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	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Spring Healthcare 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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. 42783 Based on observation and interviews, it was determined that the facility failed to ensure a Resident was treated with dignity during care. This was found to be evident for 1 (Resident #75) out of 3 Residents reviewed for dignity during medication administration. The findings include: During an observation conducted on 01/29/25 at 7:39 AM, the Surveyors observed medication administration with Licensed Practice Nurse (LPN) #33. The LPN entered Resident #75's room and administered his/her medications. The Resident bed was located near the entry door of the room. The LPN failed to close the entry to provide privacy and dignity during the medication administration. On 01/29/25 at 7:52 AM, the LPN confirmed he had not closed Resident #75's entry door and stated that it is the facility's expectation that dignity is always provided during the care to Resident. During an interview conducted on 01/29/25 at 8:02 AM, the Director of Nursing (DON) confirmed that the expectation was that all staff provide care in a dignified manner which included closing the entry door while providing care to the Resident. The DON further stated that she would conduct an in-service and education the staff.

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	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Spring Healthcare 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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42783 Based on observations, record review and interviews, it was determined the facility failed to ensure a resident had access to the facility's communication system. This was found to be evident for 1 out of 2 Residents (Resident #76) observed for accommodation of needs during the re-certification survey. The findings include: During a random observation conducted on 01/27/25 at 9:44 AM, the Surveyors observed Resident #76's call bell on the floor behind the head of the bed. On 01/27/25 at 9:45 AM, during an interview, Resident #76 told the Surveyors that the call bell was always on the floor out of reach. The Resident stated that he/she usually did not have access to the call bell and as a result would yell out for help when assistance was needed. On 01/27/25 at 10:27 AM, the Surveyors and License Practical Nurse (LPN) #34 observed Resident #76's call bell on the floor behind the head of the bed out of reach for the Resident. The Surveyors observed the LPN remove the call bell from the floor and place the call bell on the Resident's bed. Minimum Data Set (MDS) is a standardized, primary screening and assessment tool of health status which forms the foundation of the comprehensive assessment for all residents of long-term care facilities certified to participate in Medicare or Medicaid. The MDS contains items that measure physical, psychological and psycho-social functioning. The items in the MDS give a multidimensional view of the patient's functional capacities. A review of Resident #76's MDS assessment was conducted on 01/27/25 at 10:42 AM. The assessment dated [DATE] revealed that the Resident had lower extremity impairment on both sides, was dependent and required substantial /maximum assistance. During random observations conducted on 01/29/25 at 9:35 AM, 01/29/25 at 11:16 AM, and 01/31/25 at 11:03 AM, the Surveyors observed Resident #76 in bed and the call bell on the floor behind the head of the bed.

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	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Spring Healthcare 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 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. 51790 Based on record review and an interview, it was determined that the facility failed to ensure a Resident was offered information for an Advance Directive. This was evident for 1 (Resident #76) out of 1 resident reviewed for Advance Directives. The findings include: According to the Centers for Medicare and Medicaid (CMS) the definition of an Advance Directive is a document that appoints an agent and records a patient's medical treatment wishes based on their values and preferences. Advance Directives can be different from state to state. A record review on 01/28/25 at 07:38 AM showed there was not an Advanced Directive found or documentation that Advance Directive information was offered in the electronic medical record of Resident #76. A review of Resident #76 ' s paper chart on 01/28/25 at 08:16 AM revealed there was not an Advanced Directive or documentation that Advance Directive information was offered in the chart. On 02/03/25 at 11:32 AM, while interviewing Social Worker (SW) #23, this surveyor asked what the process was for obtaining an Advanced Directive for a Resident. The SW #23 stated the expectation was that within 7 days of admission, the facility should attempt to obtain the Resident ' s Advance Directive. If the Resident did not have an Advanced Directive then the facility should offer information for an Advance Directive. She further explained that there should be a social services note documented in the chart that the resident was offered information. When asked if this process was being completed for all the residents, SW #23 confirmed that this had not been done consistently. This surveyor made SW #23 aware of the concern that Resident #76 did not have an Advanced Directive in his/her paper chart or electronic medical record, and did not have documentation that the Resident was offered information for an Advance Directive. SW #23 reviewed Resident #76 ' s medical records and confirmed there was no documentation that the Resident was offered information for an Advance Directive.

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	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Spring Healthcare 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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 51491 Based on Record Reviews and Interviews it was determined that the facility failed to provide Beneficiary Notices to residents discharged from Medicare Part A Services with benefit days remaining. This was evident for 1(#19) out of 3 Residents reviewed for Beneficiary Notices. The findings include: The Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage (SNF ABN) is provided to notify Residents/Beneficiaries that their services may no longer be covered by Medicare and allows the Resident time to decide on continuing services not covered. The Notice of Medicare Non-Coverage (NOMNC) notice is provided to inform the Resident/Beneficiary of their right to file an Appeal of the decision and the right to an expedited review of Medicare non-coverage services. This form should be provided at least two days before the last day covered by Medicare. On 2/03/25 at 07:15 AM, the Director of Nursing (DON) provided this surveyor with the Skilled Nursing Facility (SNF) Beneficiary Protection Notification Review Forms that had been provided to the facility for completion. A review of the form for Resident #19 showed that the form was only partially completed. The answer to question #1 asked Was an SNF ABN, Form CMS-10055 provided to the resident? The No box had been marked but had been covered with a white correction fluid and question number 2 remained unanswered. During a review of Resident #19 ' s Medical Records on 2/03/25 at 07:18 AM it was discovered Resident #19 remained in the facility after the Medicare A benefits ended. There was no documentation that the Medicare A notification had been provided to Resident #19. During an interview with the Business Office Manager (BOM) on 2/03/25 at 2:28 PM, she discussed the Beneficiary Notification process for the facility. She explained that only Residents who had Medicare A days remaining were required to receive or should have received notification that their services would no longer be covered by Medicare A. During an interview with the BOM on 2/04/25 at 10:08 AM, she reported that the Skilled Nursing Facility (SNF) Beneficiary Protection Notification Review Form had not been completed because she had been unable to locate the form that notified Resident #19. The BOM informed the Surveyor that she would complete the form and make additional attempts to locate the form that notified the Resident of the Medicare A benefits that were to end. During a follow-up interview conducted on 02/04/25 at 10:23 AM, the BOM provided this Surveyor with the completed Skilled Nursing Facility (SNF) Beneficiary Protection Notification Review Form. The form revealed that Resident #19 ' s last day covered by Medicare Part A was 10/17/24. Question #1: asked, Was an SNF ABN, Form CMS-10055 provided to the Resident? The facility checked off the box for Other: and wrote Unable to locate. (continued on next page)

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	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Spring Healthcare 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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Question #2: asked, Was a NOMNC (CMS 10123) provided to the resident? The facility checked off the box for NO and the box for Other explain and wrote unable to locate. The BOM reported she was still unable to locate documentation that the resident was informed. She stated that she waiting to see if the Social Work Office could locate the Beneficiary Forms for Resident #19. During an interview with the Business Office Manager on 2/04/25 at 11:43 AM, she confirmed they had been unable to locate the Beneficiary notification form for Resident #19.

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	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Spring Healthcare 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51491 Based on observations and interviews, it was determined that the facility failed to provide a safe, comfortable, and homelike environment. This was found to be evident for 3 (Residents #23, #46 and #76) out of 4 Resident rooms observed for the physical environment. The findings include: 1) During an observation on 1/27/25 at 09:14 AM Resident #23 was found lying in bed with his/her television sitting on the bedside table turned off. The Resident was watching the television on the other side of his/her roommate ' s bed. An additional observation revealed another television lying on top of the Resident ' s portable closet. In the Resident ' s room, it was also found that the Hot water to the sink had no water flow upon turning the knob. There were also two ceiling tiles in his/her bathroom that were dislodged, angled downward and exposed the open space above the tiles. Additionally, there was an electrical socket behind the Resident ' s bed that had the electrical mounting box protruding out of the wall. During an interview with Resident #23 on 1/27/25 at 11:19 AM he/she reported the TV sitting on his/her bedside table was not working and the staff were aware. It was working until a staff member bumped into it and it hasn ' t been working for a while so he/she had been watching the neighbor ' s television. The Resident reported the TV lying on top of the portable closet is the facility ' s TV and it ' s also broken. The Resident reported the Hot water isn ' t working because maintenance turned it off a while ago because a pipe broke. During an interview with the Maintenance Director on 1/30/25 at 10:12 AM, he advised he makes weekly rounds looking for issues or concerns around the facility. He stated he makes a list of any concerns he finds during his rounds. He reported he doesn ' t have a current list of things that need to be repaired to provide to the surveyors. During an observation of Resident #23 ' s room on 1/30/25 at 12:26 PM, the Maintenance Assistant was observed repairing the protruding outlet. During an observation of Resident #23 room on 1/31/25 at 06:59 AM, the Resident was seen watching a television now mounted onto the wall on the Resident ' s side of the room. The Resident responded, I can now use my table to eat! as he/she points to the clear bedside table. The broken TV on the tray table and the TV on top of the portable closet had been removed. During an interview with the Maintenance Director on 1/31/25 at 12:11 PM he reported the water to Resident #23 ' s room was shut off for repairs. He was unable to advise a time frame of when it was shut off. During an interview with the Maintenance Director on 2/04/25 at 09:43 AM he reported the Hot water had not been fixed in Resident #23 ' s room and explained they are waiting for a contractor because they need a special tool to change the valve. (continued on next page)

