STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215125	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Village at Rockville	9701 Veirs Drive 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. 48168 Based on record review and interview, it was determined that the facility failed to respond timely when residents called for assistance. This was evident for 1 complaint (#MD00206835) of 6 complaints reviewed during the recertification survey. The findings include: On 10/08/24 at 3:00 PM, a review of complaint #MD00206835 was conducted. It alleged that staff were slow to answer Resident #152's call bell on 11/20/23, 11/21/23, 11/25/23, 11/26/23, and 12/04/23. On 10/11/24 at 10:15 AM - the Nursing Home Administrator (NHA) was asked to provide the call bell response log for Resident #125 for the days of concern. A review of those records revealed that on 11/20/23, 11/21/23, 11/25/23, 11/26/23, and 12/04/23, Resident #152's call bell went unanswered for 42 minutes or longer at least once. On 11/20/23, 11/25/23, and 12/04/23, this occurred twice. On 10/11/24 at 10:20 AM in an interview with Geriatric Nursing Assistant (GNA #13), she described how the call bell system worked. She said that when the resident pressed their call device, the GNAs received a phone notification on an app. The app showed the room number and if it was from the bed or the bathroom. She further explained that the expectation was to answer the call bell within 8 minutes, that she was told this in staff meetings and in orientation. On 10/11/24 at 10:26 AM, an interview with Licensed Practical Nurse (LPN #1) was conducted. She explained that call bell alerts went to the GNAs first, and if the GNA does not turn it off in 5 minutes, the nurses were alerted. The expectation was that the call bell was answered within 5 minutes. She also said the supervisor was notified when the call bell was answered. When asked if a call bell response time of 40 minutes or more was acceptable, she said No. On 10/11/24 at 10:41 AM, an interview with the Director of Nursing (DON) was conducted. When she was asked to provide the facility's call bell policy she replied that the facility does not have one. On 10/11/24 at 11:10 AM, an interview was conducted with the NHA and DON and they confirmed the delay in call bell response time and said they knew this was a deficiency.

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 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. 50573 Based on record review and interview with facility staff, it was determined that the facility failed to ensure that a primary care provider was notified of a lab result. This was evident for 1 (Resident #120) of 3 residents reviewed for urinary tract infections. The findings include: On 10/02/24 at 1:42 PM, review of Resident #120's electronic medical record revealed a urine culture and sensitivity result from the lab, dated 9/20/24 at 12:00 PM, which indicated the urine specimen was spilled in transit and that Registered Nurse, Staff #14 was informed. On 10/08/24 at 9:19 AM, an interview with the second floor Registered Nurse Care Coach/Unit Manager (Staff #1) revealed that the responsibility of the nurse with lab results is to review and notify the primary care provider of the results. Further interview revealed the nurse should document the communication with the provider of the result and the provider response. Further review of Resident #120's medical record failed to reveal any documentation to indicate that the urine was spilled in transit was communicated to a primary care provider. On 10/09/24 at 7:59 AM, the surveyor reviewed the concern with the Director of Nursing (DON) regarding the failure to notify the provider of Resident #120's lab result from 9/20/24.

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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 - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48168 Based on observation and interview, it was determined that the facility failed to 1) ensure the eanvironment in the facility was in good repair, and 2) failed to have an effective system in place to ensure that maintenance issues were reported to and addressed by maintenance staff in a timely manner. This was evident for 1) one housekeeping closet and three hallway bathrooms, and 2) for two out of thirty-two rooms observed during the survey. The findings include: 1a) On 10/02/24 at 1:00 PM, an observation of the Potomac Unit on the 2nd floor of the facility was conducted. A housekeeping closet was located across from room [ROOM NUMBER]. The closet door opened when the handle was turned. A keypad lock device was present on the door, but was partially separated from the door. The closet contained a vacuum, cleaning liquids in a wall dispenser, and large bottles of hand sanitizer. On 10/02/24 at 1:05 PM, Registered Nurse (RN #1) was interviewed, and she said the door should be locked. She turned the door handle and opened the door without using the keypad lock. She said she was unaware that the door lock was broken but said she could see that it was loose. On 10/02/24 at 1:57 PM, an interview was conducted with the Director of Nursing and Staff #1. They confirmed that the housekeeping closest was unlocked and that this was a deficiency. They said they had contacted Maintenance to make the repair. 45139 1b) On 10/04/24 at 12:30 PM, a random observation in the Potomac hallway bathroom, located across from the 2nd-floor dining room, revealed a hole in the wall opposite the toilet. Further observation revealed that the hole in the wall was in the shape of the bathroom door's handle. The hole was approximately 7 inches long, and the widest portion was 3- 1/2 inches. Continued observation revealed that the hole was stuffed with toilet paper. A second observation of the same Potomac Hall bathroom on 10/10/24 at 12:35 PM, revealed no change in the hole in the wall. On 10/10/24 at 1:25 PM, the Maintenance Director (Staff #12) and surveyor made a joint observation of the hole in the wall of the Potomac hallway bathroom. The hole in the wall was filled with toilet paper. Staff # 12 stated that he was unaware that the hole was there and said that it would be repaired immediately. On 10/10/24 at 4:20 PM, in an interview with Staff #12 and the Nursing Home Administrator, they reported that repair of the hole in the wall was in progress. On 10/11/24 at 8:55 AM, an observation of the Potomac Hall bathroom revealed that the hole was no longer visible. The area where the hole had been was covered by spackle and white primer paint. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	51213 2) On 10/02/24 at 10:46 AM in room [ROOM NUMBER], the surface of the dry wall behind the residents bed was observed to be gouged in three different areas exposing the white chalk like surface beneath. On 10/03/24 at 11:09 AM in room [ROOM NUMBER], the surface of the dry wall behind the resident's bed was observed to be gouged in five different areas exposing the white chalk like surface beneath. During observation on 10/10/24 at 11:22 AM in room [ROOM NUMBER], the drywall directly behind the bed still had the same drywall missing from five places exposing the white chalk like surface beneath. On 10/10/24 at 11:50 AM during an interview, the maintenance director (Staff #12) was asked how work orders were processed and received by his department within the facility. Staff #12 stated that if the situation was non-emergent, the staff would call the front desk. The front desk would enter a work request into the computer system, which is what the facility uses to retrieve and track work orders. Once the front desk has put the work order in the computer, the maintenance department can retrieve and track the work orders. When Staff #12 was asked if he was aware that the dry wall in rooms [ROOM NUMBERS] had dry wall gouged in several places exposing the bare surface beneath Staff # 12 replied that he was not aware. The surveyor asked if there was documentation to indicate that the maintenance director received work orders for these two rooms. He said he would check. On 10/10/24 at 1:21 PM, Staff #12 reported that the rooms need to be vacant in order to complete the repairs and the two rooms were not currently on the vacant list. Staff #12 provided documentation to indicate that work had been completed for some rooms on the same unit in July and August, however, he failed to provide documentation to indicate there were current work orders for Rooms 3146 or 3149.