STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215146	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FT Washington Rehabilitation and Wellness Center	12021 Livingston Road Fort Washington, MD 20744

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. Based on record review and interview, it was determined that the facility failed to electronically transmit the Minimum Data Set (MDS) assessments within the required timeframe. This was evident for 5 (Resident #2, #9, #16, #18 and #21) of 12 residents reviewed for resident assessment during the recertification survey.The findings include: Minimum Data Set (MDS) is a core set of screening, clinical, and functional status data elements, including common definitions and coding categories, which form the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare or Medicaid. Nursing homes are required to submit the Omnibus Budget Reconciliation Act (OBRA) required MDS records for all residents in Medicare- or Medicaid-certified beds regardless of the payer source to Centers for Medicare and Medicaid Services (CMS') Internet Quality Improvement and Evaluation System (iQIES). According to chapter 5 of the CMS'S Resident Instrument Assessment (RAI) manual, comprehensive assessments must be transmitted electronically within 14 days of the Care Plan Completion Date. All other MDS assessments must be submitted within 14 days of the MDS Completion Date. On 11/19/25 at 8:47 PM, a review of the MDS assessments revealed that the following MDS assessments were not transmitted in a timely manner: 1. Resident #2- The quarterly MDS with an Assessment Reference Data (ARD) of 9/29/25 was completed on 10/13/25, however was transmitted on 11/7/25.2. Resident #9- The annual MDS with an ARD of 9/24/2025 was completed on 10/8/25, however, was transmitted on 11/3/25.3. Resident #16- The discharge return anticipated MDS with an ARD of 9/30/25 was completed on 10/14/25, however, was transmitted on 11/12/25. - The Entry MDS with an ARD of 10/7/25 was completed on 10/14/25, however, was transmitted on 11/12/25.4. Resident #18- The quarterly MDS with an ARD of 10/16/25 was completed on 10/30/25, however was transmitted on 11/19/25.5. Resident #21- The annual MDS with an ARD of 9/16/2025 was completed on 9/30/25, however, was transmitted on 10/21/25. On 11/20/25 at 12:22 PM, during an interview with MDS Registered Nurse (RN) Team Leader and MDS Coordinator Licensed Practical Nurse (LPN), they stated that the facility is expected to adhere to the CMS's timeframe for completing and submitting MDS assessments. They verified the findings and confirmed the facility's awareness of the late transmissions and assessment backlog. They stated that corporate mobile MDS nurses were assisting them.On 11/24/2025 at 8:45 AM, the Director of Nursing (DON) was notified of the late transmission of MDS assessments

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 interview and record review it was determined that the facility failed to hold quarterly Care Plan Meetings with the Interdisciplinary Team. This was evident for 4 (Resident #21, #13, #12 and #70) of 9 Residents reviewed for care plan meetings during the recertification survey.The findings include: Care Plan meetings are meetings with a team of care providers (attending physician, a registered nurse, nursing assistant dietary services, resident, and the resident's representative if applicable) to ensure the plan is continually adjusted to meet the changing needs or concerns of residents. Care Plan meetings are required to be held quarterly. 1). During an interview with Resident #21 on 11/18/2025 at 9:30 AM he/she reported that they had not had regular care plan meetings. During a review of medical records for Resident #21 on 11/20/2025 at 12:34 PM it was discovered that the resident's care plan meetings were not being held quarterly. The last three care plan meetings occurred on 11/14/24, 4/30/25 and 9/11/25. During an interview with the Social Work Director on 11/20/25 at 1:16 PM he agreed that care plan meetings should be conducted quarterly. He confirmed that the Care Plan Meetings for Resident #21 had not been held quarterly. 2). During a phone interview with a family member of Resident #13 on 11/18/2025 at 5:31 PM he/she reported that they hadn't had regular care plan meetings for Resident #13. During a review of medical records for Resident #13 on 11/20/25 at 11:19 AM it was discovered that his/her last four care plan meetings were held on 5/16/24, 11/15/24, 3/13/25 and 9/11/25. During an interview with the Social Work Director on 11/20/25 at 1:14 PM he reported care plan meetings are completed quarterly. He agreed that Resident #13 had missed care plan meetings, and the meetings were not conducted quarterly. 