not draining. The plastic double roll toilet paper dispenser was hanging open and empty.</p> <p>Another hand sink was located outside of the bathroom. The floor below the sink was missing tiles. A pink rectangular wash basin was on the floor below the sink it was labeled 205-2.</p> <p>On 9/26/24 at 11:21 AM, Staff #10 a Licensed Practical Nurse was shown the above items in room [ROOM NUMBER]. When asked about the plastic bags he stated, they're dirty and they're not supposed to be on the floor. He was made aware of the standing water in the bathroom sink, the broken door and the pink basin on the floor. He indicated that the basins should be stored in the resident's nightstand or in their drawer.</p> <p>The kitchen was observed on 9/26/24 at 10:04 AM and the following observations were made:</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A door to the cleaning area did not fully close.</p> <p>Paint was peeling on the ceiling outside the dry storage room.</p> <p>Near the exit door were 2 ceiling tiles with a 1 - 1.5 in gap at the wall.</p> <p>In the dry storage room:</p> <p>Cobwebs were observed in the corner straight inside the doorway.</p> <p>A cheerio was laying on the floor.</p> <p>A pipe extending up the wall midway on the left side was wrapped with insulation, taped with electric tape and duct tape at the bottom which was coming off with gaps at the wall. Insulation was laying on the floor.</p> <p>Two plastic bins were observed on the floor directly in front of the pipe, one contained flour and the other had sugar in it. When moved cheerios were observed on the floor.</p> <p>Across from the bins was a metal storage rack. A hole 1.5 feet long by 1-3 wide was observed in the wall behind the storage rack.</p> <p>The 5th ceiling tile from the door in the second row in had a gap.</p> <p>During an interview on 9/26/24 at 10:12 AM Staff #26 a Dietary Aid reported the dry storage room was cleaned with each shipment. She stated the shelving was moved out and swept under. She reported she had not noticed the large hole in the wall. She stated that staff swept and mopped in there every day.</p> <p>On 9/26/24 at 10:15 AM an interview was conducted with Staff #27 the Culinary Director. She indicated she was not aware of the hole and stated if she had seen the hole, she would put it in the TEL's (electronic maintenance) system to alert maintenance.</p> <p>During an earlier interview on 9/24/24 at 1:09 PM Staff #8 a maintenance technician indicated he started working in the facility on 5/30/24. Staff #7 indicated that he is the maintenance director at a sister facility and that there had been no maintenance director in this facility for several weeks.</p> <p>Walking rounds were conducted with the Administrator, the Staff #7 and Staff #8 on 10/2/24 at 10:55 AM. They were made aware of the above concerns and shown the above findings. The standing water was no longer present in the sink in room [ROOM NUMBER]. However, no water came out of the spigot when the cold water was knob was turned on by Staff #8.</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>42886</p> <p>Based on record review and staff interview; it was determined that the facility failed to protect resident (resident #9 and #28) from physical abuse from a facility staff member. This was evident for 2 of 41 residents reviewed during a complaint survey.</p> <p>The findings include:</p> <p>1) Record review on 9/23/24 at 12:00 PM revealed resident #9 complained to the facility's administration that he/she received painful ADL care from GNA #15 on 3/7/24. The facility investigated the complaint from resident #9 and determined that GNA #15 failed to use a gait belt, an assistive device that is used to stabilize a physically impaired person during transfers including from bed to chair. The unsafe transfer caused resident #9 from his/her bed caused the resident to experience pain in the neck. Review of medical records after the incident revealed no evidence of psychosocial or physical pain from the improper transfer.</p> <p>Continued record review on 9/23/24 at 12:40 PM revealed the facility placed a corrective action for GNA #15 in the employee's personnel record on 3/8/24 which stated GNA #15 required corrective action for failing to use a gait belt when transferring resident #9 on 3/7/24. GNA #15 was required to be re-trained on transferring residents safely and the use of gait belts.</p> <p>Interview with the Director of Nursing (DON) on 9/24/24 at 9:00 AM confirmed the facility administration determined that GNA #15 incorrectly transferred resident #9 on 3/7/24. The DON provided documents that confirmed that GNA #15 was suspended from working in the facility on 3/8/24 and required to be re-trained in the safe transfer of residents and the use of gait belts before he/she could return to work. The DON also stated that GNA #15 stated that he/she did not use the gait belt to transfer resident # 9 because he/she wanted to complete the task of transferring the resident from the bed to a chair quickly.