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	11/06/2024

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

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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. 42828 Based on interviews and surveyor observations, it was determined that the facility failed to reasonably accommodate the needs and preferences of a resident by not ensuring a call bell was kept within a resident's reach and by not providing the appropriate type of call bell device needed for resident use. This finding was evident for 2 of 3 random observations (Resident #75) during the annual survey. The findings include: The Minimum Data Set (MDS) is an assessment used by staff to assist in planning care for the resident. On 10/29/24 at 9:30 AM, a surveyor interview with Resident #75 revealed that he/she was not able to use his/her call bell and would make his/her needs known by requesting his/her roommate to activate their call bell for assistance. The surveyors then requested Resident #75 to activate the call bell. Surveyors observed the resident laying on his/her back, the call bell device resting on the resident's chest area but tucked under the blanket. The resident's right hand was not near the call device. Resident #75 was not able to reach or activate the call bell. Review of Resident # 75's medical record revealed a current diagnosis of left side paralysis and severe limited use of his/her right arm. Review of the Minimum Data Set (MDS) for Resident #75's most recent admission revealed that the resident's needs were coded as dependent for all care. On 10/29/24 at 9:45 AM, an interview with the resident's roommate revealed that he/she uses their call bell multiple times daily, to alert nursing staff of Resident #75's needs. During a follow up tour of the unit on 10/30/24 at 12:02 PM, surveyors observed Resident #75 lying in bed and the call bell resting on the headboard of the bed, out of the resident's reach. On 10/30/24 at 12:10 PM, surveyors located Resident #75's licensed practical nurse (LPN), Staff #9, and requested that she assist with determining the location of Resident #75's call bell device. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff #9 located the device, then removed the call device from the resident's headboard and placed it on the resident's chest area, near his/her right hand. The surveyor asked Staff #9 if Resident was able to activate the call bell device to alert nursing staff when he/she needed assistance and Staff #9 stated that most of the time it was the roommate, Resident #78, that would alert staff when Resident #75 needed assistance. Staff #9 requested Resident #75 to press the button on the end device to activate the call device. After several minutes, the resident was not able to press the button with his/her right hand. Staff #9 told the surveyors that nursing staff conduct frequent rounding on Resident #75, however it was not identified by nursing staff that Resident #75 was not able to adequately use his/her call bell device. Staff #9 also stated that a ticket would be put into the maintenance department, requesting to replace the device with the appropriate soft touch call bell device that would allow the resident to press the call bell on his/her own. On 10/30/24 at 12:33 PM surveyors interviewed the Director of Nursing, DON, who revealed that the call bell device will be replaced with a soft touch device immediately. Surveyors toured Resident #75's room again on 10/31/24 at 11:00 AM and observed a soft touch call bell device located under the resident's right hand. Resident #75 stated that he/she was able to use the call bell device without any challenges. During an interview held with the Maintenance Director on 10/31/24 at 12:45 PM he confirmed that Resident #75's call bell device was replaced with a soft touch pad call device.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42783 Based on record review and interview it was determined that the facility failed to 1) notify the Ombudsman of a Resident's (Resident #23) transfer to an acute care facility and 2) notify the Resident (Resident #47) /Resident representative of transfer to an acute care facility in writing. This was found to be evident for 2 (Resident #23 & #47) out of 3 residents reviewed for transfers during the annual survey. The findings include: 1) During a review of Resident #23's medical record conducted on 11/01/2024 at 10:03 AM it was revealed that the resident was transferred to a Hospital emergency roiagnom on [DATE]. A review of the Ombudsman notification of transfers was conducted on 11/04/24 at approximately 9:00 AM. The notification for April 2024 and May 2024 did not show that the Ombudsman was notified of Resident #23's transfer on 04/28/2024. During an interview with the Director of Nursing (DON) conducted on 11/01/2024, this surveyor advised the Ombudsman notification did not show that Resident #23 was transferred on 04/28/2024. The DON stated that the facility's expectation is to notify the Ombudsman of all Resident Transfers. 