STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215092	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Collingswood Rehabilitation and Healthcare Center	299 Hurley Avenue Rockville, MD 20850

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 31145 Based on complaint, medical record review, and interview, it was determined the facility failed to ensure a custom-made wheelchair was available for a resident during transport to an appointment. This was evident for 1 (Resident #4) of 28 residents reviewed for complaints during a complaint survey. The findings include: On 5/12/25 a review of complaint MD00215793 was conducted, and it was alleged that Resident #4 obtained a broken ankle at the facility. Review of an investigation done by the facility revealed staff written statements that Resident #4 did not have a fall. Staff statements documented that Resident #4 was transferred with 2 people from the bed to the wheelchair in a Hoyer lift per the care plan. A written statement from Geriatric Nursing Assistant (GNA) #37 documented the resident was sliding from the wheelchair. GNA #37 and 4 other staff members helped pull the resident up and reposition the resident. Despite being repositioned, Resident #4 continued to slide from the wheelchair. At that time Resident #4 was transferred to a different wheelchair by staff. The resident denied any pain or discomfort. On 5/13/25 at 8:32 AM GNA #37 was interviewed about the incident and stated that Resident #4 was sliding out of the wheelchair. GNA #37 stated the resident normally was either in bed or went to dialysis in a geriatric (geri) chair and that the resident did not normally sit in a wheelchair except for when he/she went out to appointments. GNA #37 stated the resident never fell to the floor and never touched the ground as there were 5 total people helping the resident when he/she was observed sliding out of the wheelchair. GNA #37 stated they quickly lifted the resident up and repositioned in the wheelchair. GNA #37 stated that the resident started sliding again so they got another wheelchair and placed the resident in that wheelchair. The other wheelchair had a high back. GNA #37 stated because the resident only had 1 leg, they put a pillow under the foot rest, and it made the resident sit back in a more comfortable position. GNA #37 stated Resident #4 never complained of pain or injury. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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	215092	A. Building B. Wing	05/15/2025

