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	02/25/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to ensure a homelike environment was provided for all residents. This was evident to be true for 9 out of 44 resident rooms observed during an annual recertification survey. The findings include: During observational rounds and interview with staff #22 on 02/18/2026 at 7:45 AM the following observations were made: room [ROOM NUMBER]-bathroom sink hot water facet dial was broken off and missing with water running continuously.room [ROOM NUMBER]-bathroom wallpaper was torn, no towel rack, lightbulbs in light fixture were not working, and bathroom cove base was noted to be missing and or not in good repair.room [ROOM NUMBER]-bathroom had a brown color, resembling rust, substance found around the base of the toilet seal as well as on the back of the toilet seat. The bathroom floor was found to have several areas of a brown substance smeared throughout.room [ROOM NUMBER]-bathroom wallpaper was torn, and cove base was separating from wall and not in good repair. Doors of bathroom and room were found to have deep marring and scratches.room [ROOM NUMBER]-bathroom wallpaper was discolored and in poor repair. The bathroom floor was found to have several areas of a brown substance smeared throughout as well as the toilet and sink. Staff #22 agreed with these observations and stated, I will let them know about this. On 02/18/2026 at 08:15 AM the surveyor conducted observation rounds on the second-floor clinical unit that included rooms 204A through room [ROOM NUMBER]A. The following observations were made: room [ROOM NUMBER] A, B: the bathroom wallpaper was torn, there was no towel rack present, the residents' dresser had multiple scratches and peeled wood present, the visitor had broken wood spindles/rungs and was leaning against the wall.room [ROOM NUMBER] A, B: there were residents' clothing and shoes lying on the floor. There was a broken wooden wardrobe door and there was an absent wardrobe on the right side that had been broken off with rough edges present.room [ROOM NUMBER] A, B: the wallpaper below the window appeared water damaged and was buckling.room [ROOM NUMBER] A, B: the bathroom wallpaper had patches of spackling present, some wall paper was peeling that was located across from the bathroom. On 02/25/2026 at approximately 10:20 AM the surveyor completed walking rounds with the maintenance director and discussed the identified areas of concerns. The maintenance director stated that the identified areas of concern would be addressed in a timely manner. On 02/25/2026 during the exit conference the maintenance repair issues were reviewed with the Director of Nursing, administrator and the regional operations staff present.

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on record review and staff interviews, it was determined that the facility failed to ensure that each resident formulated an advance directive. This was evident for 2 (Resident #29, Resident #59) residents out of 36 residents reviewed for advance directives.The findings include:1) On 2/19/2026 at 9:03 AM, Review of medical records reveals that the surveyor was unable to find the advance directives for Resident #29. However, it was noted that Resident #29 has a living will.An interview with the social worker (Staff #16) was conducted on 2/19/26 at 1:37 pm, and asked if she knew where the copy of the living will was in the resident's records. Staff #16 stated that she thought that there was a copy in the records, but she was unable to locate it in the chart. She then stated that she would have to get in touch with Resident #29's daughter to get a copy.On 2/24/2026 at 9:21 AM, Review of medical records stated that Resident #29 has a living will and that his/her daughter is the Power Of Attorney. Staff #16 tried to contact the daughter to obtain a copy of the living will. Staff #16 was unable to provide a copy of the living will during the survey.2) On 2/24/2026 at 11:18 AM, a review of medical records revealed that the surveyor was unable to find documentation of advance directives for Resident #59. On 2/24/26 at 9:25 am, the surveyor interviewed Staff #16, the Social Worker, and asked if Resident #59 had advance directives. Staff #16 confirmed that Resident #59 did not have an advance directive completed during his admission evaluation.