</p> <p>2) Record review on 9/25/24 at 9:54 AM revealed RN Supervisor #17 observed Agency GNA #16 hitting resident #28 when the resident backed his/her motorized wheelchair over Agency GNA #16's feet and pinning Agency GNA #16 to wall on the evening of 9/20/22. Resident #28 also reported that he/she was physically hit by Agency GNA #16 to LPN #18 on the evening of 9/20/22.</p> <p>Continued record review on 9/25/24 at 10:00 AM revealed that facility investigated the incident between Agency GNA #16 and resident #28 and determined that Agency GNA#16 was not allowed to return to the facility as of 9/23/22.</p> <p>Interview with the Director of Nursing (DON) on 9/25/24 at 11:00am confirmed the facility administration determined that Agency GNA #16 hit resident #28 on the evening of 9/20/22 and the event was observed by RN Supervisor #17. The DON also confirmed that Agency GNA #16 was placed on the do not return list on 9/23/22.</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>31982</p> <p>Based on record review and interviews it was determined the facility staff failed to implement measures and reasonable care to prevent loss or theft of resident's belongings. This was evident for 1 (#24) of 41 residents reviewed during the survey.</p> <p>The findings include:</p> <p>A complaint pertaining to Resident #24 was reviewed on 9/26/24 at 9:25 AM. The complainant indicated that he/she discovered that 3 bags of Resident #24's clothing were missing on 8/30/22. When he/she reported it to Staff #14 at the front desk, Staff #14 informed the complainant that she observed a nurse taking bags of clothing to her car on 8/28/22. The complaint indicated that the complainant reported it to administrative staff who retrieved 2 of the 3 bags on 9/2/22 and informed him/her they would reimburse him/her for the 3rd bag. The complaint indicated that the Administrator said he would look into the matter, but the complainant never heard anything more about it. The event was reported to the police by the complainant.</p> <p>During a telephone interview on 9/26/24 at 9:11 AM the complainant recalled the incident. When asked who was responsible for labeling the resident's clothing, he/she stated Nobody labels the items. He/She indicated that he/she often brings Resident #24 new items including a pink blanket, shoes and socks that were brought to the facility for Resident #24 the previous week. He/she indicated that he/she was never instructed to label the items, and the facility hasn't labeled them either. At the time and date of the interview, reimbursement had not been received for the remaining missing items.</p> <p>On 9/26/24 at 9:20 AM, the surveyor observed a pink blanket on Resident #24's bed. A mesh bag containing clothing was located on the floor of the resident's closet and a few articles of clothing were hanging in the closet.</p> <p>In an interview on 9/27/24 at 12:30 PM Staff #11 a laundry staff member indicated she was responsible for labeling resident clothing if needed. When asked about the process, she indicated that resident's dirty laundry was sent to the laundry in bags which were labeled with the resident's name, the clothing was washed and dried, and if needed she would place labels onto the clothing based on the name found on the bag it came in.</p> <p>Staff #12, the laundry supervisor was interviewed on 9/27/24 at 12:35 PM. She explained that the nursing staff were responsible for completing an inventory of resident's belongings. She indicated that she did not have knowledge of a concern regarding Resident #24's clothing in 8/2022.</p> <p>The facility policy &amp; procedure for Inventory of Personal Items was reviewed on 9/27/24 at approximately 12:45 PM. The procedure indicated that an inventory sheet would be completed at the time of admission, signed by the resident/representative and uploaded into the electronic record. The inventory would be located in a binder at the nurses' station and that the inventory sheet would be updated by nursing staff to include changes in personal effects and uploaded into the electronic record.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/27/24 at 12:00 PM the surveyor located a binder on a wooden shelf in the nurses' station on the 2nd floor labeled: Personal Effects Inventory. The binder contained handwritten inventory sheets for 4 residents. All were dated between 3/14/24 and 4/12/24. None of the sheets belonged to Resident #24.