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/13/25 at 8:59 AM LPN #39 was interviewed and stated she was the nurse supervisor for 2 West. LPN #39 stated the resident was going out to a vascular appointment and that the VA (Veteran's Administration) scheduled the transportation which was a wheelchair transport. She reiterated that the resident did not fall or hit the floor. LPN #39 stated someone ran quickly to get a high back wheelchair. On 5/14/25 at 1:27 PM an interview was conducted with Resident #4's daughter who stated that the resident was using other people's wheelchairs. She stated that the VA had given Resident #4 a wheelchair, however the facility lost it, so the VA had a wheelchair specially made to fit the resident's needs. The daughter stated that she complained to several staff members including the previous Director of Nursing (DON), Nursing Home Administrator (NHA), the nurse manager on the unit and the nurses on the floor. When he/she went on appointments he/she was in someone else's wheelchair and the doctor asked the daughter about it and she had to tell him the facility misplaced the wheelchair. The daughter stated Resident #4 needed a wheelchair to fit him/her due to the leg amputation. The daughter stated the VA fitted the resident again for a wheelchair and the facility lost it again. On 5/15/25 at 9:07 AM the NHA was interviewed and stated she had been looking for the wheelchair but had not found any specialty wheelchairs, only power wheelchairs. The NHA stated in October 2024 during a Utilization Review meeting one of the VA reps stated the daughter asked for a chair and they knew that they had already issued a wheelchair, and they wanted the Director of Rehab to see if she could locate it or look for it. She said it has been her understanding that there have been several chairs missing. The NHA stated, no one knows where the chair is. On 5/15/25 at 9:37 AM an interview was conducted with a representative from the VA who stated they did supply Resident #4 with a wheelchair on 1/8/24. She stated the resident had a second wheelchair ordered, a custom wheelchair ordered by the VA and it was delivered directly to the facility from the vendor on 3/6/24. On 5/15/25 at 12:10 PM an interview was conducted with the NHA, and she was informed that the vendor delivered the wheelchair to the facility last year. The NHA was informed there was no follow-up with rehab knowing the chair had been ordered, where it was, and there was no follow-up with nursing staff who knew that the resident had a custom-made wheelchair with a seat belt and nobody followed up. The NHA stated she agreed with the findings that the facility failed to meet the resident's needs.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 34484 Based on medical record review and interview, the facility staff failed to notify a resident's physician timely for a change in condition (Resident #10) and failed to timely notify a resident's physician, responsible party, and dietician of a significant weight loss (Resident #22). This was evident for 2 of 28 residents reviewed during a complaint survey. The findings include: 1. The facility staff failed to notify Resident #10's physician for a low blood pressure timely. Review of Resident #10's medical record on 5/7/25 revealed the Resident was admitted to the facility in October 2024 with a diagnosis to include heart failure. Heart failure occurs when the heart can't pump enough blood to meet the body's needs. Further review of Resident #10's medical record revealed a nurse's note on 10/27/24 at 11:40 PM stated outgoing nurse reported that resident's blood pressure just suddenly dropped to 70/54, writer went to resident room blood pressure assess 81/54. Another nurse's note on 10/28/24 at 1:14 AM stated, writer assessed patient and no distress noted, paged provider about patient's low blood pressure no response. Resident's family member insisted not to send resident out to the hospital. Another nurse's note on 10/28/24 at 4:47 AM, writer continue to monitor resident's blood pressure as it continues to drop to 76/49, page on call provider no response, family at bedside. Writer discussed with family to send patient out to the hospital for further evaluation, family refused. Family agreed for Emergency Medical Services to come and assess patient in house. Writer called 911, they arrived and assess patient, family asked what they wanted to do. Family told them not to transfer to hospital. Management and provider notified. During interview with the Director of Nursing (DON) on 5/15/25 at 9:00 AM, the DON stated the expectation when the facility staff are unable to reach a resident's primary physician in a timely manner is to contact the Medical Director. Interview with the DON on 5/15/25 at 12:25 PM confirmed the facility staff failed to notify Resident #10's physician timely on 10/27/24 and 10/28/24 when the Resident had low blood pressure. 31145 2. On 5/13/25 at 10:50 AM a review of Resident #22's medical record was conducted and revealed a 12/15/23 note that Resident #22 was admitted for comprehensive rehabilitation and had admitting diagnoses that included cerebral infarction without residual deficits, hypertension, type 2 diabetes mellitus with hyperglycemia and a sacral wound. Review of the weight section of Resident #22's medical record documented on 12/14/23 the weight was 128. 0 lbs. and on 12/15/23 the weight was 128.0 lbs. The next weight was taken on 1/5/24 and was 102.2 lbs. which was a 25.8 lb. or 20 percent weight loss in 3 weeks. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Continued review of the medical record failed to produce documentation that the physician, dietician, and family were notified of the weight loss when it was found on 1/5/24. The previous dietician did not assess Resident #22 until 1/16/24, which was 11 days after the documented weight loss. There was no documentation that Resident #22 was evaluated in weekly risk meetings until 1/18/24 which was 13 days after the documented weight loss. Review of the Change in a Resident's Condition or Status Policy that was given to the surveyor on 5/13/25 at 1:34 PM documented a policy statement that stated, our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition. Number 1 stated, the nurse will notify the resident's attending physician or physician on call when there has been a(an): d. significant change in the resident's physical/emotional/mental condition; e) need to alter the resident's medical treatment significantly. Number 2 documented, A significant change of condition is a major decline or improvement in the resident's status that: a) will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, c) requires interdisciplinary review and/or revision to the care plan; and d) ultimately is based on the judgment of the clinical staff and the guidelines outlined in the Resident Assessment Instrument. On 5/14/25 at 10:05 AM an interview was conducted with Physician #29 who stated that she would expect to be notified of that amount of weight loss right away to determine if it was excessive fluid loss or wanted weight loss. On 5/15/25 at 10:44 AM an interview was conducted with the Director of Nursing (DON). The DON stated she was not here at the time, and they have since put weight loss and notification in place along with doing a change in condition.