48393 2) On 11/04/24 at 10:13 AM, a review of Resident #47's clinical record revealed that Resident #47 was transferred to the hospital for further evaluation of his/her medical needs on the following dates: 4/12/2024, 4/25/2024 and 5/5/2024. Further review of Resident #47's clinical record revealed no documentation that the resident/resident representative was notified in writing of the hospital transfers. On 11/06/24 at 7:20 AM, an interview conducted with the Divisional Director of Quality Assurance revealed that it is the expectation of nursing staff to notify the resident/resident representative of hospital transfers verbally and send a written copy of the hospital transfer/discharge form along with the resident when they transfer out. The Divisional Director of Quality Assurance further stated that copies of the resident's written hospital transfer/discharge form and bed hold policy are kept in a separate binder. On 11/06/24 at 8:15 AM, the surveyor requested and reviewed the separate binder which showed no evidence that the facility staff had provided written notice of transfer at the time of transfer or as soon as was practicable for resident #47's hospital transfers on 4/12/2024, 4/25/2024 and 5/5/2024. At the time of exit conference, the facility did not provide any evidence that a written notice of transfer was given to Resident #47 and the resident's representative.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 48393 Based on clinical record review and staff interview, it was determined that the facility failed to notify the resident/resident representative in writing of the bed hold policy upon transfer of a resident to an acute care facility. This was evident for 1 (#47) out of 3 residents reviewed for hospitalization s during the annual survey. The findings include: On 11/04/24 at 10:13 AM, a review of Resident #47's clinical record revealed that Resident #47 was transferred to the hospital for further evaluation of his/her medical needs on the following dates: 4/12/24 and 5/5/24. Further review of Resident #47's clinical record revealed no documentation that the resident / resident representative was notified of the bed hold policy in writing. On 11/04/24 at 10:55 AM, an interview conducted with the Business Office Manager revealed that she was not able to locate any evidence that a written copy of the bed hold policy was given to the resident/resident representative for hospital transfers on 4/12/24 and 5/5/24. At the time of exit conference, the facility did not provide any evidence that a written copy of the bed hold policy was given to Resident #47 and the resident's representative for hospital transfers on 4/12/24 and 5/5/24.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. 50502 Based on record review and interview, it was determined that the facility failed to transmit Minimum Data Set (MDS) assessments within 14 days of completion. This was evident for 1 (Resident #74) of 2 residents reviewed for resident assessments during the annual survey. The findings include: Minimum Data Set (MDS) is a core set of screening, clinical, and functional status data elements, including common definitions and coding categories, which form the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare or Medicaid. The data elements (also referred to as items) in the MDS standardize communication about resident problems and conditions within nursing homes, between nursing homes, and between nursing homes and outside agencies. MDS assessments need to be accurate to ensure each resident receives the care they need. Nursing homes are required to submit the Omnibus Budget Reconciliation Act (OBRA) required MDS records for all residents in Medicare- or Medicaid-certified beds regardless of the payer source to Centers for Medicare and Medicaid Services (CMS') Internet Quality Improvement and Evaluation System (iQIES). Skilled nursing facilities (SNFs) are required to transmit additional MDS assessments for all Medicare beneficiaries in a Part A stay reimbursable under the SNF Prospective Payment System (PPS). Assessment Transmission: Comprehensive assessments must be transmitted electronically within 14 days of the Care Plan Completion Date. All other MDS assessments must be submitted within 14 days of the MDS Completion Date. On 11/1/24 at 7:28 AM, a record review of the MDS assessment was conducted for Resident #74 with a discharge date on 5/9/2024. The MDS assessment Discharge Return Not Anticipated (DCRNA) with an Assessment Reference Date (ARD) of 5/9/24 was completed on 5/15/24, however, the assessment was not transmitted to CMS' iQIES for over 120 days. On 11/1/24 at 8:19 AM, during an interview with the MDS Coordinator, she stated that the timeline for completing and submitting MDS assessments was 14 days. She added that all assessments were required to be transmitted regardless of the payor source such as Entry, Admission and Discharge assessments, except the 5 day assessment for insurance or private pay residents. She also stated that she transmitted the MDS assessments weekly or twice a week to CMS. The surveyor showed the MDS Coordinator the DCRNA assessment of Resident #74 with an ARD of 5/9/24. She verified that the DCRNA assessment was not submitted and confirmed that it was an error, and she stated that she would immediately fix it. On 11/01/24 at 8:55 AM, the [NAME] President of Clinical Services was notified that the DCRNA assessment for Resident #74 was completed on 5/15/24 but never transmitted to CMS.