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 50573 Based on record review and interview, it was determined that the facility failed to 1) report allegations of abuse within two hours, and 2) identify and report potential abuse to the administrator. This was evident for 1) four facility reported incidents (FRIs) (#MD00202347, #MD00198954, #MD00181634, MD00187540) of seventeen FRIs, and 2) one (Resident #33) of twenty-one residents reviewed for potential abuse. The findings include: 1a) On 10/08/24 at 11:55 AM, a review of the facility reported incident #MD00202347 revealed that Resident #36's responsible representative made the facility aware of an allegation that female residents on the second floor were being compromised at night. Staff were made aware of the allegation on 2/06/24 at 3:15 PM, but failed to report the allegation to the Office of Healthcare Quality until 2/07/24 at 6:07 PM. On 10/09/24 at 8:24 AM, the surveyor reviewed the concern with the Director of Nursing (DON) regarding the failure to report an allegation of abuse within 2 hours. 1b) On 10/09/24 at 9:03 AM, a review of the facility self reported incident #MD00198954 revealed that Resident #67's responsible representative made the facility aware of an allegation that Resident #67 told him a staff member put his/her head in the toilet but could not indicate if it happened at the facility. Staff were made aware of the allegation on 10/25/23 at 2:40 PM but failed to report the allegation to the Office of Healthcare Quality until 10/26/23 at 7:17 AM. On 10/09/24 at 08:25 AM, the surveyor reviewed the concern with the Director of Nursing (DON) regarding the failure to report an allegation of abuse within 2 hours. 51213 1c) On 10/10/24 at 8:50 AM, facility report MD # 00181634 was reviewed. This review revealed that Resident # 139 reported an allegation of abuse on 8/2/22 at 4:30 PM. The date of the initial email regarding the self-report was sent to the state survey agency on 8/3/22 at 11:23 AM. On 10/10/24 at 4:04 PM, the Director of Nursing was asked what the time frame was to report an allegation of abuse. The DON's response was 2 hours. She confirmed that the facility reported incident #MD00181634 was reported after the required timeframe. 37276 1d) On 10/10/24 9:40 AM, a review of facility reported incident, MD00187540 revealed documentation that, on 1/9/23 at 1:16 PM, a family member of Resident #138 reported to facility staff that Resident #138 alleged s/he was being abused and retaliated against by the staff. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of email confirmation of when the facility's initial self-report was sent to the state agency revealed documentation that the incident was reported to the state agency on 1/9/23 at 6:34 PM. The facility failed to forward a first report of an allegation of abuse to the state agency immediately, but not later than 2 hours once the facility staff became aware of the abuse allegation. On 10/10/24 at 4:05 PM, during an interview, the concerns with failing to report an allegation of abuse immediately, but not later than 2 hours were discussed with the Director of Nurses (DON). At that time, the DON acknowledged the concerns and stated that the time to report an allegation of abuse was within 2 hours. 16218 2) A review of Resident #33's medical record revealed the resident required staff assistance with transfers from bed to wheelchair and back to bed. A review of the facility reported incident (MD00189254) revealed that on 2/19/23 the geriatric nursing assistant (GNA Staff #15) refused to assist Resident #33 back to bed when the resident requested assistance. The incident was reported to the state survey agency on 2/20/23. A review of the facility's interview with Resident #33, dated 2/21/23 revealed that on 2/19/23 the resident was in the dining room for lunch. After lunch the resident asked GNA #15 to take the resident back to his/her room. The GNA said No, and indicated when she (GNA) was ready she would take the resident back. The resident then told the GNA that his/her legs hurt and that he/she wanted to go back to his/her room. The GNA again refused to assist the resident and, according to the resident's statement, said: Shut up. I don't want to hear you complaining. You're going to have dinner there. At 3:00 PM the resident said I'm going back, the GNA responded: No, I'll take you after dinner. The resident then got upset and called the GNA a son of a #####. The resident then proceeded to wheel him/herself back toward his/her room until another staff person (GNA #24) came to assist the resident. A review of the facility's interview with GNA #15, dated 2/21/23, revealed the statement of events on 2/19/23: After lunch [the resident] said that [s/he] wanted to go back to [his/her] room and I told [the resident], 'no'. [The resident] also asked a few visitors if they could help [him/her] to bed and I told the visitors, 'no' and that we would assister [him/her] to bed later. Did [the resident] tell you that [s/he] called me a '#####'? A review of the facility's interview with Nurse #16, dated 2/20/23, revealed that on 2/19/23 Resident #33 requested to be put to bed. The Nurse #16 asked the assigned GNA (#15) to assist the resident back to bed but GNA #15 said: No, she is not going to put [the resident] to bed because [the resident] called her a #####. Nurse then asked GNA #24 to assist the resident. The Nurse #16 then informed the Care Coach (Staff #1) what happened on the unit. A review of the interview statement from Care Coach (Staff #1), dated 2/21/23, revealed she spoke with the GNA #15 after Nurse #16 had reported that the GNA did not assist a resident to bed when requested. The statement included: [GNA #15] stated to me that she just got the resident up and that she wanted to wait until after dinner to assist the resident back to bed. She told me that the resident called her a son of a ##### (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of the Care Coach's interview statement failed to reveal documentation to indicate the Care Coach spoke with the resident on the evening of 2/19/23. On 10/10/24 at 9:35 AM an interview was conducted with Care Coach (Staff #1). She reviewed her statement from 2/21/23 and confirmed that it was correct. The Care Coach was unable to recall if she spoke with the resident that evening. When asked if she told anyone else about the incident that evening, the Care Coach reported that she did not think it was a customer complaint, she was not aware at the time that the resident had requested, and GNA had refused, to assist; and that she just thought it was the GNA telling the nurse no. Further review of the investigation documentation revealed the resident reported the incident to the then Assistant Director of Nursing (ADON) on the morning of 2/20/23. On 10/10/24 at 10:39 AM the Director of Nursing (DON) was interviewed. The DON confirmed that she was not aware of the incident until the day the report was sent in, and stated: I wasn't made aware until the 20th, from what I understand he/she (Resident #33) requested to speak with the ADON. When the surveyor expressed the concern that there was no follow up with the resident that evening, the DON reported they did identify the concern that the incident was not identified as abuse when it occurred. The DON went on to report that she did inform the Care Coach that she should have spoken with the resident and taken the GNA off the schedule. The facility also provided documentation that training was conducted with staff on 2/23/23 and 2/25/23 regarding the Resident's [NAME] of Rights and Reporting Abuse.