STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215095	A. Building B. Wing	10/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montcare at Bethesda	6530 Democracy Boulevard Bethesda, MD 20817

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, it was determined that the facility failed to update the comprehensive care plan. This was found to be evident for 1 (Resident #11) out of 12 residents reviewed for care plans.The findings include:According to the Centers for Medicare & Medicaid Services (CMS), a comprehensive care plan is a detailed, individualized plan developed for each resident that addresses the resident's medical, nursing, psychosocial, and functional needs. The care plan specifies interventions, services, and treatments required to meet the resident's needs and achieve the desired outcomes, and it must be reviewed and updated regularly to reflect any changes in the resident's condition or care requirements.On 10/08/2025 at 8:57 AM, this surveyor conducted a record review of Resident #11's progress notes. A Skin and Wound Note documented, Patient has new wounds to [Resident #11's] bilateral buttocks abscess.On 10/08/2025 at 10:14 AM, a review of the documentation for Resident #11's Wound assessment dated [DATE] showed that Resident #11 had developed a new wound, identified as an abscess of the bilateral buttocks.On 10/09/2025 at 10:39 AM, a record review of Resident #11's Care Plan, including its revision history, showed that the resident's care plan had not been updated to include a care plan for the resident's new wound.On 10/08/2025 at 2:02 PM, this surveyor conducted an interview with Nurse Practitioner (NP) #5. During the interview, NP #5 confirmed that the resident had developed an abscess on 08/04/2025 during a wound care assessment.On 10/09/2025 at 1:19 PM, this surveyor conducted an interview with the Director of Nursing (DON). The surveyor explained the concern that the comprehensive care plan had not been updated after the resident developed a new wound. The DON reviewed Resident #11's chart and confirmed that the care plan had not been updated when the wound developed on 08/04/2025.The DON explained that around this time (08/04/2025), the facility employed a wound treatment nurse who was responsible for updating care plans. He stated that the care plans were not being updated as required and confirmed that the employee was subsequently terminated. When asked what an appropriate care plan entry for a new wound would include, the DON stated it would indicate potential/actual impairment to skin integrity r/t [related to] [insert specific wound description here]. The surveyor communicated that this concern would be brought to the Office of Health Care Quality for review.

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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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. Based on review of facility-reported incident and a complaint, record review and interview, it was determined that the facility failed to obtain a physician's order prior to performing a straight catheterization. This was evident for 1 (Resident #4) of 14 residents reviewed during the complaint survey. The findings include:A straight catheterization is a procedure where a thin, hollow tube is inserted into the bladder through the urethra to drain urine and then removed after the bladder is empty.On 10/6/25 at 11:24 AM, a review of the facility-reported incident #292100 dated 11/3/24, at 8:27 PM, revealed an incident involving Resident #4 and the alleged Licensed Practical Nurse (LPN #3) and Registered Nurse (RN #4). Both nurses were suspended pending investigation. Also, a complaint #292101 regarding the same issue was reported by Resident #4 on 11/4/25 at 3:34 PM.On 10/7/25 at 8:26 AM, a review of progress notes written on 11/2/24 at 10:40 PM indicated that the Director of Nursing (DON) received a call from Resident #4, who stated that on 11/1/24 around 3:00 AM, 2 nurses collected a urine sample against his/her will.On 10/7/25 at 9:00 AM, a review of the physician orders showed an order written on 10/31/2024 which stated: Check Complete Blood Count (CBC), Complete Metabolic Panel and Urinalysis with Culture and Sensitivity (UA C & S) to rule out infection, one time only until 11/1/2024. However, there was no evidence that a straight catheterization was written.On 10/7/25 at 9:18 AM, a review of Resident #4's medical record revealed a BIMS (Brief Interview for Mental Status) score of 15 which indicated intact cognitive function. On 10/7/25 at 10:44 AM, in an interview with Resident #4, he/she confirmed that the incident occurred around 3:00 AM. Resident #4 stated that 2 nurses asked if he/she could walk to the bathroom for a urine sample, to which the resident replied no. However, the nurses proceeded to insert a catheter without obtaining consent or explaining the procedure. The resident added that he/she contacted the local police department, feeling violated.On 10/8/25 at 12:48 PM, during an interview with LPN #2, he/she stated that the nurses were expected to inform and explain the procedure before obtaining a urine specimen from an alert resident. LPN #2 added that if nurses were to obtain urine via straight catheterization, both resident consent and a physician's order would be necessary.On 10/9/25 at 8:44 AM, a review of the facility's Catheterization policy (implemented on 5/15/23 and revised on 2/3/25) indicated the following guidelines: Urinary catheters shall be inserted by licensed nurses under the orders of the attending physician. For straight or intermittent catheterizations, obtain a physician's order for frequency of catheterization.On 10/9/25 at 11:00 AM, the DON confirmed that a straight catheterization order was not obtained because the procedure was completed based on the nurse's judgement. The DON was notified of this concern.On 10/9/25 at 12:38 PM, the [NAME] president of Clinical Services was notified and acknowledged this concern.