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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. 42783 Based on record reviews and interviews it was determined that the facility failed to ensure a care plan was revised. This was found to be evident for 2 (Resident #50 & #92) out of 5 Residents reviewed for care plan revisions. The findings include: Psychotropic medications are used to treat mental health disorders. There are five main types of psychotropic medications, and each type has its own specific uses, benefits, and side effects. The five main types are anti-anxiety agents, antidepressants, antipsychotics, mood stabilizers, and stimulants. 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. Anticoagulant therapy is the use of anticoagulants, or blood thinners, to prevent or treat blood clots. Heparin injection is an anticoagulant. It is used to decrease the clotting ability of the blood and help prevent harmful clots from forming in blood vessels. 1) A review of Resident #50's Medication Administration Record (MAR) conducted on 11/01/2024 at 07:22 AM revealed that the Resident received the following psychotropic medication: busPIRone HCl 7.5 mg and Seroquel 25 mg. On 11/01/24 at 07:31 AM a review of Resident #50's Care Plan did not reveal a care plan for the psychotropic medications. During an interview conducted on 11/01/2024 at 9:00 AM, the Divisional Director of Quality Assurance stated that it's the facility's expectation that psychotropic medications are Care Planned with a focus, goal and interventions. 50502 2) On 11/01/24 at 8:41 AM, a record review of Resident #92's medications indicated that he/she was on Heparin Sodium (Porcine) Injection Solution 5000 UNIT/ML (Heparin Sodium (Porcine)Inject 5000 unit subcutaneously every 8 hours for Deep Vein Thrombosis prophylaxis. On 11/04/24 at 10:34 AM, further review of Resident #92's medical record revealed no evidence that a care plan was developed and implemented to monitor bruising and bleeding related to anticoagulant therapy. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/04/24 at 10:53 AM, during an interview with Licensed Practical Nurse (LPN #16), he/she stated that the monitoring and the care plan for blood thinners should be in the electronic system. He/she added that the Unit Managers initiated the care plan in the medical record. The surveyor asked LPN #16 to show an example of a care plan that addressed blood thinners, he/she replied that he/she had no idea where to find it. On 11/04/24 at 11:06 AM, an interview with Unit Manager (UM #10) revealed that the UMs created the residents' care plan on admission. The surveyor asked UM #10 to locate the care plan of Resident #92 related to anticoagulant therapy. He/she confirmed that there was no care plan developed to address potential for bleeding and bruising for Resident #92. He/she then initiated a care plan even though Resident #92 had been discharged from the facility. He/she stated that he/she just wanted to find out if the problem and interventions would show in Resident #92's care plan. On 11/06/24 at 7:53 AM, during an interview with the Assistant Director of Nursing (ADON), she revealed that it was expected that if a resident had an order of blood thinner, a care plan should be initiated in the resident's medical record. She added that the UMs were responsible for developing the care plans. ADON was made aware that Resident #92 had no Anticoagulant care plan.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 50504 Based on observations, record review and interviews, it was determined that the facility failed to provide appropriate treatment and services to a resident receiving tube feedings. This was evident for 1 (Resident #72) of 1 Resident reviewed for tube feedings. The findings include: A gastrostomy tube, also known as a G-tube or feeding tube, is a tube that is inserted through the abdomen and into the stomach to provide nutrition, fluids, and medicine. A G-tube should be checked for placement before feeding, flushing or administering a medication to ensure it is not clogged or displaced outside the stomach. On 10/30/24 at 08:44 AM during medication pass, the surveyor observed Staff #9 flush Resident #72's G-tube with 30ml of water. Staff #9 did not check for G-tube placement before administering the flush. The surveyor inquired about the facility's policy for checking the placement of G-tubes. Staff#9 stated I should have checked for placement by aspirating the contents of the stomach before I give anything. I will do so now. A review of the facility policy for Verifying Placement of Feeding tube which was revised on 5/8/24 stated. Before beginning a feeding, flushing the tube, or administering a medication via feeding tube, proper placement and functioning will be verified. On 10/30/24 at 11:31 AM the Assistant Director of Nursing (ADON) was made aware of the surveyor's concerns. ADON stated that the G-tube should have been checked for placement before the flush was administered and she would do an inservice with the nurses on G-tube placement checks.