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 37276 Based on review of facility reported incident investigations and interview, it was determined that the facility failed to thoroughly investigate allegations of abuse. This was evident for 1 (#138) of 21 residents reviewed for abuse. The findings include: On 10/10/24 9:40 AM, a review of facility reported incident, MD00187540 was conducted. The facility's initial self-report documented that, on 1/9/23, a family member of Resident #138's reported to a supervisor that Resident #138 alleged s/he was abused and retaliated against by staff assigned to the resident. Review of the documents included with the facility's investigation revealed documentation of interviews that were conducted with staff members assigned to the resident during the time frame the alleged abuse was reported to have occurred, and interviews conducted with some residents. However, continued review of the facility's investigation failed to reveal documentation of the interview conducted with the family member who reported Resident #138 had an allegation of abuse. In addition, there was no documentation in the self-report to indicate who the supervisor was that initially received the report of alleged abuse from the family member, and there was no documented interview of the supervisor was found with the facility's investigation. On 10/10/24 at 4:05 PM, during an interview, the concerns with failing to thoroughly investigate an allegation of abuse were discussed with the Director of Nurses (DON). At that time, the DON was made aware that an interview with the complainant, an interview with Resident #138, and an interview with the supervisor who received the complaint were not included with the facility's investigation and the concerns with failing to thoroughly investigate an allegation of abuse were discussed with the DON. At that time, the DON acknowledged the concerns and indicated she was surprised that the interviews were not with included in the investigation.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50573 Based on staff interviews and record review, it was determined that the facility failed to include the resident care plan with the required documentation during a transfer. This was evident for 1 (Resident #45) of 3 residents reviewed for hospitalization . The findings include: On 10/03/24 at 10:41 AM, record review revealed that Resident #45 was hospitalized on [DATE] and 4/22/24. On 10/07/24 at 12:33 PM, an interview with Licensed Practical Nurse (LPN #28) and Licensed Practical Nurse (LPN #29) revealed that the nurses use a transfer checklist to ensure required documents are sent with the resident upon a transfer. Review of the transfer form checklist provided to the surveyor during the interview failed to reveal indication of a care plan. Further interview with LPN #28) and LPN #29 revealed that they would not send the residents care plan upon transfer. On 10/07/24 at 1:26 PM in an interview with the Director of Nursing (DON), she said that the care plan should be sent with the residents upon transfer. On 10/08/24 at 9:17 AM, LPN #30 was interviewed and said that they would not send the care plan with the resident upon transfer. On 10/08/24 at 9:37 AM, LPN Staff #31 was interviewed and said that they would not send the care plan with the resident upon transfer. On 10/09/24 at 7:52 AM, the surveyor reviewed the concern with the DON regarding the failure to ensure that individual resident care plans are sent with the resident upon transfer.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 50573 Based on record review and staff interview, it was determined that the facility failed to provide written notification of transfer to the resident and resident representative. This was evident for two residents (Resident #45, #98) of 3 residents reviewed for hospitalization . The findings include: 1) On 10/03/24 at 10:41 AM, a review of Resident #45's medical record revealed she/he was hospitalized on [DATE] and 4/22/24. Further review of Resident #45's electronic medical record and paper chart on 10/03/24 at 10:45 AM, failed to reveal a that a written transfer form was provided to the resident and resident representative for the 2/2/24 and 4/22/24 hospitalization s. On 10/07/24 at 1:13 PM in an interview with the Nursing Home Administrator (NHA), she said that the hospital transfer notice forms were typically not given to the resident, but the resident representative would verbally be told of the transfer. If the responsible representative was local and wanted a copy, then the facility would send a copy, but the facility would not always send a written notice to the resident representative. Further interview with the NHA, on 10/07/24 at 1:13 PM, revealed that the transfer notice form sometimes would not get uploaded into the electronic medical record, but could be found in the paper chart. On 10/07/24 at 1:26 PM during an interview with the Director of Nursing (DON), she said that the residents' responsible representative would be called for notice of transfer if they were not at the facility and the facility would document the verbal notice. On 10/09/24 at 8:24 AM, the DON made the surveyor aware that the facility was unable to find a transfer notice form for the hospitalization s on 2/2/24 and 4/22/24. On 10/09/24 at 8:25 AM, the surveyor interviewed the NHA and reviewed the concern regarding the failure to ensure that a written notice of transfer was provided to the resident and resident representative and the NHA confirmed the deficiency. 37276 2) On 10/7/24 at 12:45 PM, a review of Resident #98's electronic medical record (EMR) revealed the resident was initially admitted to the facility in November 2023, where he/she resided for long term care, and recently transferred to a hospital on 9/29/24 following an acute change in condition. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/7/24 at 12:35 PM, a review of Resident #98's electronic medical record (EMR) revealed documentation that Resident #98 was transferred to an acute care facility on 9/29/24. Review of Resident #98's EMR revealed a SNF/NF (skilled nursing facility/nursing facility) to Hospital Transfer form, dated 9/29/24 at 1:00 PM, that documented Resident #98 was sent to the hospital on 9/29/24 at 9:55 AM, and documented the reason for the transfer was respiratory distress, and the resident's representative was notified of the transfer. In an SBAR (acronym for situation, background, assessment, recommendation; used to facilitate communication between health care members), on 9/29/24 at 9:55 AM, the nurse documented that Resident #98 had a change in condition, that the resident was having difficulty breathing, the resident was alert and responsive, the physician was notified, and ordered the resident transferred to the emergency room for respiratory distress. On 10/7/24 at 1:13 PM, during an interview, the Nursing Home Administrator (NHA) reported that when a resident was transferred to the hospital, a transfer notice form that included the facility's bed hold policy was completed and given to the resident, and a copy of the transfer notice should be found in the resident's hard chart. The NHA indicated the resident's representative (RP) would be notified of the resident's transfer verbally, and if the RP wanted a copy of the transfer notice, the RP could come into the facility to get a copy, or a copy of the transfer notice could be emailed or sent to the RP. During an interview on 10/7/24 at 1:25 PM, the Director of Nurses (DON) stated that when a resident was transferred out of the facility emergently, a transfer notification form was completed, and a copy of the transfer notice was included with a packet of documents sent with the resident upon transfer. The DON stated when the RP was in the facility, the RP would be notified of the transfer and the RP could be given a copy of the resident's transfer notice. The DON stated that when the RP was not in the facility, the RP would be notified of the resident's transfer by phone and the RP notification would be documented on the transfer form which would be then kept in the resident's medical record. Continued review of the medical record failed to reveal documentation Resident #98 and the resident's representative(s) were notified of the transfer and the reasons for the move in writing and in a language and manner they understand. On 10/7/24 at 2:00 PM, the DON provided the surveyor with a copy of a blank Notice of Transfer, Discharge, Bed-Hold and Return to the Village of Rockville form and indicated that, at the time of a resident's transfer, the form would be completed, a copy of the form would be given to the resident and/or RP, and a copy would be filed in the resident's hard chart. At that time, the above concerns were discussed with the DON who acknowledged the concerns and indicated she would check to see if medical records had a copy of the resident's transfer notice. No additional documentation was provided to the surveyor as of the time of exit on 10/11/24 at 2:00 PM.