3). During a review of Resident medical records on 11/19/2025 at 9:47 AM it was discovered that Resident #12 didn't have quarterly care plan meetings. The last three care plan meetings held for Resident #12 occurred on 2/01/24, 10/14/24 and 7/10/2025. During an interview with the Social Work Director on 11/20/25 at 1:11 PM he reported care plans are to be held quarterly. He agreed that Resident #12 had not had quarterly care plan meetings and that meetings were missed. 4). On 11/19/25 at 09:00 AM the surveyor reviewed Resident #70's clinical record. The review revealed that Resident #70's quarterly Minimum Data Set (MDS) assessment was completed on 12/9/24. There was no evidence in the clinical record to indicate that a care plan meeting was held with the resident and the interdisciplinary team within 7 days or around the time the quarterly MDS assessment was completed. The record revealed an interdisciplinary care plan meeting was not held until 03/06/25. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/21/2025 at 8:29 AM in an interview the Social Services Director reviewed the clinical record and confirmed that there was no care plan meeting was held in December 2024 or January 2025. He stated that the meeting was overlooked because the resident had recently returned from the hospital and the MDS schedule had changed.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation and interview, it was determined that the facility failed to protect and value the resident's private space by failing to knock prior to entering a resident's room. This was evident for 1 (Resident #158) of 2 residents reviewed for dignity during the recertification survey.The findings include: On 11/17/2025 at 10:19 AM, Resident #158 expressed concern about staff members do not knock before entering their room. On 11/17/25 at 10:29 AM, while the surveyor was interviewing the Resident #158, Geriatric Nurse Assistant (GNA #4) abruptly opened the bathroom door from the other side of the room. Resident stated see, that's a perfect example of what I just shared with you. On 11/24/2025 at 10:13 AM, in an interview with GNA #12, he/she stated that the staff members are expected to knock and ask permission before entering the resident's room. On 11/25/2025 at 9:53 AM, the Director of Nursing (DON) was notified and acknowledged this concern.

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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. Based on interview, record review, and observation, it was determined that the facility failed to notify the Physician and the Resident Representative of 1) a recommendation received after an eye appointment, and 2) medication errors that occurred during medication administration observation. This is evident for 2 (Resident #130 and #90) of 2 residents reviewed during the recertification and complaint survey. The findings include:1) Latanoprost a prescription eye drop medication used to treat eye conditions like glaucoma and ocular hypertension by lowering high pressure inside the eyeball. It works by essentially opening up or relaxing the eye's natural drainage pathways, allowing more fluid to flow out of the eye and into the bloodstream. If the high pressure is left untreated, it can damage the optic nerve and lead to permanent vision loss. On 11/19/2025 at 8:14 AM, Resident #130 stated that he/she could not see clearly even with eyeglasses on. He/she added that this has been going on for several months and was bothering him/him. He/she confirmed being seen by an eye doctor in October but unsure if the facility addressed the concern. On 11/21/2025 at 8:55 AM, a review of Resident #130's medical record revealed an Eye care group visit with an exam dated 10/13/2025. The provider confirmed the complaint of blurred vision all distances, both eyes, bothersome for several months and recommended Latanoprost 0.005%, apply 1 drop, both eyes, at bedtime indefinitely; Follow-Up: 1-2 Months. However, a review of Resident #130's active and completed physician orders found no evidence of the Latanoprost medication or treatment being entered or initiated.On 11/21/2025 at 10:25 AM, during an interview with Licensed Practical Nurse (LPN #7), he/she stated that when a resident returned from an appointment, the Charge Nurse or Unit Manager would check the consultation note and would notify the attending Physician and the Resident Representative (RP) if there were recommendations. LPN #7 confirmed that the Physician and the RP were not notified of the recommendations, and the order was not implemented.On 11/24/2025 at 8:45 AM, the Director of Nursing (DON) was notified of this concern. 