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	215092	A. Building B. Wing	05/15/2025

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 31145 Based on review of a complaint, interview, and observation of resident wheelchairs, it was determined the facility failed to provide maintenance services necessary to keep all wheelchairs in a sanitary, comfortable, and well-maintained condition. This was evident on 2 of 3 nursing units observed during the complaint survey. The findings include: 1) On 5/6/25 at 2:00 PM a review of complaint MD00216562 alleged that Resident #3 went out to an appointment. The resident attended the appointment in a wheelchair. The complaint alleged that the family and resident were embarrassed about the condition of the wheelchair and the padding. The complaint alleged, the doctor/nurse was also taken aback by the stench that we have complained about for months. Upon unzipping the pillow, we were all appalled, disgusted, and I, embarrassed, by the urine and fecal matter present in the gel pad and the inside of the pillow cover. The complaint stated, the presence of urine and fecal matter in and of itself can cause other issues to include wounds in the area subjected to such filth. The complaint stated that the physician/nurse showed the family how to clean the gel pad. The smell and the appearance of the pillow confirms improper or no cleaning at all. On 5/13/25 at 1:25 PM an interview was conducted with Staff #35 from housekeeping. Staff #35 stated that she had been employed at the facility for the past 4 months and was in charge of housekeeping. Staff #35 confirmed the condition of Resident #3's wheelchair cushion and stated, prior to this incident there was not a schedule for cleaning or maintenance of the wheelchairs or cushions. Anything attached to the wheelchair is cleaned by us. Staff #35 stated, the chair was pretty gross when we initially cleaned it. It looked like it was never cleaned. Staff #35 stated she just developed a cleaning schedule and started cleaning wheelchairs. On 5/16/25 at 9:10 AM the Nursing Home Administrator (NHA) confirmed that she was made aware about the condition of the wheelchair cushion from Resident #3's family member. 2) On 5/14/25 at 12:50 PM observation was made of several wheelchairs that were in disrepair. Resident #7's wheelchair was sitting in his/her room. The vinyl on the right armrest was cracked and ripped which left the edges of the vinyl sharp. Resident #41 was sitting in a wheelchair and there was no armrest on the right side of the wheelchair. A resident was sitting in a wheelchair in the memory care unit. The vinyl on the left armrest was cracked and torn in the front and along the left side of the armrest. Resident #42 was sitting in a wheelchair. The vinyl on the left armrest was torn in the front and along the side and the vinyl on the right armrest was cracked throughout. (continued on next page)

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	215092	A. Building B. Wing	05/15/2025

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #43's wheelchair right armrest was missing 6 inches of vinyl and yellow foam was exposed. Resident #44 and Resident #45's wheelchair was missing an armrest on the right side of the wheelchair. There was only the frame of the wheelchair for them to put their right arm on. Resident #46's wheelchair was missing an armrest on the left side. On 5/16/25 at 9:10 AM the Nursing Home Administrator (NHA) was informed of the condition of the wheelchairs. The NHA confirmed the issue with Resident #3's wheelchair and confirmed that Staff #35 was putting a process in place for the maintenance of the wheelchairs.

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	215092	A. Building B. Wing	05/15/2025