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	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Spring Healthcare 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) During an observation on 1/27/25 at 09:21 AM it was discovered that the portable closet in the room of Resident #46 was collapsing. The wooden cabinet ' s top shelf had detached from one side and fallen into the open space as the detached side wall of the cabinet pushed outward away from its original position. During an interview and observation with the Maintenance Director, on 1/30/25 at 10:18 AM he advised when he finds furniture in need of repair or concerns in the facilities he would make a list. The Maintenance Director reported he doesn ' t currently have a list of items that require repair. When shown the collapsing portable closet, he stated I ' ll take care of it, I ' ll have to discard it. During an interview with the Maintenance Director on 2/04/25 at 09:39 AM he reported the Resident will be getting a new portable closet. The Resident doesn ' t have it yet, but it has been ordered. 42783 3) During a random observation conducted on 01/27/25 at 9:44 AM, the Surveyors observed more than 20 pieces of candy and a black plastic container on the floor next to Resident #76 ' s bed. On 01/27/25 at 9:45 AM Resident #76 reported to the Surveyors, during an interview, that the candy and container had been on the floor for several days. The Resident stated that due to his/her medical condition he/she was unable to pick up the candy and container off the floor. On 01/27/25 at 10:27 AM, the Surveyors and License Practical Nurse (LPN) 34 observed Resident the candy and black container on Resident #76 ' s floor. The LPN stated that she would notify housekeeping. During an interview conducted on 01/27/25 at 10:28 AM, LPN #34 stated that she was aware the candy and container were on Resident #76 floor. The LPN confirmed that the Resident notified her a few days ago and stated that she would follow up with housekeeping. Minimum Data Set (MDS) is a standardized, primary screening and assessment tool of health status which forms the foundation of the comprehensive assessment for all residents of long- term care facilities certified to participate in Medicare or Medicaid. The MDS contains items that measure physical, psychological and psycho-social functioning. The items in the MDS give a multidimensional view of the patient's functional capacities. A review of Resident #76 ' s MDS assessment was conducted on 01/27/25 at 10:42 AM. The assessment dated [DATE] revealed that the Resident had lower extremity impairment on both sides, was dependent and required substantial /maximum assistance. During an interview conducted on 01/27/25 at 10:47 AM, the Unit Manager (UM) 1 stated that LPN #34 should have removed the items from the floor. The Surveyors observed UM #1 remove the items from Resident #76 ' s floor.

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	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Spring Healthcare 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 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. 50502 Based on observation, interview and record review, it was determined that the facility failed to develop and implement a comprehensive care plan for 1) the resident's refusal to use palm protector and 2) the use of an anticoagulant. This was evident for 2 (Residents #32 and #53) of 39 residents reviewed for care planning during the recertification survey. The findings include: 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. Palm Protectors offer relief from hand contractures and cramping. They are put over the thumb and around the hand, providing a cushioning pad for the fingers to curl onto. This prevents the nails from digging into the palms and keeps the fingers warm and supported. A contracture is an abnormal shortening of muscle tissue causing the muscle to be resistant to stretching. Failure to protect the palm of the hand when the hand is contracted can result in injury to the palm of the hand caused by the pressure of fingers/fingernails pressing into the palm of the hand. An anticoagulant, also known as blood thinner, is a medication that prevents blood clots from forming or growing. 1) On 1/27/25 at 9:45 AM, Resident #32 was noted with left hand contracture. Also, the left thumb fingernail was observed curled inwards approximately half of an inch long. There was no evidence of any device worn on the left contracted hand during the first visit. On 1/27/25 at 9:55 AM, a record review revealed that Resident #32 had Left hand contracture, limitation to Range of Motion (ROM) to upper extremity on one side. An active physician order that was written on 5/27/2023 indicated, Left palm protector to be worn daily as tolerated. On in the morning after Activities of Daily Living (ADL) care, off at bedtime. On 1/28/25 at 11:40 AM, Resident #32 was observed lying in bed with his/her left hand clenched and his/her long fingernails pressing into his/her palm. The resident did not have a protective device (palm protector) to prevent pressure on the palms of the hands. On 1/28/25 at 11:45 AM, the surveyor requested Registered Nurse supervisor (RN #9) to come to Resident #32's room. The surveyor showed RN surveyor #9 the long fingernails of Resident #32. RN supervisor #9 stated that the nursing staff cut the fingernails of the resident, however, Resident #32 had a history of refusals. On 1/28/25 at 12:06 PM, during an interview with RN supervisor #9, he/she confirmed that the resident had an order to wear a palm protector, however, the resident had been refusing. (continued on next page)

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	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Spring Healthcare 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/28/25 at 12:31 PM, a review of Resident #32's care plan revealed that a plan for the use of palm protector on the left palm related to hand contracture and to monitor for skin breakdown were initiated, however, there was no evidence that the care plan was updated to address the resident's refusal to wear the palm protector. On 1/29/25 at 12:46 PM, during an interview with the Director of Nursing (DON), she confirmed that there were no progress notes/documentation and care plan for Resident #32's refusal to wear palm protector. 2) On 1/31/25 at 3:13 PM, a record review of Resident #53's active medication list revealed that the resident was placed on an anticoagulant since 4/7/2024. The order read, Eliquis Oral Tablet 5 MG (Apixaban) Give 1 tablet by mouth every 12 hours for pulmonary embolism. On 2/03/25 at 7:45 AM, the surveyor reviewed Resident #53's care plan, however there was no evidence that a care plan to address anticoagulant use was developed. On 2/3/25 at 7:50 AM, in an interview with RN supervisor #9, he/she stated that all the nurses created and updated the residents' care plans as needed when there were changes in condition. He/she added that he/she was responsible in ensuring that residents' care plans were developed. On 2/03/25 at 7:55 AM, the DON described the process of creating and updating care plans. She stated that normally, only the RNs created and updated the care plans if there were changes in condition and changes in medications. The DON was made aware that Resident #32's care plan was not updated to reflect the refusal to wear palm protector and Resident #53 had no care plan for anticoagulant use. On 2/04/25 at 7:35 AM, the Nursing Home Administrator (NHA) was made aware of the concerns.

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	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Spring Healthcare 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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51790 Based on interviews and record review, it was determined that the facility failed to have routine care plan meetings for residents. This was evident for 5 (Resident #36, #76, #1, #50 and #52) out of 39 residents reviewed for care plan meetings. The findings include: According to Centers for Medicare and Medicaid (CMS) a care plan meeting is a regularly scheduled gathering where healthcare professionals, residents (or their family representatives), and relevant staff from a facility discuss and review a resident's individual care plan, ensuring it accurately reflects their needs, preferences, and any necessary adjustments based on their current health status; these meetings are typically held quarterly and are a key part of quality care in nursing homes. 1) During an interview with Resident #36 on 01/27/25 at 12:13 PM, when asked about attendance for care plan meetings, he/she reported that he/she did not recall being involved in care plan meetings. 2) During an interview with Resident #76 on 01/29/25 at 09:30 AM, he/she reported that he/she was never invited to a care plan meeting. A record review for Resident #36 and #76 on 01/29/25 at approximately 12:44 PM, showed there was no documentation that quarterly care plan meetings occurred for these residents. During an interview with the Director of Nursing (DON) on 02/03/2025 at 09:43 AM, when asked what her expectations are for how often the care plan meetings should occur, she stated that the first care plan meeting should be within the first seven days of the resident ' s admission. Thereafter, a care plan meeting should be held every three months or sooner if needed. On 02/03/25 at 11:36 AM, during an interview with Social Worker #23, when asked about care plan meeting occurrences, she stated that due to the turnover of new social services staff, care plan meetings have not been happening as they should have. She stated that normally she would expect a care plan meeting to occur within seven days following each Assessment Reference Date (ARD) assessment. When asked what her expectations are for residents being involved in care plan meetings, she expects all residents to be invited and that she would document in the Electronic Health Record (EHR) if the resident refused. She further explained that on the day of the resident ' s care plan meeting, she expected that the resident would be asked again if they would like to attend the meeting. If the resident refused again, then she would document this in the EHR as well. This surveyor discussed the concern with Social Worker #23 that Resident #36 and #76 reported that they had not recalled being invited to care plan meetings and a review if their medical records did not show documentation for care plan meetings. Social Worker #23 reviewed Resident #36 ' s medical record and confirmed the Resident had not received a care plan meeting since 06/28/23. The Social Worker also confirmed that Resident #76 had not received a care plan meeting since his/her admission on 10/17/24. (continued on next page)