2) On 11/20/2025 at 8:52 AM, during the medication administration observation, Registered Nurse (RN #1), crushed the following medications of Resident #90 along with other medications in 2 separate plastics for pill crusher and mixed them in apple sauce: 1. 1 tablet of Aspirin 81 mg enteric coated tablet, however the Physician's order indicated that Aspirin was to be administered in a chewable form.2. 1 tablet of Ferrous sulfate delayed release 325 (65 Fe) MG (Ferrous Sulfate) tablet3. 2 tablets of Levetiracetam 750 mg tablet4. 1 tablet of Metformin 500 mg tablet RN #1 stated that Resident #90 preferred to take the medications in powdered form and mixed in apple sauce. On 11/20/2025 at 9:11 AM, while RN #1 was administering the crushed medication mixture, Resident #90 complained of the taste and subsequently vomited immediately after ingestion. RN #1 stated an intent to notify the Physician.On 11/20/25 at 11:18 AM, the Director of Nursing (DON) provided a copy of Med that should not be crushed trchealthcare dated April 2025- Resource #410460 from Pharmscript of Maryland confirming that the following medications were not to be crushed with its comments:- Aspirin EC- gastric irritant- Ferrous Sulfate- mucosal irritation- Levetiracetam tablet-bad taste- Metformin- modified releaseA review of the facility's Medication Administration policy indicated the following:a. Section f. Observe the five rights in giving each medication- the right medicineb. Section x. Report medication errors.On 11/23/2025 at 3:42 PM, a review of the nurses progress notes dated 11/20/2025 indicated Patient reported nausea triggered by the taste of crushed medications mixed with applesauce during the 9:00 AM medication administration. Patient vomited immediately after ingestion of medications, expelling both the administered medications and recently ingested feeds. The Physician was notified of the event and ordered to re-administer medications. However, the Physician was not notified that a medication error had occurred (crushing non-crushable medications), and the Resident Representative was not notified of either the medication error or the episode of vomiting.On 11/24/2025 at 8:45 AM, the DON was notified of these findings and acknowledged them.

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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. Based on observations and interviews, it was determined that the facility failed to provide a safe and homelike environment. This was found to be evident for 2 (Residents #12 and #13) out of 28 resident rooms observed for the physical environment. The findings include:1. During an observation conducted on 11/18/2025 at 9:50 AM it was discovered that the electrical outlet wall plate beside the bed of Resident #13 was broken in half and the upper socket was exposed without a wall plate surrounding it. The broken half was missing.During an observation with the Nursing Home Administrator (NHA) and Maintenance Director on 11/19/2025 at 12:44 PM they confirmed the plate was broken and needed to be repaired. The HNA reported the face plate would be repaired right away.During an additional observation on 11/25/2025 at 1:43 PM it was discovered that the socket plate had not been repaired.2. During an observation conducted on 11/18/25 at 10:33 AM, it was discovered the smoke detector in the room of Resident # 12 was not secured to the wall and was hanging by it's wires coming out of the wall.During an observation with the Nursing Home Administrator (NHA) and Maintenance director on 11/19/25 at 12:39 AM. The Maintenance Director reported the detector was pulled down about two weeks ago when the fire inspector was in the facility doing inspections and that it needed to be replaced. The NHA reported they would replace the detector. During an additional observation on 11/25/25 at 1:46 PM it was discovered that the smoke detector had not been repaired and was still hanging from the wall by it's wires.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interviews, it was determined that the facility failed to provide written notification to the local ombudsman when residents transferred to the hospital. This was evident for 2 (Resident #15 and #145) out of 5 residents reviewed for written notice requirements before transfer/discharge.The findings include:On 11/25/25 at 9:13 AM, a review of Resident #15's clinical record revealed that Resident #15 was transferred to the hospital on [DATE] for further evaluation of his/her medical needs. Continued review of Resident #15's clinical record revealed no documentation that the local ombudsman was notified in writing of the hospital transfer. On 11/25/25 at 09:42 AM, a review of Resident #145's clinical record revealed that Resident #145 was transferred to the hospital on 7/11/25 for further evaluation of his/her medical needs. Further review of Resident #145's clinical record revealed no documentation that the local ombudsman was notified in writing of the hospital transfer. On 11/25/25 at 09:59 AM, a review of the facility's policy titled Transfer and Discharge Policy revealed that the facility is required to send a copy of the written transfer or discharge notice to the Office of the State Long-Term Care Ombudsman. Continued review of the policy revealed that for emergency transfers, the Social Services Director or designee is required to provide notice of the transfer to the State Long-Term Care Ombudsman via a monthly list. On 11/25/25 at 10:07 AM, an interview with the Social Services Director revealed that written notification is not sent to the local ombudsman when a resident is transferred to the hospital. The Social Services Director also stated that the facility sends the ombudsman a monthly discharge calendar and emails when submitting self-reports, but not for hospital transfers. On 11/25/25 at 11:41 AM, an interview with the Director of Nursing (DON) confirmed that the facility does not send written notifications to the local ombudsman when residents are transferred to the hospital. The DON also stated that there is no current process in place to provide written notice of hospital transfers to the local ombudsman. At the time of exit conference, no additional documentation was provided to show that written notification to the local ombudsman was completed for Residents #15 and #145's hospital transfers, as required.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined that the facility failed to complete an admission comprehensive MDS (Minimum Data Set) assessment within the required timeframe. This was evident for 1 (Residents #158) of 12 residents reviewed for resident assessment during the annual survey.The findings include:Minimum Data Set (MDS) is a core set of screening, clinical, and functional status data elements, including common definitions and coding categories, which form the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare or Medicaid. According to Chapter 2 of CMS's Resident Assessment Instrument (RAI) manual, the admission assessment is a comprehensive assessment for a new resident that must be completed by the end of day 14, counting the date of admission to the nursing home as day 1 if this is the resident's first time in this facility On 11/20/25 at 12:22 PM, during an interview with MDS Registered Nurse (RN) Team Leader and MDS Coordinator Licensed Practical Nurse (LPN), they stated that the facility is expected to follow the CMS's timeframe when completing and submitting MDS assessments. They confirmed that the facility was aware of the late completion of the MDS assessments and backlog. They added that the facility has corporate mobile MDS nurses who were assisting.On 11/24/2025 at 8:26 AM, a review of Resident #158's MDS assessment revealed that the admission assessment was not completed within the required time frame. Resident #158 was admitted on [DATE]. An admission assessment was initiated with an ARD of 11/6/25, however, the assessment was still in progress at the time of review. On 11/24/2025 at 8:45 AM, the Director of Nursing (DON) was notified of the late completion of MDS assessments

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation and staff interview, it was determined the facility staff failed to ensure Minimum Data Set (MDS) assessments were accurately coded. This was evident for 1 (Resident #122) of 40 residents selected for review during the recertification survey. The findings include:Minimum Data Set (MDS) is part of the U.S. Federally mandated process for clinical assessment of all residents in Medicare or Medicaid certified nursing homes. This process provides a comprehensive assessment of each resident's functional capabilities and helps nursing home staff identify health problems. MDS assessments are required for residents on admission to the nursing facility and then periodically, within specific guidelines and time frames. The facility staff failed to accurately document the Oral/Dental Status of Resident #122 on a Significant Change MDS dated [DATE].Upon admission to the facility on 5/31/24, Resident #122 was assessed and the documentation on the Nursing admission Evaluation Form -V6, Section 3B 4 Oral Status stated, Obvious or likely cavity or broken natural teeth.On 11/18/25 at 9:16 AM the surveyor observed the resident lying in bed with broken teeth that were blackish/greyish in color along with other teeth that were similarly discolored. A review of the clinical record on 11/20/25 at 7:15 AM failed to reveal evidence that the resident was ever evaluated by a dentist while he/she resided in the facility.Further review of Resident #122's medical record revealed a Significant Change MDS was completed on 10/18/25. Under Section L0200 of the MDS, there were several choices for the resident's Oral /Dental Status and a notation stating, check all that apply. Among the choices was D. Obvious or likely cavity or broken natural teeth. The MDS was coded Z. None of the above were present.The MDS Team Leader was interviewed on 11/24/25 at 10:38 AM. She reviewed Resident #122's clinical record including the Nursing admission Evaluation Form dated 5/31/24 and confirmed that the MDS was incorrectly coded.