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 31145 Based on reviews of facility reported incidents and interview, it was determined the facility failed to report allegations of abuse to the regulatory agency, the Office of Health Care Quality (OHCQ) within 2 hours of the allegation. This was evident for 3 (Residents #6, #1, #18) of 13 residents reviewed for facility reported incidents during a complaint survey. The findings include: 1) On 5/8/25 at 12:13 PM a review of facility reported incident MD00212791 was conducted and revealed Resident #6 was noted with a laceration to the right thumb area on 12/17/24 at 5:40 PM. Resident #6 was non-verbal and cognitively impaired and could not verbalize how the injury happened. Review of the facility's investigation revealed the injury happened on 12/16/24. Licensed Practical Nurse (LPN) #19 confirmed that he worked on 12/16/24 and stated that the physical therapist had reported to him that the resident was bleeding from the right thumb. LPN #19 stated he did not document the incident or notify the supervisor. Facility administration did not become aware of the incident until the next day. Review of the email confirmation revealed the initial self-report was sent to OHCQ on 12/17/24 at 7:38 PM which was not within 2 hours of an injury of unknown origin. On 5/15/25 at 7:50 AM the report was discussed with the DON who confirmed the findings. 2) On 5/12/25 at 9:43 AM a review of facility reported incident MD00217118 was conducted and revealed Resident #1 had an x-ray done on 4/24/25 with a result of a dislocation to the left shoulder. Resident #1 had a diagnosis of tracheostomy, G-tube status, Diabetes, hemiplegia and hemiparesis, and was dependent on a ventilator for breathing. Resident #1 was sent out to the hospital for evaluation and treatment. Review of the facility's investigation revealed the dislocation was found on 4/24/25 and then confirmed on 4/25/25 at 13:02 PM. Review of the initial report email confirmation to OHCQ for an injury of unknown origin revealed the report was not sent until 4/26/25 at 10:06 AM. It was not reported within 2 hours of the findings. On 5/15/25 at 7:50 AM an interview was conducted with the DON who confirmed the findings. The DON was not employed at the facility at the time. 3) On 5/13/25 at 1:21 PM a review of facility reported incident MD00206042 was conducted and revealed Resident #18's spouse reported to the nurse that a geriatric nursing assistant (GNA) physically assaulted Resident #18 on 5/24/24 at 4:15 PM. (continued on next page)

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	215092	A. Building B. Wing	05/15/2025

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's investigation revealed Resident #18 alleged that on 5/24/24 GNA #16 pulled the resident's beard to get the resident to open the mouth and punched the resident on the right side of the face to get the resident to open the mouth. The DON was not notified until the morning of 5/25/24. A written statement from GNA #16 stated that the GNA came back from lunch break on 5/24/24 and the family was accusing him of slapping the resident which was false. GNA #16 stated the nurse called him to the room because the resident had fallen. A written statement from the nurse who worked that evening documented she took care of the resident after the allegation, however a written statement from the evening supervisor documented that he was never made aware of any physical abuse or concerns during his shift. Review of the initial email confirmation revealed the initial report was sent to OHCQ on 5/25/24 at 10:30 AM which was not within 2 hours of an abuse allegation. On 5/15/25 at 7:50 AM an interview was conducted with the DON who confirmed the findings of late reporting. The DON was not employed at the facility during that time.

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	215092	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Collingswood Rehabilitation and Healthcare Center	299 Hurley Avenue Rockville, MD 20850