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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. Based on record review and staff interviews, it was determined that the facility failed to ensure that the comprehensive care plan was reviewed and revised by an interdisciplinary team composed of individuals who know the resident and his/her needs, and failed to ensure that each resident's care plan meeting was done quarterly. This was evident for 4 (Resident #29, #9, #32, and #59) out of 36 residents reviewed for comprehensive care plan revision.The findings include:The Interdisciplinary team (IDT) must, at a minimum, consist of the resident's attending physician, a registered nurse, and a nurse aide with responsibility for the resident, a member of the food and nutrition services staff, and, to the extent possible, the resident and resident representative, if applicable.1) On 2/18/2026 at 11:51 AM, the surveyor conducted an interview with Resident #29 and asked if s/he participated in their care plan meetings. Resident #29 stated that s/he has not had any care plan meetings.On 2/24/2026 at 11:07 AM, a review of medical records revealed that Resident #29's last care plan meeting was 12/27/24.On 2/24/2026 at 11:25 AM, an interview with the social worker, Staff #16, was conducted in reference to care plan meetings. Staff #16 was asked how often care plan meetings were conducted with residents. Staff #16 answered that care plan meetings were conducted with the residents and their representatives within the first 14 days of admission, quarterly (every 3 months), when there is a significant change with the resident, or annually. Staff #16 was asked who was involved in the care plan meetings for each resident. Staff #16 responded that social work, nursing, rehab, activities, and the resident and/or the resident representative usually attend the meetings. Staff #16 was asked if she was aware that a GNA and the doctors should be involved in the care plan meetings. Staff #16 answered no.Staff #16 was then asked when the last time Resident #29 had a care plan meeting. Staff #16 reviewed the resident's records on her laptop and stated that the last care plan meeting for Resident #29 was 12/27/24. When Staff #16 was asked why the facility had not conducted a care plan meeting for Resident #29 in over a year, she responded that she was not sure.2) On 2/19/2026 at 8:43 AM, the surveyor conducted an interview with Resident #9. When asked if they attend care plan meetings Resident #9 stated that s/he had not attended a care plan meeting in a while.On 2/24/2026 at 11:30 AM, an interview with the social worker, Staff #16, was conducted. Staff #16 was asked when the last care plan meeting was done with Resident #9. Staff #16 reviewed the resident's records on her laptop and answered on 1/16/26. Staff #16 was asked when the care planning meeting was done before that. Staff #16 reviewed the resident's records on her laptop and responded on 10/10/25. Staff #16 was asked to open the document and tell the surveyor why there was an error next to the document. Staff #16 opened the document and said that the error indicated that the document was not complete and signed off. Staff #16 was then asked who the social worker working on the document was. Staff #16 stated that the social worker was no longer working at the facility and that the document could not be completed. Staff #16 was then asked if this document was to be considered a completed care plan meeting; she responded no.3) On 2/19/2026, a record review was conducted for Resident #32. During this review, it was revealed that the last care plan meeting was 1/9/2026, and the care plan meeting before that was 5/16/25.On 2/24/2026 at 11:30 AM, an interview with the social worker, Staff #16, was conducted. Staff #16 was asked when the last care plan meeting was done with Resident #32. Staff #16 reviewed the resident's records on her laptop and answered on 1/9/26. Staff #16 was then asked when the care planning meeting was done before that. Staff #16 reviewed the resident's records on her laptop and responded on 5/16/25. Staff #16 was then asked why the care plan meetings were not completed quarterly. Staff #16 was unable to answer.4) On 2/22/26, a record review was conducted for Resident #59. During this review, it was revealed that the last care plan meeting was 1/9/2026, but when the meeting notes were opened, the document was blank. The care plan meeting done before that was on 10/10/2025 and 3/28/25.On 2/24/2026 at 11:30 AM, an interview with the social worker, Staff #16, was conducted. Staff #16 was (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	asked when the last care plan meeting was done with Resident #59. Staff #16 reviewed the resident's records on her laptop and answered on 1/9/26. Staff #16 was then asked to open the document. When she opened the care plan meeting notes, she noted that it was blank. Staff #16 was then asked who the social worker was who was working with the resident at that time. Staff #16 stated that the social worker was no longer working at the facility and that the document could not be completed. Staff #16 was then asked when the care planning meeting was done before that. Staff #16 reviewed the resident's records on her laptop and responded on 10/10/25. The surveyor then asked for the date before that. Staff #16 reviewed the resident's records on her laptop and responded on 3/28/25. Staff #16 was then asked why the care plan meetings were not completed quarterly. Staff #16 was unable to answer.