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	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Spring Healthcare 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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	51491 3) During a review of Resident Medical Records on 1/28/25 at 07:34 AM it was discovered that Resident #1 didn ' t have quarterly Care Plan Meetings regularly. The last documented Care Plan Meeting was held on 1/11/24. During a telephone interview conducted on 1/29/25 at 08:42 AM, Resident #1's family member stated he/she had concerns about Resident #1 and had been unable to have his/her questions answered. He/she reported they are the Power of Attorney for Resident #1 and had not been invited to any care plan meetings. The family member is reportedly waiting for a Care plan meeting to be scheduled to discuss his/her concerns. During an interview with the [NAME] President of Social Work for Maryland on 2/03/25 at 11:38 AM, she advised Care Plan meetings should be documented in the electronic medical records. She confirmed that the facility is behind on Care Plan Meetings and stated it seems common that care plan meetings haven ' t been held and I don't believe quarterly Care Plan meetings are up to date. She confirmed Resident #1 had not had a recent Care Plan Meeting. 50504 4) On 1/30/25 at 08:55AM the surveyor reviewed Resident #50's clinical record. The review revealed that Resident #50's quarterly MDS assessment was completed on 08/22/24 and an annual assessment was completed on 11/20/24. There was no evidence in the clinical record to indicate that a care plan meeting was held with the resident and the interdisciplinary team within 7 days or around the time of either the last quarterly or annual MDS assessment. The record revealed that the most recent interdisciplinary care plan meeting was held on 07/12/23 On 01/30/25 at 08:45 AM in an interview, the DON stated that the Social Worker was out sick, and she was unable to provide the details of the care plan meetings for Resident #50. Later, on 01/30/25 at 01:45 PM the Regional Nurse RN stated he is assisting in locating the resident's records and gave the surveyor a copy of a progress note confirming the most recent interdisciplinary care plan meeting for Resident #50 was on 7/12/23. 5) On 1/27/25 at 8:40AM during an interview, Resident #52 informed the surveyor that he/she had never been to a care plan meeting. A review of Resident # 52's clinical record revealed that resident was admitted to the facility on [DATE] and the most recent interdisciplinary care plan meeting was held on 08/10/23. The records also revealed that the most recent quarterly MDS assessments were completed on 09/18/24 and 10/19/24. There was no evidence in the clinical record to indicate that a care plan meeting had been held with the resident and the interdisciplinary team after 08/10/23. On 02/03/25 at 11:30 AM the surveyors interviewed the facility's [NAME] President for Social Work (VPW). The VPW stated that the interdisciplinary care plan meetings usually follows the MDS schedule and are held within 7 days of the schedule. However, because of the staffing issues at the facility, care plan meetings were not held in a timely manner. When asked about the care plan meetings for Resident # 50 and Resident #52, the VPW confirmed that the most recent interdisciplinary care plan meeting for Resident #50 was 07/12/23 and for Resident #52 was 08/10/23.

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	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Spring Healthcare 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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50504 Based on observation, record review and interviews, it was determined that the facility failed to ensure that residents receive podiatry services for overgrown toenails. This was evident in 1 (Resident #52) of 1 resident reviewed for podiatry care. The findings include: Resident #52 was admitted to the facility on [DATE] with diagnoses including Paraplegia, Seizures, Adult Failure to Thrive and Major Depressive Disorder. On 01/28/25 at 8:11 AM the surveyor observed Resident #52 lying in bed. Resident #52's toenails on both feet were long, thickened and curled over the bottom of his/her toes. On 01/28/25 at 11:11AM a review of Resident #52's record revealed a physician order dated 10/17/24 for podiatry consult as needed. On 01/28/25 at 11:32 AM the surveyor interviewed Staff #9 and enquired about the process for podiatry care. Staff #9 stated that residents are assessed upon admission and as needed for podiatry care. The residents' facesheets and physician orders are then faxed to the podiatry service provider. The service provider creates appointment schedules for the residents and follows up with the facility. If a resident's condition requires a podiatry consult in between visits, an appointment would be made by the nurses. On 01/28/25 at 11:43 AM the surveyor informed Staff #9 of Resident #52's long, thickened toenails. Staff #9 accompanied the surveyor to the resident's room and confirmed the findings. Staff #9 stated, I will fax a request for the resident to see the podiatrist. On 01/30/25 at 10:22 AM a review of Resident # 52's clinical record revealed that the facility had scheduled an appointment for February 7th, 2025 which was the earliest appointment date available. On 01/31/25 at 08:32 AM the Director of Nursing was notified of the surveyor's findings.

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	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Spring Healthcare 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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. 51790 Based on interviews and review of medical records, it was determined that the facility failed to provide routine appointments for vision services. This was evident for 1 (Resident #36) out of 1 resident reviewed for vision services. The findings include: During an interview conducted on 01/27/25 at 12:18 PM, Resident #36 reported having a concern with seeing an eye doctor. The Resident stated that he/she now sees little black spots and had lots of headaches. The Resident further stated that he/she reported the need to see an ophthalmologist for an eye exam and for the recent little black spots to the nursing supervisor. On 01/31/25 at 08:04 AM, a record review of Resident #36 ' s nurse notes showed a note from 1/9/2025 at 12:00 PM by Licensed Practical Nurse (LPN) #30. The note stated Resident complained of having dark spots before her eyes. Medical Staff notified. Stated that it has been ongoing for 7 days but did not report it to anyone. A review of Resident #36 physician orders revealed a consult by Nurse Practitioner (NP) #28 that was placed on 01/10/2025. The consult DX (diagnosis) stated Patient complained of see dark spots. There was another order for a consult dated 12/26/24 for Ophthalmology placed by the Primary Attending Physician (PA) #29. During a follow up interview conducted on 01/31/25 at 11:04 AM, Resident #36 stated that he/she reported the need to see an Ophthalmologist about a month ago to PA #29. The Resident further reported that he/she was told there was an Ophthalmologist in the facility recently, however, he/she was not provided services. On 02/03/25 at 10:11 AM, during an interview with LPN #25 in the hallway, it was confirmed that she was caring for Resident #36 that day and had cared for the Resident in the past. When asked if Resident #36 had mentioned anything to her about making appointments that day, she stated that Resident #36 wanted to see an ophthalmologist about seeing spots. This surveyor asked LPN #25 if they knew when was the last time Resident #36 had an eye appointment. LPN #25 stated that this information would be in HealthDrive. She explained that HealthDrive is a company that provides ophthalmology, dental, audiology and podiatry in house services to the residents. On 02/03/25 at 10:19 AM, during an interview with Unit Manager Registered Nurse (RN) #1 at the nurse ' s station, she confirmed that she reconciles this list and receives emails from HealthDrive containing updated lists of residents and the services they will receive. This surveyor asked for a copy of the most the HealthDrive lists for the past 3 months. On 02/3/2025 at approximately 12:15 PM, during record review of the HealthDrive lists provided by Unit Manger RN #1, it showed on the 11/25/2024 list that Resident #36 had been on a DNT (Do Not Treat) list for optometry, since 11/06/2024. The DNT reason for optometry stated New Consent Required for Future Treatment. This was also stated the same for HealthDrive lists for 12/02/2024, 01/08/2025, and 01/25/2025. (continued on next page)

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	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Spring Healthcare 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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/03/25 at 01:41 PM , during an interview with the Director of Nursing (DON) in her office, it was confirmed that DNT means Do Not Treat. When asked how it is determined that residents get on a Do Not Treat list, she answered that it could be insurance reasons, the resident is combative and/or the resident refuses the services. She further explained her expectation is that the facility is to cover the costs of treatment for services if the resident does not have insurance. When asked what the expectation was for attempting to get services for a resident who is combative or refusing services, the DON answered that they would want to get families/loved ones involved to come and speak with the resident, to try and convince them that they need such services. On 02/03/25 at 01:50 PM, during an interview with the DON in her office, this surveyor discussed the concern that Resident #36 had not received an ophthalmologist appointment since reporting seeing black spots on 1/9/2025, per LPN #30 ' s note. This surveyor showed the DON the HealthDrive lists that were provided by Unit Manager RN #1, which indicated Resident #36 on the Do Not Treat list. The DON confirmed that she would have expected Resident #36 to have eye exams when requested.