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50573 Based on record review and staff interview, it was determined that the facility failed to orient, prepare, and document a resident's transfer. This was evident for two (Resident #45, #98) of 3 residents reviewed for hospitalization . The findings include: 1) On 10/03/24 at 10:41 AM, a review of Resident #45's medical record revealed that he/she was hospitalized on [DATE] and 4/22/24. On 10/09/24 at 8:24 AM, in an interview with the Director of Nursing (DON), she said that when a resident was sent to the hospital, the documentation of the residents transfer was written in the progress notes. On 10/09/24 at 8:24 AM, further interview with the DON on 10/09/24 at 8:24 AM revealed that the facility also used a transfer form where they documented the reason for the residents transfer and that the resident representative was notified of the transfer. On 10/09/24 at 8:25 AM, the surveyor reviewed progress notes around the two dates of hospitalization and the transfer form completed for Resident #45's hospital transfers on 2/2/24 and 4/22/24. The review failed to reveal that the resident was prepared and oriented for the transfer. On 10/09/24 at 8:28 AM, the surveyor reviewed the concern with the DON regarding the failure to ensure residents were prepared and oriented for transfers, and she confirmed the deficiency. 37276 2) On 10/7/24 at 12:35 PM, a review of Resident #98's medical record revealed documentation that Resident #98 was transferred to an acute care facility on 9/29/24 and failed to reveal evidence that the resident was oriented and prepared for the transfers in a manner s/he could understand and there was no documentation of the resident's understanding of the transfer. On 9/29/24 at 9:55 AM, in a SBAR (acronym for situation, background, assessment, recommendation; used to facilitate communication between health care members), the nurse documented that Resident #98 had a change in condition, that the resident was having difficulty breathing, the resident was alert and responsive, the physician was notified, and ordered the resident transferred to the emergency room for respiratory distress. No documentation was found in the medical record to indicate that Resident #98 had received an explanation of why he/she was going to the emergency room and the potential response of the resident's understanding. On 10/11/24 at 11:00 AM, the Director of Nurses (DON) was made aware of the above concerns. At that time, the DON acknowledged the concerns, and the guidance related to preparing a resident for transfer was discussed with the DON.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37276 Based on medical record review, it was determined that the facility failed to notify the resident and/or the resident representative in writing of the bed-hold policy upon transfer of the resident to an acute care facility. This was evident for 2 (#98, #45) of 3 residents reviewed for hospitalization . The findings include: On 10/7/24 at 12:35 PM, a review of Resident #98's electronic medical record (EMR) revealed documentation that Resident #98 was transferred to an acute care facility on 9/29/24. In an SBAR (acronym for situation, background, assessment, recommendation; used to facilitate communication between health care members), on 9/29/24 at 9:55 AM, the nurse documented that Resident #98 had a change in condition, that the resident was having difficulty breathing, the resident was alert and responsive, the physician was notified, and ordered the resident transferred to the emergency room for respiratory distress. In an admission note on 10/2/24 at 4:08 PM, the admissions manager documented Resident #98's bed hold status was confirmed with the resident's representative. Continued review of Resident #98's medical record failed to reveal documentation that upon transfer to the hospital, Resident #98 and his/her representative were given written notice of the facility's bed hold policy at the time of the resident's transfer, or in the case of an emergency transfer, within 24 hours. During an interview, on 10/7/24 at 1:13 PM, the Nursing Home Administrator (NHA) reported that when a resident was transferred to the hospital, the resident was given a transfer notice form that included the facility's bed hold policy and the resident's representative (RP) was verbally notified of the resident's transfer. The NHA indicated that, if the RP wanted a copy of the transfer notice, the RP could come into the facility to get a copy, or a copy of the transfer form could be emailed to the RP, and a copy of the transfer form should be in the resident's hard chart (paper medical record). During an interview on 10/7/24 at 1:25 PM, the Director of Nurses (DON) stated that when a resident was transferred out of the facility emergently, a copy of a completed a transfer notification form with the bed hold was included in a packet of documents sent with the resident upon transfer. The DON stated that if the RP was in the facility, the RP could get a copy of the resident's transfer notice, and, when the RP was not in the facility, the RP would be notified of the transfer by phone, and this would be documented on the transfer form. Continued review of the resident's EMR and hard chart failed to reveal evidence a transfer form that included the bed hold policy was completed and provided to Resident #98 and/or the RP upon the resident's transfer to the hospital on 9/29/24. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/7/24 at 2:00 PM, the DON provided the surveyor with a copy of a blank Notice of Transfer, Discharge, Bed-Hold and Return to the Village of Rockville form and indicated that at the time of a resident's transfer, the form would be completed, a copy of the form would be given to the resident and/or RP, and a copy would be filed in the resident's hard chart. At that time, the DON was made aware of the above concerns, and indicated that she check to see if medical records had a copy of the resident's transfer notice. No additional documentation was provided to the surveyor as of the time of exit on 10/11/24 at 2:00 PM. 50573 On 10/03/24 at 10:41 AM, a review of Resident #45's medical record revealed that he/she was hospitalized on [DATE] and 4/22/24, but failed to reveal a written bed hold policy notification form for either hospitalization . On 10/07/24 at 1:13 PM an interview with the Nursing Home Administrator (NHA) revealed that bed hold policy notification forms are not usually given to the resident, but the resident representatives were verbally told of the bed hold policy. If the responsible representative was local and wanted a copy, then the facility sent them a copy, but the facility did not always send a copy of the form to the resident's representative. Further interview with the NHA on 10/07/24 at 1:13 PM, revealed that the written bed hold policy notifications of transfer were not always uploaded into the electronic medical record, but could be found in the paper chart. On 10/07/24 at 1:26 PM, an interview with the Director of Nursing (DON) revealed that the residents' responsible representative would be called about the notice of transfer and then the facility documented the verbal notice. On 10/09/24 at 7:52 AM, the surveyor requested evidence that the bed hold policy was provided to the resident and resident representative for Resident #45's hospitalization s on 2/2/24 and 4/22/24. On 10/09/24 at 8:24 AM, the DON made the surveyor aware that the facility was unable to find documentation of the written bed hold policy notification for Resident #45's hospitalization s on 2/2/24 and 4/22/24. On 10/09/24 at 8:25 AM, the surveyor reviewed the concern regarding the failure to ensure a written notice of the facility's bed hold policy was provided to Resident #45 or their resident representative.

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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. 37276 Based on record review and staff interview, it was determined that facility staff failed to develop and implement comprehensive resident centered care plan plans for residents. This was evident for 1) one (#118) of 5 residents reviewed for unnecessary medications, and 2) one (Resident #120) of 3 residents reviewed for communication during the recertification survey. The findings include: A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess and evaluate the effectiveness of the resident's care. Staff utilize care plans to provide resident centered care that includes support, services, and resources to address the needs of a resident. 1) Psychosis is a condition that causes a person to lose touch with reality, making it difficult to distinguish what is real and what is not. It is a term used to describe a group of symptoms, rather than a diagnosis. Symptoms include hallucinations, delusions (false beliefs) disorganized thinking or speaking; difficulty trusting others, and withdrawing from others. On 10/3/24 at 2:02 PM, a review of Resident #118's medical record was conducted and revealed the resident was admitted to the facility in early September 2024. Review of Resident #118's admission assessment with an assessment reference date of 9/14/24 documented the resident's BIMS (brief interview for mental status) summary score was 11, indicating the resident was moderately cognitively impaired, and had diagnoses which included anxiety disorder, depression. Review of Resident #118's September 2024 Medication Administration Record (MAR) revealed that the resident received psychotropic medications. The resident had a 9/10/24 order for Quetiapine (Seroquel) (antipsychotic) by mouth one time a day for hallucinations, that was documented as given every day from 9/11/24 to 9/15/24, then discontinued, and a 9/16/24 order for Seroquel (Quetiapine) by mouth two times a day for psychosis, that was documented as given twice a day, since 9/17/24 On 9/16/24, in a Psychiatric Evaluation & Consultation visit note, the Nurse Practitioner (NP) documented that Resident #118's had a history of dementia, hallucination, agitation, and restlessness and was seen by the NP per facility request for agitation, restlessness, and anxiety and Resident #118 was alert, confused, agitated, anxious, and verbally responsive. The NP documented resident's diagnosis was other depressive episodes, moderate severity; chronic illness with exacerbation, and to continue to monitor symptoms. The NP further wrote that, upon assessment, it was recommended for Resident #118 to start Ativan twice a day for 14 days for agitation, restlessness and anxiety, and the resident took Seroquel for psychoses. Review of Resident #118's care plans revealed the resident had a care plan: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident uses psychotropic medications r/t Behavior management, psychosis, created on 9/11/24, with the goal, The resident will be/remain free of psychotropic drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction or cognitive/behavioral impairment through review date, and the interventions, 1. Administer psychotropic medications as ordered by physician. Monitor for side effects and effectiveness q-shift, 2.Consult with pharmacy, MD to consider dosage reduction when clinically appropriate at least quarterly. 3.Monitor/document/report PRN any adverse reactions of psychotropic medications: unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, behavior symptoms not usual to the person. The care plan goal addressed the resident's response to possible psychotropic drug related complications, however, continued review of Resident #118's care plans failed to reveal evidence that a comprehensive care plan with measurable goals and non-pharmaceutical interventions had been developed. The above concerns were discussed with the Director of Nurses (DON) on 10/8/24 at 5:20 PM and the DON acknowled the concerns at that time. 50573 2) On 10/07/24 at 8:38 AM a review of Resident #120's recent Minimum Data Set (MDS) with an assessment reference date (ARD) of 9/4/24 revealed that the resident had a hearing aid. The Minimum Data Set (MDS) is an assessment of the Resident that provides the facility information necessary to develop a care plan, provide the appropriate care and services to the Resident, and modify the care plan based on the Resident's status. The assessment reference date (ARD) is the specific end point of look-back periods of resident status for the MDS assessment process. On 10/07/24 at 8:42 AM a review of Resident #120's care plan revealed a hearing deficit focus, but failed to reveal any indication that the resident had a hearing aid device. The most recent care plan meeting after the MDS was completed was on 9/18/24 and the care plan was not revised to reflect the resident 's status. On 10/11/24 at 8:23 AM, an interview with the Director of Nursing (DON) revealed that, when a resident had a hearing aid, it would be indicated on the care plan. On 10/11/24 at 8:25 AM, surveyor interviewed the DON who confirmed the deficiency that Resident #120's care plan lacked any indication that the resident had a hearing aid.

