

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 02/04/2025
NAME OF PROVIDER OR SUPPLIER Silver Spring Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 13908 New Hampshire Avenue Silver Spring, MD 20904	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<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>50502</p> <p>Based on a review of facility-reported incident investigation, record review and interview, it was determined that the facility failed to prevent further abuse, neglect, exploitation and mistreatment from occurring while the investigation was in progress. This was evident for 1 (Resident #53) of 6 residents reviewed for abuse during the recertification survey.</p> <p>The findings include:</p> <p>On 1/27/2025 at 11:25 AM, a review of facility-reported incident MD00213513 revealed that on 1/12/2025, Resident #53 reported that he/she fell on the floor and Licensed Practical Nurse (LPN #19) picked him/her and threw him/her back on the floor. The report also indicated that 2 Geriatric Nurse Assistants (GNA #26 and #27) assisted LPN #19. Registered Nurse Supervisor (RN #9) asked Resident #53 to describe the staff, he/she stated, don't play dumb, they're all Africans. He/she repeated this statement when he/she was interviewed by the local law enforcement.</p> <p>On 1/29/2025 at 9:15 AM, in an interview with Resident #53, he/she stated that he/she fell on the floor on January 12 and confirmed that LPN #19 along with 2 GNAs, picked him up and threw him back on the floor. He/she denied any further incidents and declined to speak further.</p> <p>On 1/29/25 at 10:10 AM, a review of Resident #53's medical record indicated a BIMS score of 12 of 15, moderate impairment (Brief Interview for Mental Status, BIMS, is a screening tool used to assess basic cognitive function in patients in long-term care facilities.)</p> <p>On 1/29/25 at 12:58 PM, in an interview with the Director of Nursing (DON), she described that for any allegations of abuse, the facility immediately investigated. She added that abuse training was also conducted. She stated that it was also expected that the alleged perpetrator/s would be suspended pending investigation.</p> <p>The DON was notified that based on the review of the facility investigation, there was no evidence that an abuse in-service training was conducted after the incident and the alleged perpetrator/s were removed from the schedule.</p> <p>On 1/30/25 at 10:03 AM, the DON gave the surveyor copies of the schedules of LPN #19 and GNA #26 and confirmed that they were not removed from the schedule pending investigation.</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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/31/25 at 7:05 AM, In an interview with LPN #19, he/she confirmed that after the incident, he continued to work with Resident #53.</p> <p>On 2/4/2025 at 7:35 AM, the NHA was made aware of the concerns.</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>49815</p> <p>Based on observations, interviews and record reviews it was determined that the facility staff failed to ensure nursing standards of practice were followed for medication-controlled drugs and security. This was found to be evident for 4 (Resident #45, #48, #77 and #384) out of 4 Residents reviewed for medication-controlled drugs and security.</p> <p>The findings include:</p> <p>The Maryland Nurse Practice Act (NPA) is legislation that influences the nursing profession by establishing Maryland Board of Nursing rules and regulations which outlines requirements for Maryland nursing education programs, setting minimum care standards that must be met. The NPA exists to regulate and protect the public from practitioners who are a risk to the health, safety, and welfare of the citizens within its state board jurisdiction. This protection principle is accomplished by assessing competence at initial licensure and throughout the career of the nurse. The NPA protects the public from incompetent and unsafe care. The primary purpose of the NPA is to protect the public and sets out the scope of practice.</p> <p>A blister pack/card is a form of tamper-evident packaging where an individual pushes individually sealed tablets through the foil of the blister pack/card in order to access the medication.</p> <p>The narcotic count must be completed by two licensed nurses at the end of each shift for all narcotics. The primary function of narcotic count is to ensure that narcotics are not being diverted or stolen for purposes not intended by the prescriber.