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on medical record review and interviews it was determined that the facility failed to provide appropriate wound care. This was evident for 1 (Resident #8) of 1 residents evaluated for pressure ulcer care during the complaint survey.The findings include:A pressure ulcer, also known as a bed sore or decubitus ulcer, is a localized area of skin damage that develops when prolonged pressure or shear forces disrupt blood flow to the tissues resulting in damage to the underlying tissue. Pressure ulcers are staged based on their severity from Stage I (area of persistent redness), Stage II (superficial loss of skin such as an abrasion, blister, or shallow crater), Stage III (full-thickness skin loss involving damage to subcutaneous tissue presenting as a deep crater) or Stage IV (full thickness skin loss with extensive damage to muscle, bone or tendon). During a medical record review on 10/07/25 at 1:17 PM it was revealed that Resident #8 had a Stage #3 pressure ulcer to the sacral area. A Skin and Wound progress note from 8/20/25 written at 6:56 PM reported the sacral wound was improving without complications and the wound care provider added a wound treatment recommendation for Collagen to undermine area to base of the wound to be completed three times a week. During additional medical record review it was discovered that the recommendation added by the wound care provider was not added to the treatment orders for Resident #8. During continued medical record review of a Skin and Wound progress note from 8/27/25 written at 7:41 PM it was revealed the wound care provider documented, Sacral pressure wound worsening on this exam, order was updated to Dakins fluffed gauze twice a day and will reevaluate next week. The Wound Assessment report from 8/27/25 listed the following wound treatment recommendations made by the wound care provider:1. Cleanse with 0. 125% Dakins solution2. Apply Dakins moistened fluffed gauze, Zinc Oxide Paste to periwound to base of the wound3. Secure with transparent film. 4. Change Twice per Day During additional medical record review it was revealed that the recommendations added by the wound care provider on 8/27/25 were not initiated for Resident #8. The orders added to the Treatment Administration Record (TAR) for Resident #8 on 8/29/25 at 8:37 AM stated, Sacral wound - Cleanse with Normal Saline Solution, pat dry, apply Dakins fluffed gauze, zinc oxide paste to peri wound and cover with transparent film daily as needed and one time a day every Monday, Wednesday, Friday for wound healingDuring further review of Wound Care Progress notes from 9/03/25 written at 11:03 AM it was discovered that the Wound Care Provider evaluated Resident #8 and determined the sacral wound had worsened, it was now a Stage 4 Pressure Ulcer. The Wound Care Progress notes further added, will recommend transfer to hospital and a nursing progress note written on 9/03/25 at 11: 23 AM reported the responsible party requested resident to be transferred to the emergency room for further management of non-healing sacral ulcer.During an interview with the Director of Nursing on 10/09/2025 at 12:38 PM he advised he would expect the wound care provider's recommendations to be followed. He confirmed the wound care provider recommendations for Resident #8 and the order added by the facility to the Resident's TAR were different. He agreed Dakins Cleanse should have been used in place of the Normal Saline Solution as recommended by the Wound Care Provider and the treatment should have been ordered to be completed two times a day, not once a day on Monday, Wednesday and Friday as ordered by the facility.During additional review of the Treatment Administration Record (TAR) on 10/09/25 at 1:38 PM it was discovered that there was no documentation of wound care being completed from 8/28/25 - 8/31/25 and there was wound care documented as being completed once on 9/01/25 and 9/03/25.During an interview with the 1st floor Unit Manager on 10/10/25 at 10:20 AM he agreed the recommendations made by the Wound Care Provider should have been entered into the TAR for Resident #8. He confirmed the orders in the TAR were different from the Wound Care Provider's recommendations. He was not sure why the facility orders were different from the wound care provider recommendations. He was made aware of no wound care documentation on 8/28/25 - 8/31/25 and was not sure why wound care was not completed.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on medical record reviews and interviews it was determined that the facility failed to ensure medical records were accurate. This was evident for 1 (Resident #9) of 12 residents reviewed for accurate medical record documentation during the complaint survey. The findings include:A mediport is a small, implantable device with a catheter, surgically placed under the skin to provide long-term, reliable venous access for medications, blood transfusions, and blood draws.During a medical record review on 10/08/25 at 10:07 AM it was discovered Resident #9 had a mediport in place and had an order starting on 5/04/25 to Flush implanted port monthly every day shift every 1 month starting on the 4th for 28 days. It was revealed the order had been signed off as completed daily from 5/04/25 -5/31/25, 6/04/25 - 6/31/25, 7/01/25, 7/04/25 -7/07/25 on the Treatment Administration Record (TAR).Additional record review revealed that Resident #9 had his/her mediport removed on 6/13/25. The order to flush the mediport monthly continued to be signed off as completed every day from 6/14 -6/30, on 7/01, and on 7/04 - 7/07.Further record review revealed the order to flush the mediport monthly was discontinued for Resident #9 on 7/08/25 due to port removed.During an interview with the Director of Nursing on 10/10/25 at 12:10 PM he advised that the order should not be signed off unless it was completed and the order should have only been signed off as completed on the date it was due, the 4th of the month. He confirmed the order to flush the mediport should not have been signed off as completed on the dates after the mediport was removed.