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. Based on observation, record review, and staff interviews, it was determined that the facility failed to provide the resident with a diet that meets his/her nutritional needs. This was evident for 1 resident (Resident # 116) out of 8 residents reviewed during the annual recertification survey.The findings include: On 02/21/2026 at 7:47 AM, the surveyor observed Resident #116's breakfast tray. Resident #116's breakfast tray was observed to have scrambled eggs, toasted white bread, oatmeal, a banana, a 4-ounce carton of cranberry juice, and a carton of reduced fat milk. On 02/21/2026 at 7:48 AM, the surveyor conducted a record review. The record review revealed that Resident #116's breakfast meal ticket, dated 02/21/2026, indicates that Resident #116 has a standing order for 4 ounces of cranberry juice and a half cup of fresh apples. When the surveyor compared Resident #116's breakfast meal ticket to the breakfast tray, it revealed that Resident #116 did not receive a half cup of fresh apples. On 02/21/2026 at 7:50 AM, the surveyor conducted a staff interview. During the staff interview, the Payroll and Scheduler, Staff #10, who was passing out resident breakfast trays, verified that Resident #116's breakfast tray had scrambled eggs, toasted white bread, oatmeal, a banana, a 4-ounce carton of cranberry juice, and a carton of reduced fat milk, and did not have a half cup of fresh apples. On 02/21/2026 at 8:09 AM, the surveyor conducted a staff interview. During the staff interview, the Food Service Director, Staff #7, confirmed that Resident #116's breakfast tray did not have a half cup of fresh apples, and that Resident #116's breakfast tray should have contained a half cup of fresh apples.

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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 record reviews and staff interviews, it was determined that the facility failed to ensure that residents' records were accurate and complete. This was evident for 2 (Resident #9 and #59) residents out of 36 residents reviewed during this annual Medicare/Medicaid recertification survey.The findings include:1) On 2/24/2026 at 11:30 AM, an interview with the social worker, Staff #16, was conducted. Staff #16 was asked when the last care plan meeting was done with Resident #9. Staff #16 reviewed the resident's records on her laptop and answered on 1/16/26. Staff #16 was asked when the care planning meeting was done before that. Staff #16 reviewed the resident's records on her laptop and responded on 10/10/25. Staff #16 was asked to open the document and tell the surveyor why there was an error next to the document. Staff #16 opened the document and said that the error indicated that the document was not complete and signed off. Staff #16 was then asked who the social worker working on the document was. Staff #16 stated that the social worker was no longer working at the facility and that the document could not be completed. Staff #16 was then asked if this document was to be considered a completed care plan meeting; she responded no. 2) On 2/24/2026 at 11:30 AM, an interview with the social worker, Staff #16, was conducted. Staff #16 was asked when the last care plan meeting was done with Resident #59. Staff #16 reviewed the resident's records on her laptop and answered on 1/9/26. Staff #16 was then asked to open the document. When she opened the care plan meeting notes, she noted that it was blank. Staff #16 was then asked who the social worker was who was working with the resident at that time. Staff #16 stated that the social worker was no longer working at the facility and that the document could not be completed.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation and interviews it was determined the facility failed to maintain patient care equipment in working operating conditions. This was evident for 1 resident #83 out of 5 residents reviewed for patient care equipment. The findings include:During observational rounds and interview on 02/18/2026 at 7:45 AM with Staff #22, Resident #83's bed was observed having a pressure reducing mattress and pump that was not on and not working. Staff #22 confirmed this observation and was unable to get the air mattress pump to work and stated, It is not working and I will have someone come and look at it. Review of Resident #83's medical record on 02/18/2026 at 11:30 AM revealed an order dated 10/28/2025 for Resident #83 to have a pressure reducing mattress every shift.During observational rounds and interview on 02/19/2026 at 9:15 AM with the Director of Nursing, Staff #3, Resident #83's bed was still observed having a pressure reducing mattress and pump that was not on and not working. Staff #3 stated, I will get Maintenance to look at it. During an interview on 02/20/2026 at approximately 1:00 PM, Staff #14 stated; We do not have residents' air mattresses and pumps as part of the facility preventive maintenance program.