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48259 Based on record review and staff interviews, it was determined that the facility failed to provide Cardiopulmonary Resuscitation (CPR) to an unresponsive resident whose active Maryland Orders for Life Sustaining Treatment (MOLST) instructed to Attempt CPR if cardiac and/or pulmonary arrest occurs. This was evident for 1 (#137) of 21 residents reviewed for abuse during the survey. This deficient practice led to an immediate jeopardy for Resident #137 on [DATE]. Following the incident, the facility implemented effective and thorough corrective measures. The facility's plan and action were verified during this survey; therefore, this deficiency was cited as past noncompliance. The date of correction was [DATE]. The findings include: Cardiopulmonary resuscitation (CPR) refers to any medical intervention used to restore circulatory and respiratory function that has ceased. Maryland MOLST is a portable and enduring form for orders about cardiopulmonary resuscitation and other life-sustaining treatments. It makes one's treatment wishes known to healthcare professionals. Do Not Resuscitate (DNR)Order refers to a medical order issued by a physician or other authorized non-physician practitioner that directs healthcare providers not to administer CPR in the event of cardiac or respiratory arrest. Code Status refers to the level of medical interventions a person wishes to have started if their heart or breathing stops. A review of Resident #137's medical record revealed a MOLST, completed on [DATE], with Resident #137 as the decision maker and instructed to Attempt CPR. A review of a facility self-report MD00203965 for Resident #137, dated [DATE] indicated that, at approximately 4:30 AM on [DATE], staff #7, a geriatric nurse aid (GNA), noticed that Resident #137 was unresponsive upon entering his/her room. Staff #7 alerted the assigned nurse for Resident #137, staff #8, a registered nurse (RN). Further review revealed a clinical note for Resident #137 written by staff #8 and dated [DATE]. The note recorded that during routine check, resident was observed to have a cold clammy skin, no rise and fall of chest wall, pupils dilated to bright light. Vitals signs [respiration, pulse, blood pressure, temperature] weren't recordable. However, the review failed to show that staff #8 initiated CPR on Resident #137, as indicated on his/her MOLST form. A continued record review showed that staff #8 notified staff #9, the RN nurse supervisor, that Resident #137 was unresponsive and had a DNR order. Staff #9 then checked the resident's physical chart, which contained a MOLST that instructed staff to attempt CPR. The review failed to show that CPR was initiated at this point. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] at 1:04 PM with staff #1, an RN supervisor, she revealed that the form the nurses previously used for their change of shift report used to contain residents' code status. Staff #1 added that, due to inconsistencies, staff were educated to review the residents' physical charts for code status. In an interview on [DATE] at 9:06 AM, the director of nursing (DON) indicated that her investigation revealed that staff #8 used a form for her change of shift report with a code status for Resident #137. However, the DON was unaware of the form and expected staff # 8 to review Resident #137's MOLST for his/her code status. During an interview on [DATE] at 3:10 PM, staff #8 reported that this was her first time working with Resident #137 on [DATE]. Staff #8 continued to say that she did not initiate CPR on Resident #137 on that day because she was handed a report form at the start of her shift by the off-going nurse, which indicated that Resident #137's code status was DNR. Staff #8 added that she notified staff #9, who called Resident #137's attending provider. The provider ordered not to initiate CPR at that point because the resident was already cold to the touch and had no vital signs. A review of the certificate of death showed that Resident #137's date and time of death was [DATE] at 5:00 AM. In an interview on [DATE] at 8:33 AM, staff #16, a licensed practical nurse (LPN), indicated that the nursing staff used a form for their change of shift report, which contained residents' code status. However, after Resident #137's incident on [DATE], the nursing staff had been educated to check residents' physical charts for code status. A corrective action plan was developed and started on [DATE] after the incident occurred: 1) The staffing agency was notified of the occurrence, and staff #8 was placed on the Do Not Return list for the facility. 2) A document review was conducted on all units to ensure code status information was only available on the MOLST form in the residents' physical charts. 3) Nursing staff were re-educated on MOLST and the CPR process on [DATE]-[DATE] by the RN unit managers. 4) Policy on MOLST and CPR and education were activated in the facility's training software program for nursing staff review and acknowledgment. 5) The 3 Unit Managers (Care Coaches) also provided in-person training to all nursing staff. 6) The Medical Director provided education to all attending physicians (including Resident #137's attending provider) on [DATE]. 7) The facility audited and reviewed all residents' MOLST forms and orders. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 12:28 PM, after a review of the credible evidence of education, audits, and interviews with multiple staff, it was determined that the facility had identified this deficient practice and implemented interventions to prevent a recurrence. The date of compliance, as identified by the date on which the training was completed, was determined to be [DATE].