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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. 51129 Based on observations and interviews it was determined that the facility failed to provide the respiratory care and services that are in accordance with professional standards. This was evident for 1 (Resident #456) out of 1 resident reviewed for respiratory services. The findings include: On 10/28/2024 at 12:33 PM, the surveyor observed Resident #456's oxygen tubing and nasal cannula disconnected and laying on the floor. The Resident's son reported that water had backed up in the tubing from the oxygen concentrator. The surveyor checked the tubing and observed moving water droplets in the tubing that came from the concentrator to the Resident 's nasal cannula. It was also observed that the humidifier bottle and the tubing were not dated with the date they were connected to the oxygen concentrator. On 10/28/2024 at 12:45PM The Licensed Practical Nurse (LPN) #18 was interviewed and asked if she had seen the tubing on the floor and the water in the tubing. LPN #18 said that she had not been aware of the problem, that she had briefly checked on the resident but had not yet done her morning assessment. On 10/28/2024 at 12:50 PM The surveyor spoke to the Assistant Director of Nursing (ADON) and made her aware of the water in the tubing, and that the water bottle and tubing were not dated. ADON observed the water in the tubing and the undated water bottle and tubing and stated that she felt the water in the tubing was condensation from the oxygen concentrator being near the room heater. The ADON moved the concentrator away from the heater and changed the tubing. On 10/29/2024 at 9:45 AM the surveyor observed the Resident #456 holding the nasal cannula. The Resident stated that the oxygen had not been used all night because there was water in the tubing, and it had been dripping into my nose. The surveyor observed water still backing up in the tubing and dripping from the nasal cannula. During an interview conducted on 10/29/2024 at 10:00 AM, the surveyor spoke with the ADON and made her aware. She came into the room and stated that the problem had to be the oxygen concentrator and that it would be replaced. On 10/29/2024 at 12:30 PM the surveyor observed that the oxygen concentrator had been changed and there was no water in the tubing and the humidifier bottle and tubing were correctly dated with the date it had been connected to the oxygen concentrator. On 11/06/24 at 10:36 AM The surveyor observed that the date on the tubing on the oxygen concentrator was 10/29/2024. The surveyor interviewed LPN #18 and asked what the policy was regarding changing tubing on the oxygen concentrator. She stated it was supposed to be changed every 5 days.

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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 1) develop and implement non-pharmacological interventions of pain and 2) ensure that pain medication was given consistent with the professional standards of practice. This was evident for 2 (Resident #92 and #1) out of 2 residents reviewed for pain management during the annual 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. Non-pharmacological interventions are treatments that manage pain without the use of medication. These interventions may include but are not limited to massage, music therapy, aromatherapy, applying mild heat or cold packs and repositioning. Oxycodone and Tramadol are 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. 1) On 11/01/24 at 8:41 AM, a record review of Resident #92 revealed that Oxycodone HCl Oral Tablet 5 MG (Oxycodone HCl) Give 2 tablet by mouth every 6 hours as needed for pain was administered 18 times for the month of October. On 11/01/24 at 9:20 AM, a record review of Resident #1 revealed that Acetaminophen Oral Tablet 500 MG (Acetaminophen) Give 2 tablet by mouth every 8 hours as needed for Moderate Pain was administered twice for the month of October and Tramadol HCl Oral Tablet 50 MG (Tramadol HCl) Give 50 mg by mouth every 6 hours as needed for Severe Pain was administered 8 times for the month of October. On 11/01/24 at 10:30 AM, further review of Resident #92 and #1's medical records revealed no evidence that non-pharmacological interventions of pain were provided and documented in the Medication Administration Record (MAR), Treatment Administration Record (TAR), in progress notes nor in the resident's care plan. A review of the Minimum Data Set (MDS) with an Assessment Reference date (ARD) of 9/11/24 for Resident #92 revealed, section J Received non-medication intervention for pain? Indicated No and MDS with ARD of 10/29/24 for Resident #1 also answered No, which confirmed that no non-pharmacological interventions were provided. On 11/01/24 at 10:58 AM, the surveyor attempted to interview Licensed Practical Nurse (LPN #16) about the process of initiating non- pharmacological interventions of pain. He/she stated he was not sure and asked to verify with the Unit Manager (UM). UM #10 stated that the facility documented the interventions in the resident's medical record under pain care plan, such as music, range of motion exercises and repositioning. He/she added that the nurses sometimes added in their progress notes. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/01/24 at 11:30 AM, in an interview with UM #17, he/she stated that the non-pharmacological interventions of pain were not specified anywhere, it could be documented in the nurses' progress notes. On 11/01/24 at 11:45 AM, during an interview with the Assistant Director of Nursing (ADON), she was asked about the facility's process of providing non- pharmacological interventions prior to administering pain medication. She stated that she was not sure and would come back. On 11/01/24 at 11:59 AM, the DON returned and stated that the nursing interventions were documented in the progress notes, she confirmed that it was not incorporated in care plans nor in nursing orders. 2a.) On 11/01/24 at 8:41 AM, a record review indicated that Resident #92 was on the following PRN pain medication: Oxycodone HCl Oral Tablet 5 MG (Oxycodone HCl) Give 2 tablet by mouth every 6 hours as needed for pain, mod Further review of the nursing progress note, and the Medication Administration Record (MAR) revealed that the facility staff failed to follow the pain parameters indicated in the physician order: On 10/21/2024 at 22:00, oxyCODONE HCl Oral Tablet 5 MG Give 2 tablet by mouth every 6 hours as needed for pain, mod was administered, however the MAR indicated that Resident #92 had a pain level of 3 prior to pain medication. 2b.) On 11/04/24 at 8:55 AM, a review of the active physician orders of Resident #1 revealed the following PRN pain medications: Acetaminophen Oral Tablet 500 MG (Acetaminophen) Give 2 tablet by mouth every 8 hours as needed for Moderate Pain Tramadol HCl Oral Tablet 50 MG (Tramadol HCl) Give 50 mg by mouth every 6 hours as needed for Severe Pain Further review of the nursing progress notes, and the Medication Administration Records (MAR) revealed that the facility staff failed to follow the pain parameters indicated in the physician orders: On 10/18/2024 at 00:05, Tylenol Extra Strength Oral Tablet 500 MG Give 2 tablet by mouth every 8 hours as needed for Moderate Pain (4 - 7) was administered, however the MAR indicated pain level of 0 prior to medication administration. On 10/3/2024 at 21:59, TraMADol HCl Tablet 50 MG Give 1 tablet by mouth every 6 hours as needed for severe pain (8 - 10) was administered, however, nurse's note indicated resident required Tramadol for pain of 5 in her right leg. On 10/3/2024 at 14:18, TraMADol HCl Tablet 50 MG Give 1 tablet by mouth every 6 hours as needed for severe pain (8 - 10) was administered, however the MAR indicated a pain rating of 5. On 10/18/2024 at 17:34, TraMADol HCl Tablet 50 MG Give 1 tablet by mouth every 6 hours as needed for severe pain (8 - 10) was administered with a pain level of 7 in the MAR. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/04/24 at 10:42 AM, in an interview with Registered Nurse (RN #15), he/she stated that when entering PRN pain medication orders in the medical record, the nurses were expected to enter the medications as ordered with pain parameters of 1-4 for mild pain and 5-10 for moderate to severe pain. He/she added that the nurses documented in the MAR under PRN medication and indicated the pain level prior to giving the pain medication, after an hour the nurses went back and asked the resident if the medication was effective and recorded the pain level. On 11/04/24 at 11:06 AM, in an interview with UM #10, he/she revealed that for PRN pain medications, the MAR had a section which indicated pain level prior to giving the medication, 1-3 for mild pain, 4-7 for moderate pain and 8-10 for severe pain. He/she added that the documentation was automatically pulled in the electronic charting once the nurse entered the pain level, and the nurses would come back after an hour to document the effectiveness of the pain medication. On 11/06/24 at 7:53 AM, during an interview with the ADON, she stated that a pain scale automatically populated when nurses entered the order in the medical record. She described that the facility had a standard pain scale that nurses followed, a 0-10 pain scale for cognitive residents and non-verbal signs for non-cognitive residents. She also added that if the doctor did not specify the pain parameter in the order, the pharmacy would send an email to the facility to correct the order. She gave the following examples of pain parameters used for PRN pain medications: Tylenol for pain level of 1-3, Tramadol for pain level of 4-7 and Oxycodone for pain level of 8-10. The ADON was made aware that the PRN pain parameters in the physician orders were not followed by the nurses before the PRN pain medications were administered to Residents #92 and #1.