</p> <p>An interview was conducted with Staff #4 a Licensed Practical Nurse (LPN) on 10/1/24. She was asked where to find the residents' inventory of personal items. She indicated that the inventory list goes in the paper record, but that someone may upload it to the electronic medical record (EMR). She indicated that any additional items brought later to the facility by the family are added to the list. When asked who was responsible for labeling the clothing, she explained that most family members want to label them, and staff will provide them with a permanent marker to label them.</p> <p>On 10/1/24 at 2:25 PM Staff #5, the Regional Nurse, provided a copy of an electronic version of Resident #24's Personal Effects Inventory completed and dated 11/22/21 on admission/readmission. The form listed 2 pairs of shoes, 1 jacket and 1 sweater. The inventory was not signed by the resident nor his/her representative.</p> <p>There was no evidence that the facility staff updated or revised Resident #24's inventory since 11/22/21 including the 3 bags of items in 8/2022 or the recent addition of the residents' pink blanket, socks and shoes. The facility failed to ensure staff implemented reasonable care and consistent measures in an attempt to prevent loss, theft or misappropriation of resident belongings.</p> <p>These concerns were reviewed with the Administrator on 10/1/24 at 2:55 PM.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>31982</p> <p>Based on record review and interviews it was determined the facility staff failed to report an allegation of misappropriation of resident belongings to the State Agency. This was evident for 1 (#24) of 41 residents reviewed during the survey.</p> <p>The findings include:</p> <p>A complaint pertaining to Resident #24 was reviewed on 9/26/24 at 9:25 AM. The complainant indicated that he/she discovered that 3 bags of Resident #24's clothing were missing on 8/30/22. When he/she reported it to Staff #14 at the front desk, Staff #14 informed the complainant that she observed a nurse taking bags of clothing to her car on 8/28/22. The complainant reported it to administrative staff who retrieved 2 of the 3 bags on 9/2/22 and informed him/her they would reimburse him/her for the 3rd bag. The complaint indicated that the Administrator said he would look into the matter, but the complainant never heard anything more about it. The event was reported to the police by the complainant.</p> <p>The state agency had no record that the facility filed a self-report regarding this alleged incident.</p> <p>In an interview on 9/26/24 at 9:11 AM the complainant recalled the incident. When asked if the facility resolved the matter, he/she indicated it was never resolved, and no one ever followed up.</p> <p>On 9/27/24 at 1:41 PM the Director of nursing indicated that she was unable to find evidence that the facility reported the alleged misappropriation of Resident #24's missing clothing to the state agency.</p> <p>The Administrator was made aware of the above concern on 10/1/24 2:55 PM.</p> <p>Cross reference F 602.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>42886</p> <p>Based on record review and interviews it was determined the facility staff failed to conduct a thorough investigation after a reports of abuse and misappropriation of resident property. This was evident for 3 (#28, #24 and #11) of 41 residents reviewed during the survey.</p> <p>The findings include:</p> <p>1) Review of facility reported incident (MD 00183660) on 9/25/24 at 9:54 AM revealed resident #28 reported being hit by Agency GNA#16 on 9/20/22. Surveyor review of the facility investigation revealed the facility failed to interview other residents on the unit to determine if other residents experienced abusive treatment by facility staff including Agency GNA #16 and to ensure the residents felt safe in the facility.</p> <p>Interview with the Director of Nursing (DON) on 9/25/24 at 11:00 AM confirmed that the facility failed to interview other residents on resident #28's unit to determine if other residents experienced abusive treatment by facility staff including Agency GNA #16 and ensure the residents felt safe in the facility.</p> <p>31982</p> <p>2) A complaint pertaining to Resident #24 was reviewed on 9/26/24 at 9:25 AM. The complainant indicated that he/she discovered that 3 bags of Resident #24's clothing were missing on 8/30/22. When he/she reported it to Staff #14 at the front desk, Staff #14 informed the complainant that she observed a nurse taking bags of clothing to her car on 8/28/22. The complainant indicated he/she reported it to administrative staff who retrieved 2 of the 3 bags on 9/2/22 and informed him/her they would reimburse him/her for the 3rd bag. The complaint indicated that the Administrator said he would look into the matter, but the complainant never heard anything more about it. The event was reported to the police by the complainant.