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 48168 Based on observation, interview and record review, it was determined that the facility failed to ensure that only licensed staff fed residents. This was evident for 1 resident (Resident #39) of 32 residents observed during the recertification survey. The findings include: On 10/02/24 at 12:47 PM, an observation of the 2nd floor Potomac Unit dining room was conducted. Resident #39 was sitting in a wheelchair at a table with 3 other residents. An unidentified female without a name badge stood next to Resident #39, took a spoonful of food from the resident's tray and placed it in the resident's mouth, then walked away. The unidentified female returned at 12:53 PM, fed the resident one bite and walked away. The same female returned at 12:55 PM, fed the resident another bite, and walked away again. Multiple other facility staff were present in the dining area and in the hallways during this time. On 10/02/24 at 12:58 PM, an interview was conducted with Geriatric Nursing Assistant (GNA #3) who was in the hallway next to the dining room. When asked, GNA #3 reported that the female who fed Resident #39 was not staff, she was a private duty aide (PDA #2) for another resident (Resident #11). GNA #3 said she was familiar with Resident #39 and confirmed that the resident required feeding assistance. On 10/02/24 at 1:03 PM, an interview with Registered Nurse (RN #1) was conducted. She said she was the unit manager. When asked who fed Resident #39, she confirmed that it was a private duty aide (PDA #2) who was privately hired to assist Resident #11. RN #1 confirmed that PDA #2 was not staff, was not licensed, and should not have fed Resident #39. On 10/02/24 at 3:52 PM, the Director of Nursing (DON) was interviewed and explained that PDA #2 had worked with Resident #11 at the facility for at least for a year, maybe longer. The DON said that the Resident #11 and Resident #39 sat at the same lunch table and that Resident #11 asked PDA #2 to assist Resident #39 to eat. When the DON was informed that other GNA staff were present and observed PDA #2 feeding Resident #39, the DON could not explain why staff did not intervene. The DON said her expectation was that PDA #2 should have gone to the nurse or assigned GNA and informed them of the Resident #39's need for assistance. She confirmed the deficiency.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 50573 Based on observation, record review and interview with facility staff, it was determined that the facility failed to obtain informed consent prior to the initiation of bed rails. This was evident for 2 (Resident #23 and #120) of 4 residents reviewed for physical restraints. The findings include: Bedrails or side rails are adjustable bars that attach to the bed. They vary in size, including full, half, and quarter lengths depending on their intended purpose. They can be used to prevent falls, help assist residents with movement, and provide a feeling of security. Bed rails also have potential risks associated with them. The facility should obtain a signed consent form before the use of bedrails. 1) On 10/02/24 at 9:59 AM, the surveyor observed Resident #120 in bed with two bed rails up on either side of the top end of the bed. On 10/03/24 at 11:33 AM, a review of Resident #120's medical record failed to reveal a consent form for the bed rail use. On 10/09/24 at 7:47 AM during an interview with the Director of Nursing (DON), the DON explained that the facility used enabler quarter rails, the residents were assessed prior to their initiation, and the rails were assessed and maintained quarterly. The DON further explained that the consent could be found on the assessment form. During the interview with the DON on 10/09/24 at 7:47 AM, the surveyor reviewed the bed rail assessments for Resident #120 which failed to reveal consent. The surveyor requested documentation of consent for the resident's bed rail use. On 10/10/24 at 7:33 AM, the Nursing Home Administrator (NHA) informed the surveyor that there was no consent for Resident #120's bed rail use. On 10/10/24 at 7:49 AM, the surveyor reviewed the concern with the DON regarding the failure to ensure that consent was obtained prior to bed rail use. 2) On 10/02/24 at 9:38 AM, the surveyor observed Resident #23 in bed with two bed rails up on either side of the head end. On 10/03/24 at 11:33 AM, review of Resident #23's medical record failed to reveal a consent form for the bed rail use. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/09/24 at 7:47 AM in an interview with the DON, she explained that the facility used enabler quarter rails, the residents were assessed prior to their initiation, and the rails were assessed and maintained quarterly. The DON further explaind that the consent could be found on the assessment form. During the interview with the DON on 10/09/24 at 7:47 AM, the surveyor reviewed the bed rail assessments for Resident #23 which failed to reveal consent. The surveyor requested documentation of consent for the resident's bed rail use. On 10/10/24 at 7:33 AM the NHA informed the surveyor that there was noconsent for Resident #23's bed rail use. On 10/10/24 at 7:49 AM, the surveyor reviewed the concern with the DON regarding the failure to ensure consent is obtained prior to bed rail use.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 45139 Based on record review and interview, it was determined that the facility failed to ensure the pharmacists recommendations regarding medications irregularities were communicated to the resident's physician. This was evident for three residents (Resident #51, # 111, and #117) of 5 residents reviewed for unnecessary medications during a survey. The findings include: 1) On 10/04/24 at 9:30 AM, Resident #51's medical records were reviewed. The review revealed that Resident #51 was a long-term resident at the facility and was receiving multiple medications. Further review revealed that a pharmacist reviewed Resident #51's medications for irregularities every month from November 2023 through September 2024. On 10/04/24 at 10:09 AM, a review of progress notes revealed a pharmacy note, dated 11/06/23, that indicated Resident #51's medications were reviewed and included that statement See report for any noted irregularities and or recommendations. On 10/04/24 at 12:20 PM, the Director of Nursing (DON) was interviewed and reported that she was unable to provide the 11/06/23 pharmacy report for Resident # 51. In addition, the DON failed to provide information about whether any irregularities were noted in the 11/06/23 pharmacy review and if they were addressed by the resident's physician. On 10/04/24 at 2:23 PM in another interview with the DON, she explained that the pharmacist reviewed residents' medications every month. If the pharmacist did not note any irregularities, they would document t in the progress notes as, No Irregularities noted. If the pharmacist found irregularities they would document see report for any noted irregularities and or recommendations. The pharmacist then emailed this report to the facility clinical management staff which included nursing supervisors (care coaches). The care coaches then printed the report out and gave it to the appropriate physician. The physician reviewed and signed the report, and documented on the report if he/she agreed or disagreed with the pharmacist recommendations and any new orders. After the physician documented on the report, it was then faxed back to the pharmacist. The report was kept in a binder at the unit nurses' station for three years. On 10/10/24 at 4:20 PM, the above concerns with discussed with the Director of Nursing (DON) and Administrator. The DON confirmed that there was no documentation that the above pharmacist recommendations were communicated to the Physician. 2). On 10/04/24 at 10:56 AM, Resident # 111's medical record was reviewed and revealed that the he/she was a long-term resident of the facility and had numerous medications ordered. Further review revealed that a pharmacist had reviewed the resident's medications for any irregularities every month between October 2023 and September 2024. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/04/24 at 12:20 PM, the Director of Nursing (DON) was interviewed interview and reported that she was unable to provide the 10/10/23 pharmacy review for Resident #111. In addition, she failed to provide what the noted irregularities were in the 10/10/23 pharmacy reviews and if they were addressed by the resident's physician. On 10/04/24 at 2:23 PM, the Director of Nursing was interviewed and she reported that the pharmacist reviews every resident's medication every month. If the pharmacist does not note any irregularities, they will document this in the progress notes as No Irregularities noted. If the pharmacist finds irregularities, this will be documented in the progress notes as see report for any noted irregularities and or recommendations. The pharmacist emails this report to the facility, clinical management staff, including the nurse unit's supervisor (care coaches). The care coaches print the report out and give it to the appropriate physician. The physician reviews and signs the report. In addition, he documents on the report if he agrees or disagrees with the pharmacist recommendations and any new orders. After the report is completed by the physician, the report is then faxed back to the pharmacist. The report is kept in a binder at the unit's nurses' station and kept for three years at the nurse's station. On 10/10/24 at 4:20 PM, the above concerns with discussed with the Director of Nursing (DON) and Administrator. The DON confirmed that there was no documentation that the above pharmacist recommendations were communicated to the Physician. 