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	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Spring Healthcare 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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 50502 Based on observation, record review and interview, it was determined that the facility failed to provide the prescribed treatment for limited mobility. This was evident for 1 (Resident #32) of 2 residents reviewed for positioning and mobility during the recertification survey. The findings include: A contracture is an abnormal shortening of muscle tissue causing the muscle to be resistant to stretching. Failure to protect the palm of the hand when the hand is contracted can result in injury to the palm of the hand caused by the pressure of fingers/fingernails pressing into the palm of the hand. Palm Protectors offer relief from hand contractures and cramping. They are put over the thumb and around the hand, providing a cushioning pad for the fingers to curl onto. This prevents the nails from digging into the palms and keeps the fingers warm and supported. On 1/27/25 at 9:45 AM, Resident #32 was noted with left hand contracture. Also, the left thumb fingernail was observed curled inwards approximately half of an inch long. There was no evidence of any device was worn on the left contracted hand during the first visit. On 1/27/25 at 9:55 AM, a record review revealed that Resident #32 had Left hand contracture, limitation to Range of Motion (ROM) to upper extremity on one side. An active physician order that was written on 5/27/2023 indicated, Left palm protector to be worn daily as tolerated. On in the morning after Activities of Daily Living (ADL) care, off at bedtime. On 1/28/25 at 11:40 AM, Resident #32 was observed lying in bed with his/her left hand clenched and his/her long fingernails pressing into his/her palm. The resident did not have a protective device (palm protector) to prevent pressure on the palms of the hands. On 1/28/25 at 11:45 AM, the surveyor requested Registered Nurse Supervisor (RN #9) to come to Resident #32's room. The surveyor showed RN surveyor #9 the long fingernails of Resident #32. RN #9 stated that the nursing staff cut the fingernails of the resident, however, Resident #9 had a history of refusals. On 1/28/25 at 12:06 PM, during an interview with RN supervisor #9, he/she confirmed that the resident had an order to wear a palm protector, however, the resident had been refusing. On 1/29/25 at 7:37 AM, a review of December 2024 and January 2025 Treatment Administration Record (TAR) revealed that the left palm protector order to apply in the morning and remove at bedtime were signed daily by the nurses, except on 1/03/25. On 1/29/25 at 8:10 AM, the surveyor conducted a 3rd observation of Resident #32 and confirmed that the resident was not wearing the palm protector. (continued on next page)

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	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Spring Healthcare 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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/29/25 at 8:12 AM, in an interview with RN #13, he/she stated that he/she had Resident #32 on Tuesday, 1/28/25. He/she added that he/she applied the palm protector to the resident's left palm in the morning during medication administration. On 1/29/25 at 8:20 AM, Licensed Practical Nurse (LPN #12) was observed standing in front of the medication cart outside Resident #32's room. During an interview, he/she stated that she applied the palm protector during medication administration. The surveyor asked LPN #12 to see the palm protector of the resident, however he/she could not locate it. LPN #12 walked towards the nurse's station while the surveyor stayed outside the resident's room. LPN #12 was observed talking to RN supervisor #9 and RN #13. LPN #12 returned to Resident #32's room together with RN #13 at 8:25AM and they proceeded to look for the palm protector. While the 2 nurses were inside the resident's room looking for the palm protector, the surveyor asked Resident #32, do nurses apply the palm protector every morning?, the resident loudly replied with a no. LPN #12 and RN #13 were unable to locate the palm protector. On 1/29/25 at 8:26 AM, the Director of Nursing (DON) and the Nursing Home Administrator (NHA) were made aware of the concerns.

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	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Spring Healthcare 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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42783 Based on observations, interviews and record reviews, it was determined that the facility failed to supervise and provide protective devices for Residents that smoked. This was found to be evident for 2 (Resident #18 & #61) out of 4 Residents observed for smoking. The Maryland Office of Health Care Quality (OHCQ) determined that this concern met the Federal definition of Immediate Jeopardy, and the facility was notified verbally and in writing of this determination at 4:05 PM on 01/29/25. The facility provided a plan to remove the immediacy while the surveyors were onsite. The removal plan was accepted by the OHCQ at 8:37 PM on 01/29/25. On 01/30/25 the survey team confirmed the facility met the compliance date of their action plan and the Immediate Jeopardy was abated on 01/29/25. After removal of the immediacy, the deficient practice continued with a scope and severity of D with potential for more than minimal harm for the remaining residents The findings include: During a random observation conducted on 01/29/25 at 11:19 AM, the Surveyors observed resident #61 in the dining room with multiple burn holes in his/her sweatpants. The wheelchair cushion appeared to have multiple burns as well. Resident #61 was also observed holding a pack of [NAME] Cigarettes and a yellow lighter. When asked if those were burn holes in his/her pants the resident stated, yes from when I smoke. The resident was asked if he/she wore an apron or other protective device when he/she smoked, the resident stated no. On 01/29/25 at 11:20 AM Residents #61 and #18 were observed outside in the designated smoking area unsupervised. Resident #18 was observed smoking a cigarette without an apron or protective device. Resident #61 was not smoking but had a pack of [NAME] cigarettes and yellow lighter in his/her hand without an apron or protective device. During the continued observations, the Activities Director (AD) at 11:29 AM, entered the designated smoking area located outside and asked Resident #68, #61, #18, & #5 if everyone was ok. The AD then exited the smoking area and returned to her office. During an interview conducted on 01/29/25 at 11:36 AM, the AD stated that Resident #68, #61, #18, & #5 currently do not require supervision, only those that are dependent require supervision. The AD further stated that only Resident #11 who at the time was not outside, required supervision and a smoking apron. A review of Resident #61's medical records conducted on 01/29/25 at 11:42 AM, revealed a care plan that stated the resident may smoke with apron and supervision. A review of Resident #61's smoking assessment dated [DATE] stated that the resident was unable to light own cigarette, required supervision, and a smoking apron. (continued on next page)

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	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Spring Healthcare 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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 01/29/25 at 11:54 AM a review of Resident #18's smoking assessment dated [DATE] stated the resident was unable to light own cigarette and required supervision while smoking. A review of Resident #18's care plan conducted on 01/29/25 at 11:56 AM stated, provide supervision during designated smoke times. During an interview conducted on 01/29/25 at 12:13 PM, the Director of Nursing (DON) stated that it is the facility's policy and expectation that all smoking residents are supervised. The DON further stated that Residents that require a smoking protective device such as an apron are required to wear the device while smoking. A review of all Resident smoking assessments conducted on 01/29/25 at 1:14 PM revealed Resident #18, #9, #38, & #62 required supervision while smoking. Resident #11, #61, and 44 required supervision and a smoking apron. An immediate jeopardy was declared on 1/29/2025 at 4:05 pm. The Administrator submitted the initial plan of correction to OHCQ on 01/29/25 at 6:21 PM and it was determined to be unacceptable. The second version was submitted to OHCQ on 01/29/25 at 7:32 PM and it was determined to be unacceptable. A third version was submitted to OHCQ and was also determined to be unacceptable. A fourth version was submitted for review on 01/29/25 at 8:14 PM and was determined to be unacceptable. The 5th and final version was submitted for review on 01/29/25 at 8:29 pm and was determined to be acceptable and the immediacy was removed at 8:37 PM. The provision of the plan to remove the immediacy had a completion date of 01/29/2025 and included the following: The facility plan for the removal of the immediate jeopardy stated that staff would be educated on safety for Residents that smoked, supervision and protective devices. Corrective actions were taken to replace burnt clothing, wheelchair equipment, and skin assessments performed for residents who were not provided with protective devices while smoking. All smoking assessments were reviewed to determine the safety needs of each smoker and revised as needed. A list was created for the staff to identify all Residents that required supervision and /or a protective device. The facility also created a schedule that assigned staff to supervise the smokers during designated smoking times. The plan also stated that the Administrator, Director of Nursing, or shift supervisor will audit smoking breaks to evaluate whether supervision is being provided as required and whether aprons are being provided as required. These audits will occur during each smoking break for two days, four times a day for two weeks, and then daily for eight weeks. Negative findings will be addressed immediately. Results of these audits will be reported to the Quality Assurance/Performance Improvement Committee and considered for further action if needed.