</p> <p>On 9/27/24 at 1:41 PM the Director of nursing indicated that she was unable to find that the facility conducted an investigation related to Resident #24's missing clothing in August or September of 2022.</p> <p>This concern was reviewed with the Administrator on 10/1/24 at 2:55 PM. Cross reference F 602.</p> <p>3) A facility reported incident #MD00200935 was reviewed on 9/30/24 at 9:45 AM. The facility report indicated that Resident #11's roommate reported witnessing Resident #42 remove money from Resident #11's nightstand. The facility reported the incident to the state agency. The facility's investigative documentation consisted of a Facility Reported Incident Follow-Up Investigation Report Form. There were no written statements or interviews from the victim, the perpetrator, the resident who reported and allegedly witnessed the event, staff nor other residents. The facility concluded that it was one resident's word against the other. However, there was no evidence that a thorough investigation was conducted prior to their conclusion</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/30/24 at 11:00 AM Staff #5, the Regional Nurse was made aware of the above findings and was asked if there was any additional investigation documentation. She returned at 12:08 PM and informed the surveyor that she did a deep dive but was unable to find additional information.</p> <p>This concern was reviewed with the Administrator on 10/1/24 at 2:55 PM.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>42886</p> <p>Based on record review and interview, the facility nursing staff failed to follow standards of practice by failing to report a resident's injury to a provider (resident #31). This was evident for 1 out of 41 residents reviewed during a complaint survey.</p> <p>The findings include:</p> <p>Record review for resident #31 on 9/25/24 at 11:41 AM revealed NP #20 reported on 7/11/22 that LPN #19 failed to report the formation of a bruise on the resident's left knee. NP #20 discovered the left knee bruise when he/she assessed resident #31 on 7/11/22 at approximately 2:00 PM. Continued review of NP#20's complaint revealed the facility investigated the cause of resident #31's left knee bruise and determined that LPN#19 was aware of the left knee bruise on the morning of 7/11/22 but failed to report the injury to his/her supervisor or administration. Further review of resident #31's records revealed facility administration issued a teachable moment notice on LPN #19's personnel record on 7/12/22 . The facility required LPN#19 to be re-educated on facility policy on reporting injuries to supervision.</p> <p>Interview with the Director of Nursing (DON) on 9/25/24 at 1:00 PM confirmed that the facility issued a teachable moment notice to LPN#19's personnel record when LPN #19 failed to report the injury of resident #31's left knee. The DON also provided documentation confirming that LPN #19 was re-educated on facility reporting policy.</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>30428</p> <p>Based on medical record review and interview with resident and facility staff, it was determined that the facility failed to provide care to a resident that is dependent on staff for activities of daily living (ADL). This was evident during the review of a complaint for 1 of 4 (#35 ) residents related to quality of care.</p> <p>The findings include:</p> <p>1. Review of the medical record for Resident #35 on 9/30/24 at 8:05 AM revealed diagnosis which includes cellulitis and lymphedema in the bilateral lower extremities causing bed bound status. Resident #35, reported in 2022 concerns related to lack of care provided on the weekends of 3/5-3/7/22 and 3/11-3/14/22.</p> <p>A review of the bowel and bladder continence record for the month of March 2022 revealed no documentation on any of the 3 shifts that the resident had either a bowel or bladder movement on 3/6, 3/7, 3/11, 3/13 and 3/14.</p> <p>Surveyor met with Resident #35 on 9/30/24. Though care has improved, s/he verbalized and reiterated about the lack of care and treatment that was provided from the time reported in the complaint for the weekends in March 2022.</p> <p>Further review on 9/30/24 at 11:00 AM of the quarterly minimum data set for functionality section 'G' for Resident #35, completed January 2022, noted that s/he was extensive assist of 2 people for toileting and the corresponding section 'H' noted for both bowel and bladder that s/he is frequently incontinent.</p> <p>On 9/30/24 at 11:13 AM surveyor reviewed concerns with the DON and corporate nurse regarding the failure of staff to provide and document the necessary ADL care that was provided to Resident # 35.</p>