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	215095	A. Building B. Wing	11/06/2024

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 staff interviews it was determined that the facility failed to 1) maintain a safe and effective system for securing medication and 2) store medications properly. This was found to be evident for 1 out of 3 medication carts observed during the re-certification survey. The findings include: 1) During an interview conducted on 10/31/24 at 1:12 pm, Resident #85 gave this surveyor a set of keys on a lanyard that he/she stated were found on the hallway floor of the 1st floor nursing unit on the evening of 10/30/24. The Resident further stated that the keys belonged to the medication cart. An interview was conducted on 10/31/24 at 1:15 PM with the Nursing Home Administrator (NHA) and the Director of Nursing (DON). During the interview this surveyor gave the keys to the medication cart to the NHA. This surveyor advised both the NHA and DON that a resident was in possession of the keys and asked if they were aware that a set of keys to the medication cart had been missing or lost. The DON stated they were not aware but would immediately investigate and inform the surveyor of the results. During observation of the 1st floor medication cart conducted on 10/31/2024 at 1:19 PM, this Surveyor and Licensed Practical Nurse (LPN) #16 reviewed all the narcotics and confirmed the narcotic counts were accurate and matched the narcotic log. During an interview conducted on 11/01/24 8:07 AM, the DON stated that he identified the nurse as Registered Nurse (RN) #15, the RN was disciplined and educated on ensuring the medication cart is secured and notifying administrations if keys are lost. The DON stated that the RN used a spare set of keys to access the medications in the medication cart to administer medications after the keys were lost and that all Residents received their medications as ordered. The DON further stated that both him and the VP of Clinical Services reconciled the medication cart and did not find any medications including narcotic discrepancies. 50504 2) On 11/1/24 at 6.45AM, a medication storage observation was conducted on the medication carts on the Embassy Unit with Staff Nurse # 14 present. The surveyor observed a Humalog Kwik Pen100 unit/ml insulin pen for Resident #224 and a Glargine Solostar 100unit/ml pen for Resident #20 were in a basket stored in the 3rd drawer of the medication cart. Both Insulin pens were unopened with a pharmacy label which stated refrigerate until opened. During an interview conducted on 11/01/24 at 7:10 AM both the Director of Nursing (DON) and Staff Nurse #14 acknowledged the surveyor's findings.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 42828 Based on observations and interviews with residents and facility staff, it was determined that the facility failed to ensure that food was delivered to residents at an appropriate and palatable temperature. This was evident for 1 out of 1 observation of test tray temperatures. This practice has the potential to affect all residents who eat food prepared by the facility. The findings include: On 10/28/24 at 12:30 PM, the surveyor reviewed complaint Office of Health Care Quality (OHCQ), MD002210552, in which Resident #78 alleged that all his/her meals were delivered cold. The Surveyor conducted a breakfast tray observation that began on 10/31/24 at 7:10 AM. The surveyor requested a test tray to be added to the last meal cart. The last meal cart was going to the first-floor units where Resident # 78 resided. During the tray line observation on 10/31/24 at 8:45 AM, the surveyor observed that the plates loaded onto the meal cart did not have bottom plate warmers (pellets) added to keep the plates warm. On 10/31/24 at 08:56 AM the Surveyor and Kitchen Manager, Staff #19, followed the meal cart to the unit on the first floor. The geriatric nursing assistants (GNAs) working on the unit passed out all trays by 9:15 AM. Test tray temperatures were tested at the time with Staff #19. Staff #19 confirmed the temperatures were: scrambled eggs, 90 degrees Fahrnheit and hashbrowns 95 degrees Farenheit. At the end of the test tray process around 9:20 AM, Staff #19 stated that her expectation was that the meals were to be delivered with in minutes as soon as the meal carts were on the unit to ensure adequate temperatures of 120F for hot foods. During an interview on 11/06/24 at 10:43 AM, the Food Service Director confirmed that 24 pellets (plate warmers) were ordered.