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	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Spring Healthcare 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 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. 48393 Based on observations, clinical record review and staff interviews, it was determined that the facility failed to maintain respiratory therapy equipment according to professional standards of practice. This was found to be evident for 1 (#34) out of 2 residents reviewed for respiratory care during the annual survey. The findings include: Ipratropium- Albuterol is a medication used to treat wheezing and shortness of breath. It can be administered via an inhaler or via a nebulizer. A nebulizer turns the medication into a fine mist that is inhaled into the resident's lungs. Nebulizer treatments are considered an aerosol-generating procedure (AGP). On 01/28/2025 at 11:35 AM, the surveyor observed a clear, plastic zip lock bag on Resident #34's bedside table that contained two nebulizer face masks and nebulizer tubing. The nebulizer face mask and nebulizer tubing were not labeled as to when they were put to use or should be replaced. On 01/31/2025 at 08:46 AM, a review of Resident #34's clinical record revealed the following physician order: Date 04/08/2024 Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML (milligrams per 3 milliliters) (Ipratropium-Albuterol) 1 vial inhale orally every 6 hours for wheezing During a second observation on 01/29/2025 at 08:40 AM, Resident #34's nebulizer face mask and tubing were in a clear zip lock bag on Resident #34's bedside table and were not labeled. On 01/31/25 at 09:34 AM, an interview with LPN #11 confirmed that there was no label on Resident #34's respiratory therapy equipment and stated the nebulizer face mask and tubing should be changed and labeled every day. LPN #11 stated, I will take care of this now. During a follow up interview with the Director of Nursing (DON) on 01/31/2025 at 09:46 AM, the DON stated that it is the expectation of nursing staff to change and label respiratory therapy equipment every 7 days.

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	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Spring Healthcare 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 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. 50502 Based on record review and interview, it was determined that the facility failed to ensure that pain medication was given consistent with the professional standards of practice. This was evident for 1 (Resident #53) of 2 residents reviewed for pain management during the recertification survey. The findings include: The medical abbreviation PRN stands for pro re nata, a Latin phrase that translates to as needed or as the situation arises. Oxycodone is strong painkillers from a group of medicines called opiates, or narcotics used to treat moderate to severe pain. Pain parameters are the specific aspects of pain that are evaluated during an interview to understand a person's pain experience. On 1/30/25 at 9:18 AM, a record review of Resident #53's active physician orders indicated that he/she was on Oxycodone HCl Oral Tablet 15 MG (Oxycodone HCl) Give 2 tablets by mouth every 6 hours as needed for pain level 5-10, hold for sedation. On 1/30/25 at 10:47 AM, further review of Resident #53's Medication Administration Record (MAR) revealed that the facility staff failed to follow the pain parameter indicated in the physician order. Oxycodone HCl 5 mg tablet (2 tablets) was ordered for pain level of 5-10. However, the medication was administered to the resident for a pain level of 3 on the following dates: 1/3/25 1/4/25 1/8/25 1/9/25 1/13/25 1/14/25 1/16/25 1/23/25 1/26/25 1/27/25 (continued on next page)

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	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Spring Healthcare 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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/30/25 at 11:58 AM, in an interview with Licensed Practical Nurse (LPN #31), he/she revealed that the doctors wrote orders in the electronic health record and the nurses confirmed the orders with the pharmacy. He/she stated that the nurses followed a standard pain scale of 0-10 when giving PRN pain medications. He/she described that the nurses asked the residents to rate the pain level and documented in MAR prior to administering the pain medication and made a follow assessment after an hour to check the effectiveness of the pain medication. On 1/31/25 at 8:16 AM, the Director of Nursing (DON) and the Executive Director (ED) were made aware about the pain management concern. On 2/04/25 at 7:35 AM, the Nursing Home Administrator (NHA) was made aware of the issue.

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	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Spring Healthcare 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 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 50504 Based on review of Geriatric Nursing Assistant personnel files and staff interviews, it was determined that the facility failed to conduct yearly performance reviews at least every 12 months for 2 (Staff #18 and #22) of 5 staff members reviewed. The findings include: Performance reviews are to be completed at least every 12 months to identify in-service education needed to address competencies of the geriatric nursing assistants. On 01/28/25 at 11:02 AM the surveyor conducted a review of 5 Geriatric Nursing Assistants personnel files. Staff #18 was hired on 07/12/21 and Staff #22 was hired on 08/17/23. The records revealed that Staff#18's performance review was due on 05/31/24 and Staff #22's performance review was due on 08/17/24. A further review of the records revealed that performance reviews were not completed for Staff #18 and Staff #22 on the due dates, nor were they completed for the calendar year 2024. On 01/30/25 at 01:00PM in an interview with the Executive Director (EO), the surveyor was informed that annual performance reviews for geriatric nursing assistants were conducted annually and as needed by the facility. The surveyor informed the EO of the findings and requested a copy of the record. Later, on 01/30/25 at 02:00PM the surveyor was given a document by the EO confirming that the annual performance reviews for Staff #18 and Staff #22 were not completed for the calendar year 2024. On 02/03/25 at 7:00 AM the Director of Nursing was made aware of the findings.

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	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Spring Healthcare 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 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. 50502 Based on record review and interview, it was determined that the facility failed to respond to the recommendation made by consulting pharmacist in a timely manner. This was evident for 1 (Resident #6) of 5 residents reviewed for unnecessary medications during the recertification survey. The findings include: On 1/31/25 at 10:05 AM, a review of Resident #6's medications revealed an order that read, Dicyclomine HCl Oral Tablet 20 MG (Dicyclomine HCl) Give 1 tablet by mouth every 8 hours for abdominal cramping. On 2/03/25 at 7:35 AM, the surveyor reviewed Resident #6's medical record, however, was unable to locate a Medication Regimen Review (MRR) in the electronic medical record and the paper chart. On 2/03/25 at 7:40 AM, in an interview with Licensed Practical Nurse (LPN #11), he/she described that after each consultant pharmacist visit. The pharmacy faxed the recommendations to the Director of Nursing (DON) and she forwarded the recommendations to be addressed by the attending physician. The physician indicated if there were changes that needed to be made to the current orders. The nurses filed the MRR in the resident's paper chart. On 2/03/25 at 7:55 AM, the DON was made aware that the surveyor was unable to locate MRR in Resident #6's medical record. The surveyor requested copies of the MRR for the months of November, December and January. On 2/03/25 at 10:12 AM, the surveyor received the requested documents from Staff #20. He/she confirmed that the November 2024 pharmacy recommendation for Resident #6 was not addressed. The November 2024 Consultant Pharmacist's MRR indicated the following: Issues/concerns: This resident is currently receiving Dicyclomine 20 mg tablet with instructions to take 1 tablet by mouth every 8 hours for abdominal cramping. Unless the patient has a diagnosis of Inflammatory Bowel Disease, there is no direct indication for long term use. Recommendation: Please review the use of Dicyclomine 20 mg and add a potential stop date if possible. On 2/04/25 at 7:35 AM, the Nursing Home Administrator (NHA) was made aware of the concern.