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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate foot care.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 31982</p> <p>Based on record review and interview with staff it was determined that the facility staff failed to ensure that residents received proper foot care and treatment. This was evident for 1 (#34) of 41 residents reviewed during the survey.</p> <p>The findings include:</p> <p>A complaint regarding the care and services provided to resident #34 was reviewed on 10/1/24 at 11:31 AM.</p> <p>The complaint indicated the resident experienced pain as they attempted to put shoes onto his/her feet in preparation for discharge and that upon closer look, Resident #34's toenails were long, and his/her feet and nails did not appear to have been adequately cared for by the facility.</p> <p>A review of Resident #34's medical record was conducted at that time and revealed the resident was admitted to the facility on [DATE] and discharged on [DATE]. His/Her diagnoses included but were not limited to Diabetes Mellitus, and Dementia. A physician's order was written on 10/4/21 for consults including Podiatry.</p> <p>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.</p> <p>A care plan was developed to address Resident #34's Diabetes. The plan included the interventions Podiatry consult, and Educate the resident/resident representative on medication management and importance of adherence to prevent complications of the disease, it included close monitoring skin integrity/wound healing and foot care.</p> <p>Further review of the medical record failed to reveal documentation that Resident #34 was seen by a podiatrist during his/her 7 month stay in the facility as per their physicians' order and plan of care.</p> <p>In an interview on 10/1/24 The Director of Nursing (DON) was asked to explain how the facility provided foot care for diabetic residents. She indicated that staff are not to trim nails, that diabetic residents are seen by a podiatrist for foot care.</p> <p>Review of the facility policy for Foot Care revealed Diabetic residents and those with chronic circulatory problems will be treated by licensed professionals.</p> <p>Staff #2 a Licensed Practical Nurse (LPN) was interviewed on 10/2/24 at 10:15 AM. She indicated that the facility has an in-house Podiatrist that visits routinely, the nurse receiving an order for podiatry puts the resident on a list which is given to Medical Records. Medical Records then sends the list to the Podiatrist, the next time they come to the facility they will see the resident. She added that new admissions are automatically put onto the list to be seen.</p> <p>(continued on next page)</p>		

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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/2/24 at 10:36 AM Staff #5 the Regional Nurse indicated that they were not able to find evidence that Resident #34 received foot care by a Podiatrist while residing in the facility.</p> <p>The Administrator and DON were made aware of the above concerns on 10/2/24 at 12:10 PM.</p>		

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<p>F 0712</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that the resident and his/her doctor meet face-to-face at all required visits.</p> <p>30428</p> <p>Based on medical record review and interview with facility staff, it was determined that the facility failed to have a discharge summary on the medical record. This was evident for 1 of 3 (#20) residents reviewed for discharges during a complaint survey.</p> <p>The findings include:</p> <p>During the review of the medical record for Resident #20 on 9/24/24 regarding a complaint related to timely discharge, it was noted that there was no physician discharge summary on the chart. The summary was requested on 9/24/24 at 1:35 PM.</p> <p>On 9/25/24 at 8:08 AM a physician discharge summary was provided to the survey team. Review of the summary noted that it was dated for 9/24/24 and stated that the resident was seen 'TODAY' in all capital letters in his/her room.</p> <p>However, according to record review on 9/24/24 and again on 9/25/24 at 8:12 AM, Resident #20 left the facility against medical advice on 11/19/22 and has not returned.</p> <p>This concern was reviewed with the regional nurse on 9/25/24 at 8:18 AM.</p> <p>The attending physician was interviewed on 10/1/24 at 12:10 PM. She stated that she was asked by the Director of nursing to look at the chart and complete a discharge summary. She further stated that she did a quick scan and completed the note, but did state she did not see the resident that day. I reviewed her note with her and that the resident was discharged 2 years ago. She stated that she needs to get familiar with the regulations related to the timeliness of getting discharge notes on resident charts.