STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215065	A. Building B. Wing	05/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Suites Rehabilitation and Wellness Center	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)
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. Based on record review and interviews, it was determined that the facility failed to ensure that staff accurately document medication administration for each resident in accordance with accepted professional standards and practices. This was evident for 3 (Resident #16, #3, and #97) of 4 residents reviewed for medication administration during the recertification survey. The findings include: 1)During the screening process of the survey on 5/12/26 at 09:41AM, Resident #16 stated that sometimes he/she gets his/her medications and sometimes he/she does not get them, because the nurse would say they are not available. The medical records review on 5/12/2026 at 1:05 PM noted that resident has a Brief Interview of mental status (BIMS) score of 15 (indicating intact cognition) with diagnoses not limited to hypertension, chronic kidney disease, end stage renal disease with dependence on renal dialysis. Further medical record review on 5/12/2026 at 1:19 PM, found that the resident goes to dialysis on Mondays, Wednesdays, and Fridays. Further review of the residents' Medication Administration Record (MAR) revealed that there was no documentation of medications given on the following shifts that were not dialysis days for the resident: -On 4/6/2026: 6 medications were not documented for the Evening and Night shifts as administered, no vital signs were documented, and no Finger sticks with results were documented. -On 4/9/2026 and 4/23/2026: 4 medications were not documented as administered on the AM shift and 1 on evening shift. No documented Finger sticks was resulted on the before lunch shit (11 AM), no monitoring for hypo or hyperglycemia was documented, and no pain level was assed for both AM shifts. On 5/12/2026 at 2:43 PM Staff #8 was asked what the staff would do if medications were not available. Staff #8 stated that he/she would call the pharmacy to send medications stat or check the Omnicell for some of the medications not available in the medication carts; and write a progress note to explain the situation. On 5/13/2026 at 02:50 PM, a follow up interview was done with the DON who stated that it was not a matter of missing medications, but an Agency nurse was working on those days and that Agency nurse was made a Do not Return (DNR) to the facility because she failed to complete her documentation. The DON was made aware that this was a concern because no documentation is proof that the resident did not get his medications as he/she voiced. The DON agreed. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215065	A. Building B. Wing	05/15/2026

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) On 05/13/2026 at 11:45 AM, a review of Resident #3's Medication Administration Record (MAR) and orders revealed that resident had an order for Insulin Lispro Injection Solution 100 UNIT/ML (Insulin Lispro) Inject as per sliding scale: if 70 - 150 = 0 units Blood sugar (BS) less than 70mg/dl follow hypoglycemia protocol; 151 - 200 = 2units; 201 - 250 = 3 units; 251 - 300 = 4units; 301 - 350 = 5units; 351 - 400 = 6 units Blood sugar greater than 400, give 7 units, repeat BS, and call provider, subcutaneously before meals and at bedtime for DM -Start Date04/07/2026 2100. A review of Resident #3's MAR revealed that on 05/12/2026 at 11 am was BS 154 but MAR documented comment #9 (other/see nurses notes). Resident ordered to receive 2 units of insulin. On 05/09/2026 the resident's BS was 155 at 9 PM but MAR documented #9 (other/see nurses notes). On 05/08/2026 there was no documented evidence that the resident's BS was obtained on 4:30 PM and 9 PM, the MAR was blank. A review of the resident progress notes revealed that there was no documentation to explain why the resident did not receive the medication as ordered. On 05/14/2026 at 9:51 AM, in an interview with the Director of Nursing (DON), the DON explained that she spoke with nurses and they reported that Resident #3 refused to take the insulin if the blood sugar was less 200mg/dl but the DON stated that the nurses did not document the refusal. The DON stated that the Nurse Practitioner was notified and the insulin orders were updated to meet the resident's needs. 3) On 05/12/2026 at 08:43 AM, in an interview with Resident #97, the resident reported I take thyroid medication in the morning, and I missed two different doses because the doctor changed the medication and the medication time and it was not communicated to me. It was changed between May 7th-9th. On 05/13/2026 at 3:40 PM, a review of Resident #97's orders and Medication Administration record revealed: Synthroid Oral Tablet 125 MCG (Levothyroxine Sodium) Give 1 tablet by mouth one time a day for hypothyroidism -Start Date05/06/2026 0700 -D/C Date05/08/2026'; on 5/7/2026 MAR documentation revealed: comment #9, which indicated (other/see nurses notes). Synthroid Oral Tablet 175 MCG (Levothyroxine Sodium) Give 1 tablet by mouth one time a day for hypothyroidism -Start Date04/16/2026 0700 -D/C Date04/17/2026; on 04/16/2026 documentation revealed: comment #9 (other/see nurses notes). A review of the resident progress notes revealed that there was no documentation to explain why the resident did not receive the medication as ordered. On 05/13/2026 3:48 PM, in an interview with the DON, the DON was informed that the MAR indicated that the resident did not receive his/her medication on 5/7/2026 and 4/16/2026. She stated she will look into it further. On 05/14/2026 at 9:52 AM, the DON acknowledged that the missing medication documentation for Resident #97 was a communication issue. She explained that after following up with the nurse responsible for medication administration they explained that the Resident refused the medication because of the medication changes. The DON acknowledged that the information should have been documented in the resident's record and was not.