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on medical record reviews and interviews it was determined that the facility failed to ensure a Pre-admission screening and Resident Review (PASSR) was completed. This was evident for 1 (Resident #12) out of 28 Resident's reviewed during the annual survey. The findings include:During a review of medical records for Resident #12 on 11/18/2025 at 11:24 AM it was discovered that he/she had been diagnosed with bipolar disorder, major depressive disorder and paranoid schizophrenia. A Preadmission Screening and Resident Review (PASRR) is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care. PASRR requires the facility to Evaluate all applicants for serious mental illness (SMI) and/or intellectual disability (ID).During further review of the medical records for Resident #12 it was revealed that the resident did not have an updated PASSR completed. A PASSR was discovered that had been completed on 2/22/2018 and it reported that the resident did not have a documented mental illness at that time. The Resident was discharged on 1/19/2019.During further record review it was discovered that there was a History and Physical for Resident #12 that was completed on 1/22/2019 that reported the resident had Major Depressive disorder and cognitive impairment. An additional form labeled as a Provider Attestation for Schizophrenia, Schizoaffective or Schizophreniform Diagnosis was found. The form reported Resident #12 had Paranoid Schizophrenia and was taking Depakote for treatment, the form was dated 1/23/2023. There was no updated PASSR found that was completed identifying the paranoid schizophrenia or the major depressive disorder diagnosis. During an interview with the Social Work Director on 11/20/2025 at 1:21 PM he advised that he was not with the facility at the time Resident #12 was admitted into the facility but agreed that if the Resident was admitted with a mental illness then he/she should have had a PASSR that identified those mental illnesses. He confirmed that the diagnosis of schizophrenia should have been identified on the PASSR for Resident #12. During an interview with the Social Work Director on 11/21/2025 at 9:56 AM he reported that he had reviewed the PASSR for Resident #12 and confirmed his/her diagnosis were not on the residents PASSR so he submitted a new PASSR. He reported he was not with the facility at the time the resident was readmitted and is not sure why a new PASSR was not completed.During a review of the facility's Maryland PASRR policy on 11/25/2025 at 11:32 AM it stated Under PASRR, nursing facilities cannot admit or retain an individual who has a serious mental illness, intellectual disability, developmental disability or another related condition unless the Developmental Disabilities Administration (DDA) or the Mental Hygiene Administration (MHA) has determined that a nursing facility placement is appropriate for the individual.

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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. Based on observation, record review and interview, it was determined that the facility failed to develop and implement a comprehensive person-centered care plan for residents with oxygen therapy orders. This was evident for 2 (Resident #163 and #145) of 36 residents reviewed for care planning during the recertification survey.The findings include: 1) 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. Oxygen therapy is a treatment that provides a person with extra oxygen to breathe in. It is also called supplemental oxygen. A nasal cannula is a thin, flexible tube that delivers oxygen through the nose. On 11/17/25 at 11:15 AM, Resident #163 was observed receiving oxygen therapy via nasal cannula that was connected to the concentrator. On 11/21/2025 at 8:11 AM, a review of the active physician orders confirmed an order of 02 (oxygen) at 2LPM (liters per minute) via NC (nasal cannula) continuous every shift for SOB (shortness of breath). On 11/21/2025 at 8:11 AM, a review of the Resident #163's medical record revealed no evidence that a respiratory care plan was initiated for the use of oxygen. On 11/21/2025 at 9:27 AM, the Director of Nursing (DON) stated that care plans were initiated by the nurse upon admission and that any nurse could add and update the care plans later. On 11/21/2025 at 9:43 AM, the surveyor received a copy of the respiratory care plan from Licensed Practical Nurse (LPN #21). The document indicated that the care plan was initiated on 11/21/25 after surveyor intervention. On 11/21/2025 at 10:18 AM, during an interview with LPN #7, he/she stated that residents' care plans were initiated upon admission. He/she added that the Nurse Managers conduct a chart review the following day and the Minimum Data Set (MDS) nurse will add the missing care plans. On 11/21/2025 at10:28 AM, the DON was notified of this concern. 