</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 31982</p> <p>Based on observation and interview with staff it was determined the facility failed to ensure a functioning call system to allow residents to call for staff assistance in each toilet and bathing facility. This was evident for 2 of 4 resident bathrooms observed.</p> <p>The findings include:</p> <p>A tour of the facility was conducted on 9/24/24 at 10:00AM.</p> <p>1) Observation of the bathroom located between and shared by the residents in room [ROOM NUMBER] and 217 revealed a call bell activation box on the wall in the shower approximately 6 feet above the floor. A short red cord was attached to the call bell activation switch. The end of the cord was located approximately 5 feet above the floor and could not be reached by a resident sitting/lying on the shower floor or seated on a shower chair.</p> <p>2) The bathroom located between rooms [ROOM NUMBERS] had call bell activation switches located on the walls to the left and right of the toilet. The activation switch on the wall to the left of the toilet was in the up (off) position, there was no pull cord or other means by which a resident lying on the floor could activate the call light.</p> <p>The activation switch on the wall to the right side of the toilet was in the down (activated) position however the indicator light in the hallway was not lit and there was no audible sound coming from the nurse's station call bell panel.</p> <p>The call bell activation switch in the shower was located approximately 6 feet above the floor. There was no pull cord or extension to allow residents to activate the call bell while in the shower.</p> <p>During another observation on 10/1/24 at 12:50 PM the call bell switches in the bathroom between rooms [ROOM NUMBERS] were in the same positions. When the call bell switch on the left side of the toilet was flipped down, a red indicator light illuminated on the switch plate and an audible tone was heard in the hallway however the indicator light located on the ceiling in the hallway did not illuminate. The indicator light in the hall failed to illuminate and no tone was heard when the call bell switch on the right side of the toilet was flipped up nor when it was flipped back down.</p> <p>On 10/2/24 walking rounds were conducted from 10:55 AM - 11:45 AM with Staff #7 the Maintenance Director, Staff #8 a maintenance assistant and the Administrator. They observed and confirmed the above concerns after rechecking the functioning of the call bells at that time.</p>

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42886</b></p> <p>Based on observation and staff and resident interview, it was determined that the facility failed to maintain an effective pest control program. This deficient practice had the potential to impact all residents.</p> <p>The findings include:</p> <p>On 9/23/24 at approximately 10:00 AM, the survey team observed evidence of mouse droppings and cockroach activity on the 1st and 2nd floors of the facility. The survey team observed pest activity in resident rooms on 9/24/24 - 9/26/24 on the 1st and 2nd floors of the facility during observation rounds and interviews with residents in their rooms.</p> <p>On 9/24/24 at 1:02 PM, the survey team informed the Assistant Executive Director of concerns of pest activity throughout the facility. The survey team also requested the facility's pest activity reporting documents to determine if the facility made attempts to provide a pest-free environment.</p> <p>On 9/24/24 at 1:15 PM, the survey team interviewed the Maintenance Director, Maintenance Assistant and the Assistant Executive Assistant regarding the facility's pest control program. Maintenance Director stated the facility has a pest control company that visits the facility generally every 3 months to treat any pest control problems.</p> <p>On 9/25/24 at 7:40 PM, the surveyor reviewed the maintenance pest control records and invoices from pest control visits from 2022 to the present. The record review revealed that the facility failed to follow the recommendations of the pest control company causing continuous pest activity in the facility from 2022 to the present.</p> <p>30428</p> <p>Surveyor tour of the facility and of room [ROOM NUMBER] on 9/24/24 at 10:22 AM identified 3 live and active roaches roaming the middle of the floor of the resident's room. The resident was lying in bed eating snacks with crumbs noted on their person and on the floor. There were multiple bins and other items noted strewn about the resident's room. The dresser drawers were all open with items hanging out and in disarray.</p> <p>The surveyor team requested on 9/24/24 at approximately 11 AM to talk to who would be responsible for pest control. The facility assistant nursing home administrator, Director of nursing and corporate nurse were present. The team was notified that there was a maintenance director that comes a few times a week, but he is the maintenance director for a new building, not the current building and there is currently an assistant that is here fulltime since May 30, 2024, however, there has been no full-time director here for some time.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215065	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/02/2024