37276 3.) On 10/08/24 at 2:00 PM, a review of Resident #117's medical record was conducted and revealed the resident resided in the facility since for long term care since February 2024. Review of Resident #117's progress notes revealed the pharmacist documented a review of Resident #117's medications monthly in a Consultant Pharmacist Note/Medication Regimen Review note, and when no irregularities were identified, the pharmacist wrote no irregularities noted, in the monthly note. Further review of the pharmacist's monthly medication regimen notes for Resident #117 revealed on 3/11/24 at 2:07 PM, 6/10/24 at 2:54 PM, and 8/2/24 at 4:15 PM, the pharmacist wrote see report for any noted irregularities and/or recommendations. Continued review of Resident #117's electronic medical record and paper hard chart, failed to reveal documentation as to what the pharmacist identified and/or recommended on these 3 pharmacy review dates. On 10/08/24 at 1:45 PM, the surveyor requested Resident #117's pharmacist's reports for the dates 3/11/24, 6/19/24 and 8/2/24. Shortly after, the Director of Nurses (DON) provided the surveyor with 3 pharmacist report forms for Resident #117 that were labeled, Note to Attending Physician/Practitioner/Prescriber, and dated 3/11/24, 6/10/24, and 8/02/24 that documented the irregularity identified by the pharmacist, the pharmacist's recommendations, and the physician/prescriber's response to the pharmacist's recommendations. At that time, the DON indicated the pharmacist's reports were kept in a binder, and were not in the resident's medical record. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In the pharmacist's report, dated 6/10/24, the pharmacist identified that Resident #117 was receiving antipsychotic therapy and recommended the physician order an Abnormal Involuntary Movement Test (AIMS) now and every 6 months. The report documented the practitioner agreed with the pharmacist and was signed and dated by the Psychiatric-Mental Health Nurse Practitioner (PMHNP) on 7/04/24. There was no documentation in the report to indicate the attending physician reviewed the pharmacist's report, or documentation of the attending physician's potential response to the pharmacist's recommendation. In the pharmacist's report, dated 3/11/24, the pharmacist identified that Resident #117 had 2 orders for similar eye drop medication, and recommended the physician discontinue one of the orders to prevent duplication of therapy. The report documented the attending physician did not agree with the pharmacist's recommendations and the report was signed and dated by the attending physician on 3/13/24. In the pharmacist's report, dated 8/02/24, the pharmacist identified that Resident #117 had duplicate medication orders for GERD (gastroesophageal reflux disease) and recommended that one of the orders be discontinued. The report documented the attending physician agreed with the pharmacist's recommendation and attending physician signed and dated the report on 8/13/24. Continued review of Resident #117's medical record failed to reveal documentation that the attending physician documented in the resident's medical record that the identified irregularity had been reviewed and what, if any, action had been taken to address it. On 10/11/24 at 11:00 AM, the guidance regarding the attending physician documenting a response to the pharmacist's recommendation in the medical record was discussed with the DON, and the DON was made aware of the above concerns, who acknowledged the concerns at that time.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. 37276 Based on medical record review and staff interview, it was determined the facility failed to keep a resident's drug regimen free from unnecessary drugs by failing to ensure orders had adequate parameters in place to indicate when to administer as needed medications for constipation. This was evident for 1 (#118) of 5 residents reviewed for unnecessary medications. The findings include: On 10/4/24 at 10:10 AM, a review of Resident #118's medical record was conducted. Review of Resident #118's September MAR revealed 3 medications to be administered as needed for constipation with no clear indication of when to give which one, and 2 of these orders were for the same medication. There was a 9/10/24 order for lactulose oral solution (laxative) by mouth every 12 hours as needed for constipation, a 9/10/24 order for Miralax Powder (Polyethylene Glycol) (laxative)17 GM (grams) by mouth every 24 hours as needed for constipation once a day as needed for no BM (bowel movement), and there was a 9/10/24 order for Polyethylene Glycol Powder, 17 GM by mouth every 24 hours as needed for constipation. There was no clear indication in the physician orders as to which as needed medication to give first for constipation. The above concerns were discussed with the Director of Nurses (DON) on 10/7/24 at 1:25 PM, and the DON expressed understanding of the concerns at that time.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 37276 Based on medical record review and staff interview, It was determined that the facility failed to ensure that a resident's medication regimen was free from an unnecessary psychotropic medication by 1) failing to adequately monitor a resident for behavior, side effects or adverse consequences related to psychotropic medication use. This was evident for 1 (118) of 5 residents reviewed for unnecessary medications. The findings include On 10/3/24 at 2:02 PM, a review of Resident #118's medical record was conducted and revealed the resident was admitted to the facility in early September 2024 following an acute hospitalization . Review of the resident's admission assessment, with an assessment reference date of 9/14/24, documented Resident #118 had moderate cognitive impairment, medically complex conditions, and multiple medical diagnoses which included dementia, anxiety disorder, and depression. The assessment also documented that Resident #118 was taking an antipsychotic, and an antidepressant, and received antipsychotics on a routine basis. Review of Resident #118's September 2024 Medication Administration Record (MAR) revealed the resident received psychotropic medications. Resident #118 had an order for Duloxetine HCl (Cymbalta) (antidepressant) by mouth one time a day for depression. a 9/10/24 order for Quetiapine (Seroquel) (antipsychotic) by mouth one time a day for Hallucination, which was discontinued on 9/16/24, and a 9/16/24 order for Seroquel (Quetiapine) by mouth two times a day for psychoses and a 9/16/24 order for Lorazepam (Ativan) by mouth 2 times a day for restlessness, agitation, and anxiety for 14 days, which was discontinued on 9/30/24. In a Psychiatric Evaluation & Consultation visit note on 9/16/24, the Nurse Practitioner (NP) documented that Resident #118 had a history of dementia, hallucination, agitation, and restlessness, the resident had the diagnosis other depressive episodes, and per facility request, the resident was seen for agitation, restlessness, and anxiety. The NP further wrote the recommendation for the resident to start Ativan twice a day for 14 days for agitation, restlessness and anxiety, that Resident #118 took Duloxetine, that the resident presently took Seroquel for psychosis, and indicated nursing would monitor the resident for mood and behavior changes and provide supportive care. In an Attending Physician's visit note on 9/16/24 at 8:10 PM, the physician documented that Resident #118 continued to be agitated and screaming for much of the day, and wrote to increase the resident's Seroquel from 12.5 mg daily to 25 mg twice a day, and to monitor the resident's response to Seroquel closely and monitor for sedation. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #118's September 2024 Treatment Administration Record revealed a 9/10/24 order, to Monitor behavior of Agitation. Document # (number) of episodes and details of intervention and outcome on progress note every 7 AM to 7 PM shift, and every 7 PM to 7AM shift and a 9/10/24 order Monitor behavior of mood decline. Document # of episodes and details of intervention and outcome on progress note every 7 AM to 7 PM shift, and every 7 PM to 7AM shift. The behavior monitoring orders did not identify specific behaviors with individualized, non-pharmacological approaches to care. In addition, continued review of Resident #118's medical record failed to reveal documentation to indicate Resident #118 was monitored for the resident specific behaviors for which the antipsychotic, Seroquel had been prescribed. The above concerns were discussed with the Director of Nurses (DON) on 10/8/24 at 5:20 PM. At that time, the DON acknowledged the concerns and indicated that the concerns with monitoring the behavior of residents on psychotropic medications were being addressed.