2) On 11/19/25 at 12:47 PM, a review of Resident #145's comprehensive care plan did not reveal a care plan addressing the resident's oxygen therapy needs. On 11/19/25 at 1:15 PM, a review of Resident #145's physician orders revealed the resident had active oxygen therapy orders, including oxygen at 2 liters via nasal cannula as needed for shortness of breath or signs and symptoms of hypoxia, with a start date of 4/27/25. The review also revealed an order to change oxygen tubing and humidifier every 7 days and as needed, with a start date of 4/27/25. On 11/20/25 at 1:25 PM, an interview with the Director of Nursing (DON) revealed that residents with (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	oxygen therapy orders should have a corresponding care plan. The DON confirmed that Resident #145 should have had a care plan addressing oxygen therapy. At the time of exit conference, no additional documentation was provided to show that a care plan addressing oxygen therapy was completed for Resident #145.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, record review, and interview, it was determined that the facility failed to administer the correct ordered medication form, follow professional standards of nursing practice and use appropriate infection control practices during medication administration. This was evident for 1 (Resident #90) of 5 residents observed during the medication administration task.The findings include:On 11/20/2025 at 8:52 AM, during the medication administration observation, Registered Nurse (RN #1), removed a pill from the bubble pack and placed it in a 2 oz clear souffle cup with the other medications. After realizing that he/she already placed the same pill in the cup, he/she used fingers to pick up a tablet and returned it to the bubble pack. He/she then crushed the following medications of Resident #90 along with other medications in 2 separate plastics for pill crusher:1. 1 tablet of Aspirin 81 mg enteric coated tablet, however the Physician's order indicated that Aspirin was to be administered in a chewable form.2. 1 tablet of Ferrous sulfate delayed release 325 (65 Fe) MG (Ferrous Sulfate) tablet3. 2 tablets of Levetiracetam 750 mg tablet4. 1 tablet of Metformin 500 mg tablet RN #1 stated that Resident #90 preferred to take the medications in powdered form and mixed in apple sauce.After crushing all the medications, RN #1 grabbed a 4oz clear plastic cup and proceeded to cut it in half with unsanitized scissors taken from the medication cart drawer. He/she poured the crushed medications coming from 2 separate plastic pill containers and mixed with apple sauce. RN #7 was informed of the infection control concerns observed during the preparation of Resident #90's medication. He/she stated she will toss the medication that he/she placed back in the bubble pack On 11/20/2025 at 9:07 AM, RN #7 went inside Resident #90's room to administer the medications and left the medication cart unlocked with her back turned away from the cart, he/she returned to the cart at 9:13 AM. On 11/20/2025 at 9:11 AM, while RN #1 was administering the crushed medication mixture, Resident #90 complained of the taste and subsequently vomited immediately after ingestion. RN #1 stated an intent to notify the Physician.On 11/20/2025 at 9:41 AM, in an interview with Licensed Practical Nurse (LPN #6), he/she confirmed that there was no list of do not crush medications on the medication cart. He/she stated that he/she was sure that Aspirin EC (Enteric Coated) is a do not crush medication.On 11/20/2025 at 10:29 AM, RN #5 confirmed that he/she has not seen a list of do not crush medications on the medication carts, however, he/she indicated that bubble packs should indicate the warning. He/she then pulled a blister pack to show a do not crush warning on the pack, such as the Acetaminophen 650 ER (Extended Release) tablet, DO NOT CRUSH.On 11/20/25 at 11:18 AM, the Director of Nursing (DON) provided a copy of Med that should not be crushed trchealthcare dated April 2025- Resource #410460 from Pharmscript of