</p> <p>On 1/29/2025 at 5:00 pm the surveyor reviewed the facility investigation file for the Facility Reported Incident (FRI) / Intake# MD00213015 dated 12/23/2024 that the facility self-reported to the Office of Healthcare Quality (OHCQ).</p> <p>The surveyor review of the facility investigation file revealed that on 12/21/2024 during the 3-11 shift narcotic count that the backs of the narcotic blister cards for Residents #48, #77 and #384 were taped for an unknown reason. There was a total of 17 spots on 4 of the narcotic blister cards that appeared to have clear tape on the back of the narcotic blister cards. The nursing staff that had conducted the narcotic count on 12/21/2024 previously had noted that the blister cards were taped but failed to report this to facility management, and on 12/21/2024 the nursing staff felt that perhaps there may have been other medications in the blister cards other than the medications that were indicated on the label.</p> <p>The surveyor interviewed the Regional Clinical RN Director (RCD) on 2/4/2025 at 10:53 AM during a phone conversation. The surveyor asked the RCD what the expectation for nurses during narcotic count was when the narcotic blister card backs were discovered with tape. The RCD stated that the expectation was for nurses to report narcotic blister cards that were taped on the backs immediately. The RCD acknowledged that the taped narcotic blister cards were not reported immediately by the nursing staff and the RCD confirmed that this was the policy of the facility to report any taped narcotic blister card.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The surveyor reviewed the Communicare Family of Companies Policies and Standard Procedures for Medication Controlled Drugs and Security. The policy indicated that any irregularities during the narcotic count which include any suspicion or evidence of substitution and/or tampering of cards such as those being taped or glued must be reported to the Director of Nursing (DON) immediately.</p> <p>The Medication Administration Record (MAR) is used in Long Term Care facilities to keep track of every dose of medication that a Resident takes or misses for whatever reason. The MAR includes key information about the Resident's medication including the medication name, dose taken, special instructions and date and time.</p> <p>On 1/30/2025 at 7:15 AM the surveyor observed the 7-3 narcotic shift count between the 11-7 and 7-3 shifts. The 7-3 Registered Nurse (RN) #13 was taking the narcotic blister cards out of the narcotic locked drawer on the medication cart and the 11-7 RN #14 was reviewing the controlled drug narcotic count sheets. Resident #45's controlled drug narcotic count sheet indicated that there were 29 Oxycodone 5 mg tablets remaining, however the narcotic blister card of the Oxycodone 5 mg had 28 tablets remaining. The 11-7 shift RN #14 stated to 7-3 shift RN #13 that he administered an Oxycodone tablet to Resident #45 at 7:00 AM. RN #14 stated that he did document on Resident #45's medication administration record (MAR), but did not document on the controlled narcotic count sheet. In front of the surveyor and 7-3 shift RN #13, the 11-7 RN #14 documented on the controlled narcotic count sheet that he had administered the Oxycodone at 7:00 AM to Resident #45.</p> <p>The surveyor interviewed RN #14 and asked what the expectation was for documenting narcotics on the controlled narcotic count sheet. RN #14 stated that narcotics were to be signed when administered on the MAR and were to be signed on the controlled narcotic count sheet when taken out of the narcotic drawer of the medication cart.</p> <p>The surveyor reviewed Resident #45's medication administration record (MAR), and the Oxycodone 5 mg was documented as given at 7:00 AM on 1/30/2025 by RN #14.</p> <p>According to the Maryland Nurse Practice Act - Practice registered nursing means the performance of acts requiring substantial specialized knowledge, judgement and skill based on the biological, physiological, behavioral or sociological sciences as the basis for assessment, nursing diagnoses, planning, implementation and evaluation of the practice of nursing and includes execution of therapeutic regimen, including medication management and administration.</p> <p>The surveyor reported the concerns with the observation of the narcotic shift count between the 11-7 and 7-3 RNs to the Nursing Home Administrator (NHA) and the Director of Nursing (DON) at 7:50 AM on 1/30/2025. NHA and the DON acknowledged the surveyor and stated that they were already notified by the nursing staff of the concerns with the narcotic count.</p>		