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	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Spring Healthcare 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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 51790 Based on observations, interviews and record reviews, it was determined that the facility failed to ensure that the medication error rates were not 5% or greater. This was found to be evident for 13 medications errors out of 28 opportunities that resulted in a medication error rate of 46.42% for 3 (Resident #14, #55 and #20) out of 4 residents observed for medication administration. The findings include: According to the Centers for Medicare and Medicaid (CMS) the Medication error rate is determined by calculating the percentage of medication errors observed during a medication administration observation. The numerator in the ratio is the total number of errors that the survey team observes, both significant and non-significant. The denominator consists of the total number of observations or opportunities for errors and includes all the doses the survey team observed being administered plus the doses ordered but not administered. The equation for calculating a medication error rate is as follows: Medication Error Rate = Number of Errors Observed divided by the Opportunities for Errors (doses given plus doses ordered but not given) X 100. 1) On 01/29/25 at 07:51 AM, the surveyors observed Licensed Practical Nurse (LPN) #33 administer the following medication error to Resident #14. MiraLax Oral Powder 17GM/SCOOP - Give 1 scoop by mouth one time a day for Laxative on Narcotics. On the back of the MiraLax bottle, this surveyor observed instructions for how much water to add to the medication: 6-8 ounces of water. LPN #33 did not measure the amount of water. The surveyor asked LPN #33 how much water they normally add to MiraLax and how they measure it. LPN #33 stated they would fill a plastic cup up to a line with water and that this should be 120 milliliters (mL) of water. 120 mL of water = 4.05768 ounces of water. 2) On 01/31/25 at 08:37 AM, the surveyors observed the following medication error by LPN #31 for Resident 55. According to the Centers for Medicare and Medicaid (CMS), aerosol or vapor inhalation involves the administration of drugs or solution of drugs by the nasal or oral respiratory route for local or systemic effect commonly administered via a nebulizer. Budesonide inhalation suspension 0.5mg/2 - 2 mL inhale orally via nebulizer two times a day for SOB/Wheezing - Rinse Mouth After Use While removing medications from the cart, LPN #31 stated to the surveyor that they were not going to give the Resident their nebulization treatment because this Resident always refused this treatment. While LPN #31 attempted to give Resident #55 their medications, it was observed that she did not attempt to ask if the Resident wanted to take their nebulization treatment. A Gastrostomy tube (G-tube) is a tube that is placed directly into the stomach through an abdominal wall. The G-tube is used to administer enteral feeding and medication administration. 3) During medication administration observation conducted on 01/31/25 at 09:21 AM, the surveyors observed LPN #31 administer the following medications in error via Resident #20 ' s G-tube: (continued on next page)

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	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Spring Healthcare 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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Tylenol - 160 MG/5 ML (Acetaminophen) - Give 5 mL via (Gastrometry) Tube G-tube two times a day for pain The LPN #31 did not assess the Resident for pain before administering medication. Modular Protein - two times a day for wound healing L-Emental Arginine Packet Via G-tube The LPN #31 added 60 mL of water to mix with the Modular Protein (Arginine). 60 mL = 2.02884 ounces. The instructions for how much water to add to the Modular Protein (Arginine) is 4-8 ounces. An insufficient amount of water was added to this medication. Ascorbic Acid Oral Tablet - 250MG - Give 1 tablet via G-Tube one time a day for supplement On the bottle of this medication, it stated 500 mg per 1 tablet. LPN took out 1 tablet. The LPN did not cut the medication in half. The resident was given 500 mg of ascorbic acid, which was the incorrect dose. Clopidogrel Bisulfate Tablet - 75 mg - Give 1 tablet by mouth one time a day for blood clot prevention LPN told the surveyors that she was going to use Resident #382 ' s Clopidogrel Bisulfate 75 mg tablet because Resident #20 did not have any more. It is a medication error to use the medication from another Resident. Cholecalciferol Tablet - 1000 UNIT - Give 2 tablet by mouth one time a day for supplement - 2 tablets On the back of the bottle, it stated 1 tablet = 1000u. The surveyors observed the LPN take out 2 tablets, which would equal 2000 units. The resident was given 2000 units of medication, which was the incorrect dose. A nasogastric (NG) tube is a thin, flexible tube that is inserted through the nose and into the stomach. It's used to deliver food, liquids, and medications, or to remove substances from the stomach. Magnesium Oxide Tablet - Give 400 mg -via NG-tube one time a day for supplement Surveyors observed LPN #31 use Resident #382 ' s Magnesium Oxide 400 mg. It is a medication error to use the medication from another Resident. The Resident also did not have an NG tube therefore this order should have been clarified with the physician. MiraLax Oral Powder - 17GM/SCOOP (Polyethylene Glycol 3350) - Give 1 scoop via G-Tube one time a day for bowel regimen. When asked LPN #31 how much water she should add to the medication, she stated 120 mL of water. On the back of the MiraLax bottle, it stated to add 6-8 ounces of water. 120 mL of water = 4. 05768 ounces of water. An insufficient amount of water was added to the medication. (continued on next page)

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	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Spring Healthcare 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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/31/25 at 09:46 AM, LPN #31 crushed the medications and stated that she normally crushed all of the medications together and then would administer the liquid medications separately. The surveyors then observed LPN #31 add 30 mL of water to mix with the crushed pills. A Kangaroo pump has a few components of its tubing setup. There is the tube feeding, the tubing that carries the tube feeding to the patient ' s G-tube via the pump, a connecter at the end of the tubing which connects to the patient ' s G-tube, and a plastic cover that clips on top of the connector. When giving medications through a G-tube, the normal process is to crush medications, mix them with water (specific instructions for administration depend on the facility ' s policy), and administer via a calibrated piston syringe with a removable plunger. The measurements on the side of the piston syringe are in milliliters (mL). On 01/31/25 at approximately 10:00 AM, the surveyors observed LPN #31 remove the cap from the connector piece of the Kangaroo pump tubing and attach that piece to the tip of the piston syringe. She then attached the piston syringe to the G-tube and confirmed placement of the G-tube in the stomach. She added 30 mL of water to the piston syringe and then administered the crushed medications and the liquid medications into the G-tube using a piston syringe. She then added the 30mL mixture of crushed medications into the syringe, followed by 30 mL of water to flush.She then added 15 mL more water to the medication cup, she explained this was to administer the remaining bits of crushed medication in the cup. She then added this mixture of 15mL water and the remaining bits of medication into the piston syringe. Lastly, she explained she was going to add 60 mL of water to the piston syringe, for the final flush after the medication administration. Surveyors observed LPN #31 add 59 mL of water to the syringe (indicated by mL on the side of the syringe) and then proceeded to add another 40 mL of water. The surveyors made LPN #31 aware that she added approximately 100 mL of water, not 60 mL. LPN #31 stated that she had measured the 60 mL of water into the cup prior to adding it to the syringe. The surveyors explained that the mL measurement could be seen on the side of the piston syringe and had observed the water reach 59 mL, and then 40 mL. LPN #31 responded Oh, then proceeded to remove the syringe from the G-tube, cap the G-tube, and went over to the sink to rinse out the piston syringe. During our observation of this medication administration, the Kangaroo tube feeding was exposed, due to the connector piece being removed and used on the piston syringe for administering medications via the G-tube. The surveyors did not observe LPN #31 administer the MiraLax medication. On 01/31/25 at 10:04 AM, the surveyors observed LPN #31 make the following medication errors. Peridex Mouth/Throat Solution - 0.12% (Chlorohexidine Gluconate (Mouth Throat)) - 15 mL dental every day and evening shift for periodontal disease. Latanoprost Solution - 0.005% - Instill 1 drop in both eyes at bedtime for glaucoma. LPN #31 used 4 lemon-flavored swabs to dip into the mouthwash and applied it to Resident #20 ' s gums, teeth, and lips. It was observed that after doing so, approximately 13 mL of the medication still remained. LPN #31 then disposed of the remaining mouthwash medication into the sink. LPN #31 then administered Resident #20 ' s eyedrops. She gave this medication in the morning, however, the order for this medication stated to be administered at bedtime. (continued on next page)

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	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Spring Healthcare 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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/31/25 at 10:16 AM, LPN #31 was asked about the MiraLax medication that remained in the water cup with the spoon. The surveyors made LPN #31 aware of our observation that she did not administer the MiraLax medication. It was observed with the LPN that the sediment of the MiraLax powder medication was visible in the water cup. According to a record review of Resident #20 ' s orders on 01/31/25 at approximately 12:00 PM, there were two conflicting orders pertaining to enteral feed orders for medication flushes: Enteral Feed Order every shift for Tube flush - Flush tube with at least 30 mL of water before and after each med pass and feeding. Enteral Feed Order every shift for Tube flush - Flush tube with at least 5 mL with each medication administration. On 02/04/25 at 08:33 AM, the surveyors conducted an interview with the Director of Nursing (DON) to make her aware of the errors seen while observing the medication administration. We expressed our concern that the medication error rate was calculated at 46.43%.The DON stated that she would immediately educate the staff on medication administration. On 02/04/25 at approximately 10:00 AM, a review of this policy revealed that their standard procedure is to Administer medication one at a time and follow with a minimum of 15 mL of water, preferably tepid, not cold, between medications unless otherwise directed to do so which prevents clogging of the tube with drug-to-drug interactions. It further stated that After final medications, flush with 60 mL ' s of tepid water or as directed by physician order. According to this policy, LPN #31 did not follow the policies and standard procedures for medication administration by enteral tube.