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. 31145 Based on medical record review and staff interview, it was determined the facility staff failed to ensure Minimum Data Set (MDS) assessments were accurately coded. This was evident for 4 (Resident #22, #24, #18, #3) of 46 residents reviewed during a complaint survey. The findings include: The MDS is part of the Resident Assessment Instrument that was Federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned based on those individualized needs, and that the care is provided as planned to meet the needs of each resident. 1a) On 5/13/25 at 10:50 AM a review of Resident #22's medical record was conducted. Review of the weight section of Resident #22's medical record documented on 12/14/23 the resident's weight was 128.0 lbs. The next weight was taken on 1/5/24 and was 102.2 lbs. which was a 25.8 lb. or 20 percent weight loss in 3 weeks. Review of the MDS Assessment with an assessment reference date (ARD) of 1/8/24, Section K, swallowing/nutritional status; K0200B weight was documented as 128 lbs. which was incorrect as it should have been documented as 102 lbs. K0300 weight loss was documented as 0. no or unknown which was incorrect and should have been documented as 2, yes, not on prescribed weight-loss regimen. Further review of the medical record revealed a note that documented Resident #22 had a fall on 12/27/23. Review of Section J, Falls, failed to capture the fall on 12/27/23. 1b) Review of Resident #22's February 2024 Medication Administration Record (MAR) documented that the resident received Metformin 500 mg. twice per day (hypoglycemic) from 2/21/24 to 2/27/24 and had received (2) insulin injections (hypoglycemic) on 2/22/24 and 2/23/24 at 16:30 requiring 2 units of insulin. Review of the MDS with an ARD of 2/27/24, Section N, Medications, failed to capture the hypoglycemics. 1c) Review of the MDS with an ARD of 12/15/23, Section N, Medications, documented that Resident #22 received an opioid medication. Review of the December 2023 MAR failed to produce documentation that the resident received an opioid. On 5/14/25 at 10:54 AM an interview was conducted with the MDS coordinators. The MDS's were reviewed with them and they confirmed errors. 2) On 5/13/25 at 1:12 PM a review of Resident #24's medical record was conducted. Review of a 10/17/23 at 23:10 document stated the resident was admitted to the facility with bilateral wounds to both heels. A 10/19/23 at 6:50 AM nurse's note documented, ABT (antibiotic) Doxycycline in progress for bilateral feet wound infection. (continued on next page)

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	215092	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Collingswood Rehabilitation and Healthcare Center	299 Hurley Avenue Rockville, MD 20850

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the October 2023 Treatment Administration Record (TAR) for Resident #24 documented treatments to the left and right heel wounds. The left and right heel were to be cleansed with NSS (normal saline solution), apply medihoney and wrap with Kerlex and an ace bandage daily. Review of the MDS assessment with an ARD (assessment reference date) of 10/24/23, Section M Skin Conditions, M0100 coded no pressure ulcer. M0150 coded no for at risk of pressure ulcer, M0210 unhealed pressure ulcer coded no, M1030 Venous and Arterial Ulcers coded no, M1040A code no to infection of the foot, M1200E code no to pressure ulcer/injury care, and M1200I coded no to application of dressings to feet. The facility failed to capture the bilateral heel wounds. Review of the 11/27/23 MDS discharge return anticipated assessment, Section M0100 coded no pressure ulcer. M0150 coded no for at risk of pressure ulcer, and M0210 unhealed pressure ulcer coded no. Review of weekly skin notes in November 2023 documented venous insufficiency (statis) ulcer for the bilateral heels. There was a 11/6/23 wound note that documented a Stage 2 pressure ulcer to the sacrum and a stage 3 pressure ulcer to the right buttock. Review of the November 2023 TAR documented treatments to both the heels, sacrum, and right buttocks. The facility failed to capture the pressure ulcers and the venous ulcers. Further review of the 11/27/23 MDS assessment, Section N coded that no medications were administered during the 7 day look-back period. Review of the November 2023 MAR documented the resident received Insulin (hypo-glycemic), Lasix (diuretic), Lyrica (opioid), Venlafaxine (anti-depressant), doxycycline (antibiotic), and Lovenox (anti-coagulant). On 5/14/25 at 10:30 AM the surveyor reviewed the MDS assessments from 10/24/23 and 11/27/23 with the MDS coordinator and the Regional MDS Coordinator. Both confirmed the errors. 3a) On 5/13/25 at 1:21 PM a review of Resident #18's medical record was conducted. Review of nursing notes revealed a note dated 5/24/24 at 19:31 that documented, Falls, lowered to floor. Review of Resident #18's MDS with an Assessment Reference Date (ARD) of 6/19/24, Section J1900, Falls since previous assessment was coded, no. The facility failed to capture the fall. Further review of the medical record revealed a skin and wound note dated 6/18/24 which documented; left heel wound, pressure, unstageable, stable eschar. Review of Section M, Skin Conditions for the MDS with an ARD of 6/19/24 documented there were no unhealed pressure ulcers and no unstageable pressure ulcers. The facility failed to capture the left heel pressure ulcer. Review of Section N, medications, was coded zero for the use of antibiotics. Review of the June 2024 medication administration record (MAR) documented on 6/13/24 the use of Firvanq for c-diff. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215092	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Collingswood Rehabilitation and Healthcare Center	299 Hurley Avenue Rockville, MD 20850