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 42828 Based on observations and staff interviews, it was determined that the kitchen failed to store food items to maintain the integrity of the specific item. This was evident during multiple observations of the kitchen on a recertification survey. The findings include: On 10/28/24 at 9:32 AM surveyors conducted an initial tour of the kitchen. During the tour, surveyors identified 2 items within the food prep refrigerator that were improperly stored: - A bottle of Red Cooking Wine marked with an open date showing 8/15/24 and a dispose date of 9/15/24 - An opened 48 oz glass container of Concord Grape Jelly without any open date and dispose date. On 10/28/24 at 9:40 AM, Surveyors reviewed these items with Cook, Staff #1, who confirmed that both items were to be removed from the refrigerator and disposed of. During a tour of the dry storage room on 10/31/24 at 8:25 AM, observations with the Kitchen Manager, Staff #19, revealed: - Two, unopened, 35 oz bags of Crispy Rice Cereal with a use-by-date of 10/2/24 - Five, unopened, 16 oz unopened boxes of Confectioners [NAME] Sugar with a use-by-date of 2/1/22 At the end of the observation, Surveyors observed Staff #19 remove the identified items from the shelf and dispose of them.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 50504 Based on observations and interviews, it was determined the facility staff failed to adhere to infection control practices and guidelines while 1.) administering medications and 2.) performing dressing change. This was evident for 2 of 4 residents (Resident #225 and Resident#72) observed for medication administration and dressing change. The findings include: 1.) A medication observation was conducted on 10/30/24 at 8:07AM. Staff # 8, a Registered Nurse, prepared and administered medications to Resident #56 who occupied bed A in a semi private room. After the medications were administered, Staff #8 did not perform hand hygiene. Staff#8 left the room, retrieved a blood pressure cart from the hallway and walked back into the same room to Resident #225 who occupied the B bed and proceeded to take the resident's blood pressure. During an interview the surveyor inquired about hand hygiene. Staff #8 stated I usually wear gloves, then walked over to the hand sanitizer unit on the wall and performed hand hygiene. 2.) On 10/30/24 at 8:44AM the surveyor observed Staff #9 who was wearing gloves, remove a contaminated dressing from Resident #72's Gastrostomy tube (G-tube) site and placed it in a trash can. Staff# 9 then reached for a clean dressing and proceeded to apply it to the resident's G-tube site. Staff#9 failed to remove the contaminated gloves and perform hand hygiene before handling the clean dressing. During an interview the surveyor asked about hand hygiene Staff #9 said I should have cleaned my hands. Staff# 9 discarded the dressing removed and discarded the contaminated gloves then performed hand hygiene. On 10/30/24 at 11:31AM the Assitant Director of Nursing (ADON) was made aware of the surveyor's observations and stated that the nurses would be reeducated on infection control and hand hygiene.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. 42828 Based on observation, and staff interview, it was determined that facility staff failed to ensure a cord used to activate/deactivate a call light was attached to the call system. This was evident for 1 of 1 unit shower rooms observed during the surveyor's initial tour of the facility during the recertification survey. The findings include: During the initial tour on 10/28/24 at 10:56 AM, surveyors observed a call bell device mounted on a wall within one of 4 shower stalls in the first-floor central shower room. The call bell device was without a cord that would be used if a resident fell on the floor and could not press the button on the mounted device. On 10/28/24 at 1:15 PM surveyors, the Maintenance Technician, and the Nursing Home Administrator (NHA), toured the first-floor central shower room. The Maintenance Technician confirmed that the call bell device was missing a long cord to turn off/on the device, and one would be installed the same day. During an interview held on 10/31/24 at 12:45 PM, the Maintenance Director confirmed the call bell device in the central shower room on the first floor was equipped with a long cord. Surveyors conducted a follow up tour of the first-floor central shower room on 11/6/24 at 10:30 AM and observed the call bell device with an adequate length cord.