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	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Spring Healthcare 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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 42783 Based on observations and interviews, it was determined that the facility failed to ensure that medications were stored properly. This was found to be evident for 3 (Residents #57& # 76 & 55) out of 5 Residents observed during medication storage. The findings include: 1) During a random observation conducted on 01/27/25 at 10:00 AM, the Surveyors observed Resident #57 at the entrance of his/her doorway. The Resident had asked a staff for water to take his/her medications. During an interview conducted on 01/27/25 at 10:02 AM, Resident #57 stated that the nurse put the medications on top of the nightstand to take after he/she ate breakfast. During an observation conducted on 01/27/25 at 10:07 AM, the Surveyors and Licensed Practical Nurse (LPN) #34 observed a medication cup with multiple medications. LPN # 34 stated that Resident #57 wanted to eat breakfast before he/she took the medications. The LPN further stated that the facility's expectation was to return the medications to the medication cart and store them in a secured medication cart when a resident refused to take the medications. 2) During an observation conducted on 01/27/25 at 10:12 AM, the Surveyors and LPN #34 observed multiple loose tablets scattered across Resident #76's side of the room and under the Resident's roommate's bed. There was also a medication cup on top of the Resident's tray table with multiple medication. The LPN stated the Resident did not want to take the medication at the time she went to administer the them. The LPN confirmed she left the medication at the bedside for the Resident to take later. The LPN further stated that she should have returned medications to the locked medication cart. On 01/27/25 at 10:42 AM, the Director of Nursing (DON) stated that it is the facility's expectation that if a resident refused their medication administration the nurse is to store the medication in the locked medication cart, wait 30 minutes and attempt to administer the medication again. If the Resident refused again then the nurse would follow the facility's policy for disposing of the medication. The Nurse would notify the physician and document the Resident's refusal. Anbesol is a local anesthetic that works by numbing the painful area. Digoxin is used to treat congestive heart failure and to slow the heart rate in patients with atrial fibrillation. 3) During a medication observation conducted on 01/31/25 at 08:52 AM, the Surveyors observed LPN #31 place 1 bottle of Anbesol on top of the medication cart along with 1 tablet of digoxin in a medication cup for Resident #55. (continued on next page)

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	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Spring Healthcare 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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Surveyors observed LPN leave both medications on top of the medication cart and enter Resident #55's room. The LPN returned to the medication cart several minutes later. The Surveyor asked the LPN what the facility's policy for medication storage was. The LPN stated that she should not have left the medications on top of the cart and that all medications should be stored and locked in the medication cart if not administered.

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	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Spring Healthcare 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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. 51790 Based on interviews and review of medical records, it was determined that the facility failed to provide routine dental services. This was evident for 1 (Resident #36) out of 1 resident reviewed for dental services. The findings include: During an interview conducted on 01/27/25 at 12:18 PM, Resident #36 stated that he/she had dental concerns. The Resident stated that he/she had not had a teeth cleaning in 3 years and had requested to have a dental appointment. However, the facility had not provided a dental service as of yet. On 01/31/25 at 08:04 AM, a record review of Resident #36 ' s physician ' s orders showed a consult for Audiology, Dental, Optometry, Ophthalmology and/or Podiatry as needed placed on 12/26/2024 by Primary Attending Physician (PA) #29. During a follow up interview conducted on 01/31/25 at 11:04 AM, Resident #36 advised the surveyors that he/she notified PA #29 of the need for dental services. The Resident further stated that he/she had not been notified of a dental appointment scheduled since the notification to the PA. On 01/31/25 at 11:30 AM, this surveyor asked License Practical Nurse (LPN) #25 if she knew when was the last time Resident #36 had a dental appointment. LPN #25 stated that this information would be in HealthDrive. She explained that HealthDrive is a company that provides dental, ophthalmology, audiology and podiatry in house services to the residents. On 02/03/25 at 10:19 AM, during an interview with Unit Manager Registered Nurse (RN) #1 at the nurse ' s station, she confirmed that she reconciles this list and receives emails from HealthDrive containing updated lists of residents and the services they will receive. This surveyor asked for a copy of the most the HealthDrive lists for the past 3 months. On 02/3/2025 at approximately 12:15 PM a record review of the HealthDrive lists provided by Unit Manage RN #1 was conducted. The HealthDrive list dated for 11/25/2024 showed Resident #36 had been on a DNT (Do Not Treat) list for dental, since 2/09/2021. The DNT reason for dental states New Consent Required for Future Treatment; Patient Needs Payer Source. This was also stated on the HealthDrive lists for 12/02/2024, 01/08/2025, and 01/25/2025. On 02/03/25 at 01:41 PM , during an interview with the Director of Nursing (DON) in her office, it was confirmed that DNT means Do Not Treat. When asked how it is determined that a resident is added to the Do Not Treat list, she answered that it could be insurance reasons, the resident is combative and/or the resident refuses the services. She further explained her expectation is that the facility is to cover the costs of treatment for services if the resident does not have insurance. When asked what the expectation is for attempting to get services for a resident who is combative or refusing services, the DON answered that they would want to get families/loved ones involved to come and speak with the resident, to try and convince them that they need such services. (continued on next page)

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	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Spring Healthcare 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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When asked how often the facility expected residents to get treatment for dental services, the DON stated that she expected a resident would receive routine dental services every 6 months. If the resident required more specific treatment, that resident would be sent out for dental services. On 02/03/25 at 01:50 PM, during an interview with the DON in her office, this surveyor discussed the concern that Resident #36 had not received a dental appointment in 3 years. This surveyor showed the DON the HealthDrive lists that were provided by RN #1, which indicated Resident #36 was on the Do Not Treat list. The DON confirmed that she would have expected Resident #36 Do Not Treat issue to have been resolved and the resident received routine dental services. The DON reported that she would work on scheduling a dental appointment for Resident #36. On 02/04/25 at approximately 12:30 PM, the DON provided written confirmation of a dental appointment scheduled for Resident #36, on 02/20/2025 at 10:30 AM.

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	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Spring Healthcare 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48393 Based on observation and interview with facility staff, it was determined that the facility failed to store and prepare food in a manner that maintains professional standards of food service safety. This was evident during the initial tour of the kitchen during the annual survey. The findings include: During the initial tour of the kitchen conducted on 01/27/2025 at 8:52 AM, the Surveyor and Certified Dietary Manager (CDM) observed one clear bag of corn opened and undated and one clear bag of garlic bread opened and undated inside of a box labeled broccoli florets in the walk-in freezer. There was also one clear bag of Salsbury steak opened and undated on the top shelf of the walk -in freezer. In an interview conducted on 01/27/2025 at 8:58 AM, the CDM confirmed the facility's food storage policy is to securely close packages/bags once opened and to label the package/bag with an open date. The CDM stated that the printed expiration on the package/bag is used to determine when items are discarded. The CDM further stated that opened bulk food should be labeled with an open date once removed from its original box/container. During a continued tour of the kitchen at 9:02 AM, Surveyor and the CDM observed a shelf in the food preparation area with multiple containers of dried herbs and seasonings that were opened and undated. The food containers were identified as follows: 1 6 ounce bottle of Rubbed Sage, 1 6 ounce bottle of Table Ground Black Pepper and 1 6 ounce bottle of seasoning labeled Garlic Powder. The powder inside the Garlic powder seasoning bottle was observed to be red in color. In an interview conducted on 01/27/2025 at 9:05 AM with the CDM, the CDM stated that she did not know what the red colored powder was inside the garlic powder bottle and that it would be discarded. The CDM also stated that the undated dried herbs and seasonings would be labeled and dated appropriately.

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	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Spring Healthcare 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 0814 Level of Harm - Potential for minimal harm Residents Affected - Some	Dispose of garbage and refuse properly. 48393 Based on observation and interview, it was determined that the facility failed to ensure waste in the outdoor garbage storage area was disposed of properly. This was evident for 1 of 1 random observation made of the facility's outdoor refuse area during the annual survey. The findings include: During a tour of the facility's outdoor refuse area on 01/27/2025 at 10:05 AM, the Surveyor and District Manager (DM) observed debris scattered around the dumpster area. The debris included several pairs of used medical gloves on the ground and clear plastic bags. In an interview conducted on 01/27/2025 at 10:07 AM, the District Manager confirmed that the expectation for trash disposal was that all trash is to be contained inside of the dumpster and stated that scattered debris and all other trash would be disposed of immediately.