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3b) Review of Resident #18's August 2024 MAR documented the resident received Eliquis, an anticoagulant used to prevent blood clots twice per day. Review of the MDS with an ARD of 8/1/24, Section N, failed to capture use of Eliquis. Review of a skin and wound note date 7/29/24 documented; left heel wound, pressure, unstageable, wound debridement, removal of necrotic tissue. Review of Section M, Skin Conditions for the MDS with an ARD of 8/1/24 failed to capture the unstageable heel ulcer. On 5/15/25 at 11:20 AM the MDS assessments were reviewed with the MDS coordinator who confirmed the findings. 4) On 5/14/25 at 2:00 PM a review of Resident #3's medical record was conducted. Review of the MDS assessment with an assessment reference date (ARD) of 2/6/25 captured that the resident had a pressure ulcer, Section M. Review of the medical record revealed weekly skin sheets that documented the left heel wound that Resident #3 had was healed as of 1/20/25. The staff should not have coded pressure ulcer. Review of Resident #3's February 2025 Medication Administration Record (MAR) revealed Resident #3 was administered Aspirin (antiplatelet), Jardiance and insulin (hypoglycemic), and Seroquel (antipsychotic), Review of Section N, Medications, failed to capture the use of the anti-platelet, hypoglycemic, and antipsychotic medications. On 5/15/25 at 11:25 AM an interview was conducted with the MDS coordinators who confirmed the errors.

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	215092	A. Building B. Wing	05/15/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 34484 Based on medical record review and interview, the facility staff failed to have quarterly care plan meetings for a resident (Resident #12). This was evident for 1 of 7 residents reviewed during a complaint survey. The findings include: Once the facility staff completes an in-depth assessment (MDS) of the resident, the interdisciplinary team meet and develop care plans. Care plans provide direction for individualized care of the resident. A care plan flows from each resident's unique list of diagnoses and should be organized by the resident's specific needs. The care plan is a means of communicating and organizing the actions and assure the resident's needs are attended to. The care plan is to be reviewed and revised at each assessment time of the resident to ensure the interventions on the care plan is accurate and appropriate for the resident. Care plan meetings are held each quarter and as needed. Review of Resident #12's medical record on 5/6/25 revealed the Resident was admitted to the facility in November 2020 with a diagnosis to include dementia. Dementia is a general term for a decline in mental ability that is severe enough to interfere with daily life. Interview with the Resident #12's representative (RP) on 5/14/25 at 1:14 PM the RP complained about the facility's lack of communication. Further review of Resident #12's medical record revealed the facility staff completed a quarterly MDS assessment 12/27/23, 3/8/24, 6/28/24 and an annual MDS assessment on 9/12/24. Review of Resident's medical record revealed the only documented care plan meeting was on 4/22/24 and a note saying a Social Services Assessment saying a care plan meeting was scheduled for 9/20/24. There is no evidence in the medical record a quarterly care plan meeting was held in January and July 2024. Further review of Resident #12's medical record revealed no documentation of a summary or what was discussed at the April and September 2024 care plan meetings. Interview with the Director of Nursing on 5/16/25 at 10:30 AM confirmed the facility staff failed to have a quarterly care plan meeting for Resident #12 in January and July 2024 and failed to include in the Resident's medical record the details of the care plan meeting in April and September 2024.