NAME OF PROVIDER OR SUPPLIER  Bel Pre Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2601 Bel Pre Road Silver Spring, MD 20906	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The pest log was requested and the system they use to document any environmental concerns. It was reported at that time that they use the TELS to communicate building concerns. Secondary to the observations and the complaints received, the workorders from February 2024 to the present were requested. The facility was also notified of the observations in room [ROOM NUMBER] at this time. They stated that they would have pest control out immediately.</p> <p>The TELS report was received on 9/25/24 at 11:40 AM. According to the TELS report and the corresponding pest company's observation report from their monthly to bi-weekly visits revealed that the observed roach problem has been documented in the facility since February 2024 from the kitchen to rooms on the second floor to the nursing stations. The pest control company, per review, noted that for each visit they treated and baited for ants and roaches in the identified areas that ranged from the kitchen to rooms on the first and second floor, many of which were repeated concerns month after month.</p> <p>Environmental tour on 10/2/24 at 11:00 AM with the NHA, Maintenance Director, Assistance Maintenance director and Assistant NHA revealed that for residents in rooms such as in 107, the facility had bought totes for the resident to put their items in, however this resident was refusing to transfer their items from the broken totes that possibly harbored more roaches and insects to the new clean totes.</p> <p>The concern that the facility was not addressing the potential root cause of the possible infestations and therefore, the pests were an ongoing documented issue potentially affecting all residents was reviewed at that time.</p> <p>40927</p> <p>On 9/26/24 at 10:04 AM a tour of the facility's kitchen was conducted. There were several areas in the kitchen that would attract and allow pest and rodents to enter the kitchen:</p> <p>Near the exit door there were 2 ceiling tiles that were not secured in the metal framework leaving a 1 - 1.5 in gap next to the wall.</p> <p>The dry storage room had cereal laying in the corner next to the metal shelving and under the bins that held the flour and sugar.</p> <p>Across from these bins of sugar and flour was a metal storage rack and between the middle and bottom shelf a hole in the wall that was 1.5 ft long and the width ranged between 1-3 in could be seen.</p> <p>The ceiling tiles above that same rack were not fitted in the metal framework creating a gap.</p> <p>An interview with Dietary Aid Staff #26 on 9/26/24 at 10:12 AM revealed that they cleaned the dry storage area every day and thoroughly on the days they received a new shipment. When asked if they moved the racks and bins to sweep under them she stated that they had. When asked about mice or roaches she denied seeing them in the kitchen.</p> <p>(continued on next page)</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Culinary Director was interviewed on 9/26/24 at 10:15 AM and reported she was not aware of the hole in the wall in the dry storage room. She reported that if she had noticed the hole she would have reported it in the maintenance system in the computer to alert maintenance. Reviewed the other concerns with her. When asked if she had seen mice or roaches in the kitchen what was the next step, she reported she would document it on the pest control log. The surveyor reviewed the logs provided and found that in June 2024 and August 24 there had been roaches found. The entry in June 2024 had been logged by the Culinary Director. When asked about that entry she stated she thought the surveyor wanted to know more recent sightings.</p> <p>Walking rounds were conducted with the Administrator, Director of Maintenance Staff #7, and Maintenance Assistant Staff #8 on 10/2/24 at 10:55 AM. The above findings were shown to them and concerns were reviewed.</p>		