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	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Spring Healthcare 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 - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 49815 Based on observations, interviews and record reviews, it was determined that the facility staff failed to ensure medical records were complete and accurate. This was found to be evident for 5 (Resident #45, # 48, #77,#384 and #68) out of 5 Residents reviewed during the recertification survey. The findings include: 1) A blister pack/card is a form of tamper-evident packaging where an individual pushes individually sealed tablets through the foil in order to access the medication. 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. 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). The surveyor review of the 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 for Residents #48, #77 and #384. 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 was when the narcotic blister card backs were discovered taped. 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 cards immediately. 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 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. 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. (continued on next page)

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	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Spring Healthcare 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 - Some	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. 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 the narcotic was taken out of the narcotic drawer of the medication cart. 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. 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 of the concerns with the narcotic count by the nursing staff. 51491 2) A Preadmission Screening and Resident Review (PASRR) is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long-term care. The PASRR process requires that all applicants to Medicaid-certified nursing facilities be given a preliminary assessment to determine whether they might have Serious Mental Illness or Intelectual Disability. This is called a Level I screen. Those individuals who test positive at Level I are then evaluated in depth, called Level II PASRR. The results of this evaluation result in a determination of need, a determination of appropriate setting, and a set of recommendations for services to inform the individual's plan of care. During a medical record review on 1/31/25 at 09:52 AM it was discovered that Resident #68 had a PASRR Level I Completed on 9/13/24. He/she was identified as having a positive screen for serious mental illness and a referral had been forwarded for a PASRR Level II to be completed. The PASRR II documentation was not found in the medical records for Resident #68. During an interview with the [NAME] President of Infection Control (VPIC) on 1/31/25 at 12:24 PM she provided a copy of the completed PASRR Level I for Resident #68. She was notified the PASRR Level II had not been found in Resident #68 Medical Records. She advised she would attempt to locate the PASRR Level II records. During an interview with the VPIC on 1/31/25 at 12:50 PM she reported that the PASRR II for Resident #68 had not been found. She advised they need more time to find the PASRR II documents and would discuss it with the Social Worker when she comes in on Monday. (continued on next page)

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	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Spring Healthcare 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 - Some	During an interview with the [NAME] President of Social Work in Maryland on 1/31/25 at 12:18 PM, she reported she was unable to locate the PASRR II for Resident #68. She has made attempts to obtain the records from the agency that conducted the PASRR II evaluation but has been unsuccessful. She advised she would make additional attempts to get a copy from the agency. She confirmed the facility does not have a copy of the PASRR II for Resident #68 and agreed the facility should have followed up with the agency if they didn ' t receive the PASRR II evaluation.

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	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Spring Healthcare 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50504 Based on observations and staff interviews, it was determined that the facility failed to ensure appropriate infection prevention and control practices. This was found to be evident for the laundry department and 1(Resident #20) of 4 Residents observed for infection control. The findings include: 1) Resident #20 was admitted to the facility on [DATE] and required tube feeding for nutrition. On 01/28/25 at 08:15 AM during rounds the surveyor observed Resident #20 lying in bed with a bottle of tube feeding attached to a pump, hanging on a pole at the bedside. The pole was visibly dirty with dark brown spots scattered along the base and the shaft. On 01/28/25 at 10:17 AM a review of Resident #20's physician order dated 5/1/24 revealed that the resident required tube feeding for 20 hours per day via pump. On 01/28/25 at 11:44 AM Staff #9 was made aware of the condition of the pole. Staff #9 acknowledged the surveyor's findings and stated that the pole would be cleaned immediately. Staff #9 also stated that the housekeepers and the nurses were responsible for ensuring the pole was kept clean. When asked about a cleaning schedule, Staff #9 stated that she was not aware of one. On 01/31/25 at 08:33 AM the DON was notified of the surveyor's findings. On 01/31/25 at 08:45 AM during another observation by the surveyor, the pole was noted to be clean. On 02/03/25 at 10:53 AM in an interview with the surveyor, the [NAME] President for Infection Control stated that the housekeepers were responsible for cleaning the poles and the nurses usually do a wipe down whenever there were spills. The surveyor requested a copy of the housekeepers' cleaning log. As of the time of exit on 02/04/25, a copy the housekeepers' cleaning log had not been provided to the surveyor. 49815 2) On tour of the laundry department in the basement of the facility at 8:00 AM on 1/30/2025 the surveyor observed the laundry aide #15 folding clean linen and storing the clean linen on the folding table and in the cubicles above the folding table. (continued on next page)

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	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Spring Healthcare 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Environmental Services Director #16 at 8:20 AM on 1/30/2025, the surveyor asked where the soiled linen entered the laundry department. The EVS Director stated that the soiled linen entered the laundry department through the stairway door into the laundry department. The clean linen folding table and the cubicles were located next to the stairway door in the laundry department. The EVS Director was asked by the surveyor where the clean linen exited the laundry department and the EVS Director stated that the clean linen exited the laundry department through the same stairway door. The EVS Director acknowledged that this was cross-contamination with the clean linen folding area and the cubicles with clean linen directly next to the stairway door where dirty linen entered, and the clean linen exited. The EVS Director stated that this was the process at the facility. The surveyor observed laundry aide #17 at 8:45 AM on 1/30/2025 picking up soiled linen from the dirty utility room on the nursing unit. The soiled linen was in plastic bags that were stored in a large barrel and transported to the staircase leading to the basement where the laundry department was located. The laundry aide #17 stated that this was how soiled linen was transported to the laundry department. The Nursing Home Administrator and the [NAME] President of Infection Control #20 were made aware of this concern with cross-contamination of clean and dirty linen entering and exiting the laundry department with the clean folding table and cubicles stored with clean linen directly next to the stairway door to the laundry department at survey exit.

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	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Spring Healthcare 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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 49815 Based on observations and staff interviews it was determined that the facility failed to ensure a safe/functional/sanitary/comfortable environment. This was found to be evident in the laundry department during the annual recertification survey. The findings include: On tour of the laundry department in the basement of the facility on 1/30/2025 at 8:00 AM with the laundry aid #15 in attendance it was observed that there were four ceiling tiles grossly soiled with large brown stains, chipped, and missing. In an interview with the Environmental Services (EVS) Director #16 at 8:25 AM on 1/30/2025, the surveyor asked what the expectation was for the replacement of these ceiling tiles that were observed grossly soiled, chipped and missing in the laundry department. The EVS Director #18 stated that the Maintenance Department was responsible for the replacement of the ceiling tiles. The EVS Director #18 further stated that these ceiling tiles became soiled from the rain outside. The surveyor interviewed the Maintenance Assistant #6 on 1/30/2025 at 8:40 AM regarding the replacement of the grossly soiled, chipped and missing ceiling tiles in the laundry department. The Maintenance Assistant #6 acknowledged that the ceiling tiles needed replacement in the laundry department. The Maintenance Department was located next to the laundry department in the basement of the facility. At 8:50 AM on 1/30/2025 the surveyor notified the Nursing Home Administrator (NHA) of the condition of the ceiling tiles in the laundry department that were grossly stained, chipped and missing.

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	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Spring Healthcare 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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 48393 Based on observations, staff interviews, and review of facility pest control records, it was determined that the facility failed to maintain an effective pest control program. This was evident for 4 of 4 random observations made during the annual survey. The findings include: During an initial tour of the facility on 1/27/2025 at 8:48 AM, the surveyor and Administrator observed a roach crawling in the hallway outside the kitchen door entry way. In an interview conducted with the Certified Dietary Manager (CDM) on 1/27/2025 at 9:45 AM, the CDM stated that she had not seen roaches in the kitchen area. During a follow up tour of the kitchen on 01/29/2025 at 08:00 AM, the surveyor observed a roach crawling on the floor under the steam table while staff prepared breakfast meal trays for residents. During an interview conducted with the District Manager (DM) on 1/29/2025 at 8:25 AM, the DM stated that he had not seen roaches in the kitchen area. The DM further stated that pest control services visit the facility weekly and as needed. On 1/29/2025 at 8:32 AM, the surveyor, DM and CDM observed a dead roach in the hallway when exiting the kitchen area. Immediately following this, the surveyor, DM, and CDM walked across the hall into the dietary office and observed another roach crawling on the floor. During a follow up interview with the DM and CDM at 8:33 AM, the DM and CDM confirmed the roach sightings and the DM stated that pest control services would be contacted right away. On 1/29/2025 at approximately 11:47 AM, the DM provided the surveyor a copy of the pest control activity log that showed that the roach sightings from 1/29/2025 were logged and reported by the CDM and addressed by a pest control technician the same day.