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 51213 Based on observations and interviews, it was determined that the facility failed to properly store food items to prevent cross contamination. This was evident for two random observations of the facility's freezers and refrigerators. The findings include: On 10/2/24 at 9:09 AM, the surveyor toured the main kitchen with the Dining Services Supervisor (Staff #33). During the observation of the walk-in freezer, the surveyor noticed what appeared to be a sausage wrapped in plastic on the shelf. This item lacked a label or date. Staff #33 removed the item from the freezer at the time of the observation. On 10/4/24 at 2:43 PM, during an observation of the second-floor kitchen in the Maryland unit, the surveyor observed one metal container with red sauce in it, the container did not have a cover or a label. A second metal container was observed with an open bag of sour cream that was 3/4th full and a serving scoop was noted to be sitting in the sour cream. Staff # 35, a dining server, was then shown the containers and identified the red sauce as salsa and reported it was served with tacos that day. Staff #35 then removed both the salsa and sour cream from the refrigerator, placed them on a cart, and stated she would dispose of them. On 10/4/24 at 2:52 PM, the surveyor spoke with the Dining Director (Staff #34) and showed her the two metal containers containing the uncovered salsa and the opened sour cream with the scoop. Staff #34 acknowledged that these items should not be left uncovered and unlabeled in the refrigerator. She then instructed Staff #35 to dispose of the salsa and sour cream.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37276 Based on medical record review and staff interview, it was determined that the facility staff failed to keep complete and accurate medical records by failing to void a residents MOLST form when an updated MOLST form was completed. This was evident for 3 (#114, #118, #10) of 11 residents reviewed for advanced directives. The findings include: Maryland Orders for Life Sustaining Treatment (MOLST) is a medical order form covering options for cardiopulmonary resuscitation (CPR) and other life-sustaining treatments. The medical orders are based on a patient's wishes about medical treatments. It is valid in all healthcare facilities and programs throughout Maryland. Section 1 includes orders to Attempt CPR or No CPR. Included in the No CPR section are three options: A-1 Intubate; A-2 Do Not Intubate but comprehensive efforts may include limited ventilatory support by CPAP or BiPAP; or Option B No CPR, Palliative and Supportive Care, do not intubate or use CPAP or BiPAP. The MOLST form shall be voided and a new MOLST form prepared when there is a change to any of the orders. If modified, the physician, NP (nurse practitioner), or PA (physician's assistant) shall void the old MOLST form and complete, sign, and date a new MOLST. 1) On [DATE] at 12:01 PM, review of Resident #114's electronic medical record (EMR) and hard chart (paper medical record) revealed the resident had 2 active MOLST forms in his/her medical record. A review of documents scanned in the EMR revealed Resident #114 had an active MOLST that was that was signed and dated by the physician on [DATE] and included an order for No CPR, Option B. A review of the resident's hard chart revealed an active MOLST for Resident #114 with an order for No CPR, Option A-2, that was signed and dated by the physician on [DATE]. The practitioner failed to void Resident #114's's previous MOLST form when a new MOLST had been created. 2) On [DATE] at 12:13 PM, a review of Resident #118's EMR and hard chart revealed the resident had 2 active MOLST forms in his/her medical record. A review of documents scanned in the EMR revealed Resident #118 had an active MOLST with an order for No CPR, Option A-2, that was signed and dated by the physician on [DATE]. A review of the hard chart revealed an active MOLST for Resident #118 with an order for No CPR, Option A-1 that was signed and dated by the physician on [DATE]. The practitioner failed to void Resident #114's's previous MOLST form when a new MOLST had been created. 3) On [DATE] 12:18 PM, a review of Resident #10's EMR and hard chart revealed the resident had more than 1 active MOLST forms. A review of scanned documents in the resident's EMR revealed that Resident #10 had an active MOLST, with an order for No CPR, Option A-2, that was signed and dated by the physician on [DATE]. A review of the hard chart revealed an active MOLST for Resident #10 with an order for No CPR, Option B, that was signed and dated by the practitioner on [DATE]. The practitioner failed to void Resident #10's previous MOLST form when a new MOLST had been created. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Following the medical record reviews, the surveyor requested a copy of the active MOLST forms for Resident #114, Resident #118, and Resident #10, and the copies for MOLST forms were provided to the surveyor on [DATE] at 2:10 PM. On [DATE] at 2:52 PM, the above concerns were discussed with the NHA (Nursing Home Administrator). The NHA indicated she became aware of the concerns when the surveyor requested copies of the MOLST forms and stated that a resident's MOLST was supposed to be in their paper chart only, and not in the EMR. The NHA stated that in-service training with the staff responsible for uploading documents in the EMR had begun, and once all persons responsible for uploading the MOLSTs were in-serviced, the MOLSTs in the EMR would be deleted. Also, at that time, the NHA acknowledged the concern

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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. 51213 Based on observation and interviews, it was determined that the facility failed to use appropriate infection control practices. This was evident for one (Resident #125) of two residents reviewed for urinary catheter use. The findings include: On 10/3/24, at 11:00 AM, a review of the records showed that Resident #125 had an order for an indwelling Foley catheter, which is used to drain urine from the bladder into a collection bag. On 10/3/24 at 11:09 AM, the surveyor observed Resident #125 lying in bed. The foley catheter bag was observed lying flat on the floor. On 10/3/24 at 11:12 AM, surveyor and the nurse (Staff #25), entered Resident #125's room, and the nurse confirmed the observation of the resident's Foley catheter bag lying flat on the floor. Staff #25 acknowledged that the Foley catheter bag should not be in contact with the floor. She then raised the bed to ensure that the catheter was no longer touching the floor and mentioned that someone had most likely lowered the bed to its lowest position.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 48259 Based on record review and interviews, it was determined that the facility failed to ensure that residents or their representatives were educated on the risks and benefits of pneumonia vaccinations. This was evident for 2 (#28, #129) of 5 residents reviewed for immunizations during the survey. The findings include: 1) Record review on 10/10/24, at approximately 8:16 AM, of Resident #28's immunization record noted that consent refused. The continued review contained a vaccination consent form, signed on 6/17/24, and documented that I do not give permission for any vaccines to be administered. Further review failed to show documentation that Resident #28 and his/her representative were fully informed of the health benefits and risks of receiving vaccinations. 2) Record review for Resident #129 showed that s/he was admitted to the facility in August 2024. Further review revealed that Resident #129's representative refused a pneumococcal vaccination on 8/26/24. However, the review failed to show that education was provided on the risks and benefits of vaccination. In an interview on 10/11/24 at 9:44 AM, staff #32, the Infection Preventionist (IP) nurse, confirmed that there was no documentation to show that education was provided to Residents #28 and #129 on the risks and benefits of vaccinations. Staff #32 added that she will email information on vaccinations to residents' representatives in the future and will also hand information to residents and their representatives upon admission to the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215125	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/11/2024
NAME OF PROVIDER OR SUPPLIER The Village at Rockville		STREET ADDRESS, CITY, STATE, ZIP CODE 9701 Veirs Drive Rockville, MD 20850	

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 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. 48168 Based on record review and interview, it was determined that the facility failed to ensure that direct care staff had mandatory communication training. This was evident for 8 staff (#15, #17, #18, #19, #20, #21, #22, #23), of 8 staff training records reviewed for communication training during the extended survey portion of the recertification survey. The findings include: On 10/08/24 at 10:34 AM, eight randomly selected employee files were requested as part of the staffing facility task of the standard survey, and included Geriatric Nursing Assistants, Licensed Practical Nurses, and a Registered Nurse. On 10/09/24 at 3:53 PM, the extended survey task was triggered due to an Immediate Jeopardy situation determined during the standard survey. As a result, the survey team determined the need to review the randomly selected direct care staff for evidence of communication training. On 10/10/24 at 9:10 AM, a record review revealed a lack of evidence of communication training for GNA #15, GNA #17, GNA #18, GNA #19, GNA #20, and LPN #21, LPN #22, and RN #23. On 10/11/24 at 11:55 AM, the Nursing Home Administrator was made aware of the lack of evidence of mandatory communication training for direct care staff. No further evidence was provided.