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	215092	A. Building B. Wing	05/15/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37586 Based on resident medical record, the facility failed to provide care (toileting/ turning/ positioning) on day shift for Resident # 37 who is extensive assistance with 2 person assistance. This is evident for 1 out of 1 person reviewed during the complaint survey. Findings include: MDS is a A Minimum Data Set (MDS) is a standardized, core set of data elements used for clinical assessment in various settings, including nursing homes and skilled nursing facilities. It provides a common language and format for collecting and analyzing data, ensuring consistency and comparability across different facilities and locations. The MDS helps identify resident care problems, informs individualized care plans, and is used for reimbursement and quality monitoring purposes. Resident was admitted to the facility on [DATE] and discharged on [DATE] due to a lack of care. On 5/6/25 at 9:28 AM, an investigation was conducted for Resident # 37. The Resident came to this facility for rehab after surgery for periprosthetic hip fracture. Complainant complained of no staffing, resident not being changed or turned and repositioned. Call bells were also not answered. Upon review of GNA (geriatric nursing assistant) documentation, it was determined that the GNA assigned to resident did not perform turning and reposition for 9/15/22, 9/16/22, and 9/17/22 and bowl and bladder care for 9/15/22, 9/16/22, and 9/17/22 day shift. According to MDS dated [DATE] resident # 37 needs extensive assistance with 2 person assist for transfers, bed mobility, dressing, toileting and general hygiene Administrator was made aware of deficient practice on 5/12/25 at 1:41 PM and stated OK.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 34484 Based on review of complaints, medical record review, and staff interview, it was determined the facility failed to provide care to meet the needs of a resident's physical, mental, and psychosocial health (Resident #10 and #13). This was evident for 2 of 28 residents reviewed during a complaint survey. The findings include: 1. The facility staff failed to address the recommendations of a consultant for Resident #10. Review of Resident #10's medical record on 5/7/25 revealed the Resident was admitted to the facility in October 2024 with a diagnosis to include anemia and thyrotoxicosis. Anemia is a problem of not having enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues and Thyrotoxicosis is a treatable condition that happens when you have too much thyroid hormone in your body. Further review of Resident #10's medical record revealed the Resident was seen by a Consultant on 12/18/24 for anemia, volume status and secondary hyperparathyroidism. Review of the Consultant's 12/18/24 note revealed the Consultant documented, The patient was seen this morning, he/she was resting in bed. His/her family member reports his/her appetite has been poor, he/she will only eat a few spoonfuls of soup a time. The Consultant note states, Consider starting appetite stimulant. Albumin is 1.9, recommend starting prosource protein supplement. Further review of Resident #10's medical record revealed the Resident was discharged from the facility on 12/30/24 and the facility staff failed to start the Resident on an appetite stimulant or prosource protein supplement prior to discharge. Interview with the Director of Nursing on 5/15/25 at 12:25 PM confirmed the facility staff failed to address the Consultant's recommendations for Resident #10 on 12/18/24. 2. The facility staff failed to properly perform neuro checks after an unwitnessed fall for Resident #13. A neuro check after a fall refers to a neurological assessment performed by a healthcare professional to evaluate potential brain injuries by checking a person's level of consciousness, orientation, pupil response, muscle strength, sensation, and coordination. Review of Resident #13's medical record on 5/6/25 revealed a nurse's change in condition note on 7/13/24 at 9:30 AM stated, Resident laying on the floor on his/her right side bedside his/her bed, assessed resident denies any pain or discomfort, denies hitting his/her head, no apparent injury noted, can move all extremities with no pain, neuro check initiated. Review of the facility's Neurological Assessment-Indications for policy provided by the Director of Nursing (DON) on 5/14/25 stated following an unwitnessed fall neurological assessment should be completed at least every 15 minutes times 1 hour, every 30 minutes times 2 hours, every 1 hour times 2 hours and then every shift until 72 hours have passed or as otherwise ordered by the physician. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the Resident's medical record revealed the Neurological Check List completed by facility staff on 7/13/24 and 7/14/24. The facility staff documented the 1st neuro check on 7/13/24 at 9:30 AM at the time of the fall. The facility staff failed to assess and document neuro checks on 7/13/24 at 9:45 AM, 10:00 AM and 10:15 AM. The neuro check documented on 7/13/24 at 10:30 AM did not include vital signs at 10:30 AM but from the 1st neuro check. The facility staff failed to assess and document neuro checks on 7/13/24 at 11:00 AM, 11:30 AM and 12:00 PM. The neuro check documented for 7/13/24 at 12:30 PM included vital signs from later that day at 5:37 PM. The neuro check documented on 7/13/24 at 2:30 PM included vitals signs from the 1st neuro check. The neuro check for evening shift was documented for 7/13/24 at 8:35 PM but included vital signs from 5:37 PM. The neuro check for night shift was documented for 7/14/24 at 1:27 AM but included vital signs from later that shift at 7:30 AM, also stated the resident was observed sleeping in bed, the extremities assessment was documented as N/A (not applicable) and stated the resident was in bed resting, not much of any activity was going on. Interview with the DON on 5/14/25 at 11:50 AM confirmed the facility staff completed neuro checks for Resident #13 at incorrect time intervals per facility protocol and inaccurately on 7/13/24 and 7/14/24.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 31145 Based on medical record review, documentation review, and interview, it was determined the facility staff failed to recognize a resident's weight loss and notify the physician and dietician promptly in order for interventions to be placed timely. This was evident for 1 (Resident #22) of 28 complaints reviewed during a complaint survey. The findings include: On 5/13/25 at 10:50 AM a review of complaint MD00202446 alleged the facility staff were not feeding Resident #22. A review of Resident #22's medical record was conducted and revealed a 12/15/23 note that Resident #22 was admitted for comprehensive rehabilitation and had admitting diagnoses that included cerebral infarction without residual deficits, hypertension, type 2 diabetes mellitus with hyperglycemia and a sacral wound. Resident #22 was prescribed a regular diet with moist ground meat, finely chopped vegetables texture, thin consistency. A physician's physical and history note dated 12/15/23 documented the resident was admitted to the hospital with weakness and decreased intake and weight loss. Review of a 12/15/23 Nutritional Risk Assessment documented Resident #22's ideal body weight was 154 pounds (lbs.), and the most recent weight was 128 lbs. as of 12/14/23. The previous dietician, Staff #36, documented a recommendation for weekly weights times 4 weeks and the RD (registered dietician) would monitor and adjust diet as indicated. The staff was to monitor weights as the resident was at risk for malnutrition. The assessment was dated 12/15/23, however was not signed by the dietician until 1/16/24. Review of the weight section of Resident #22's medical record documented on 12/14/23 the weight was 128. 0 lbs. and on 12/15/23 the weight was 128.0 lbs. The next weight was taken on 1/5/24 and was 102.2 lbs. which was a 25.8 lb. or 20 percent weight loss in 3 weeks. Further review revealed weekly weights were not taken after admission and there was no weight recheck until 1/16/24 when the resident's weight was 101.0 lbs. Continued review of the medical record failed to produce documentation that the physician, dietician and family were notified of the weight loss. Review of the medical record revealed the previous dietician did not assess Resident #22 until 1/16/24 which was 11 days after the documented weight loss. There was no documentation that Resident #22 was evaluated in weekly risk meetings until 1/18/24 which was 13 days after the documented weight loss. Review of the Weight Assessment and Intervention Policy that was received from the Director of Nursing on 5/13/25 at 1:34 PM revealed number 3, under weight assessment, any weight change of 5% or more since the last weight assessment is retaken the next day for confirmation. If the weight is verified, nursing will immediately notify the dietician in writing. Number 5 documented, the threshold for significant unplanned and undesired weight loss will be based on the following criteria: a. 1 month - 5% weight loss is significant; greater than 5% is severe. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/25 at 10:05 AM an interview was conducted with Physician #29 who stated that she would expect to be notified of that amount of weight loss right away to determine if it was excessive fluid loss or wanted weight loss. On 5/15/25 at 10:44 AM an interview was conducted with the Director of Nursing (DON). The DON stated she was not here at the time, and they have since put weight loss and notification in place along with doing a change in condition.