Maryland confirming that the following medications were not to be crushed with the comments:- Aspirin EC- gastric irritant- Ferrous Sulfate- mucosal irritation- Levetiracetam tablet-bad taste- Metformin- modified release A review of the facility's Medication Administration policy indicated the following:a. Section f. Observe the five rights in giving each medication- the right medicineb. Section k. Do not leave medication cart unlocked.c. Section s. Do not touch the medication, either when opening a liquid or a dose packd. Section t. If oral solid medications cannot be given whole, work with the appropriate clinician and the resident /representative to determine the most appropriate method for administering medications which considers the resident's safety needs, medication schedule, preferences and functional ability.On 11/24/2025 at 8:45 AM, the DON was notified of these findings and acknowledged them.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and medical record review, it was determined the facility failed to ensure that a dependent resident was properly groomed. This was evident for 1 (Resident #18) of 5 residents reviewed for ADLs care during the survey process.The findings include:Activities of Daily Living (ADLs) are activities related to personal care. They include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating.On 11/17/25 at 11:07 AM the surveyor observed Resident #18 lying in bed. The resident's fingers on both hands were contracted and bent towards each other. His/her fingernails were approximately 1/2 inch long and visibly dirty with dark substances underneath both thumbs and fingers.On 11/18/25 at 11:30 AM the surveyor reviewed the Resdent#18's care plan which was revised on 04/28/25. The care plan stated, ADL Self Care Performance deficit, requires assistance with ADL, Cognitive deficit, . Also, Resident #18's MDS assessment dated [DATE] Section GG revealed that the resident was dependent on staff for ADLs including personal hygiene. The clinical record failed to reveal documentation indicating the resident refused to have their nails cleaned and trimmed.On 11/20/25 at 10:17 AM a second observation by the surveyor revealed Resident #18 fingernails remained uncut and visibly dirty. In an interview the resident stated I eat with my hands, and I would like my nails cleaned.On 10/20/25 at 10:48 AM in an interview with Charge Nurse #10 the surveyor expressed concern regarding the condition of Resident #18's fingernails. The surveyor accompanied Charge Nurse #10 to the resident's room where the findings were confirmed. Charge Nurse #10 stated that because of the resident's contractures, she usually trims and cleans the resident's nails herself but sometimes the resident refuses. The surveyor requested documentation of Resident #18's refusals. The Charge Nurse #10 reviewed the clinical record and stated that she could not find any documentation of the refusals. The Director of Nursing was notified on 11/20/2025 at 11:13 AM of the surveyor's findings.On 11/21/2025 at 11:12 AM Resident #18 was observed lying in bed, nails cleaned and trimmed.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. Based on interview, review of a complaint, and record review, it was determined that the facility failed to provide treatment/services to maintain vision. This is evident for 1 (Resident #130) of 2 residents reviewed for communication and sensory problems during the recertification and complaint survey.The findings include:Latanoprost a prescription eye drop medication used to treat eye conditions like glaucoma and ocular hypertension by lowering high pressure inside the eyeball. It works by essentially opening up or relaxing the eye's natural drainage pathways, allowing more fluid to flow out of the eye and into the bloodstream. If the high pressure is left untreated, it can damage the optic nerve and lead to permanent vision loss. On 11/19/2025 at 8:14 AM, Resident #130 stated that he/she could not see clearly even with eyeglasses on. He/she added that this has been going on for several months and was bothering him/her. He/she confirmed being seen by an eye doctor in October but unsure if the facility was addressing the concern. On 11/19/25 at 5:21 PM, a review of complaint #2565121 indicated they felt ignored by the staff and their needs are not being addressed.On 11/20/25 at 3:42 PM, a call to the complainant confirmed the allegation.On 11/21/2025 at 8:55 AM, a review of Resident #130's medical record revealed an Eye care group visit with an exam dated 10/13/2025. The provider confirmed the complaint of blurred vision all distances, both eyes, bothersome for several months and recommended Latanoprost 0.005%, apply 1 drop, both eyes, at bedtime indefinitely; Follow-Up: 1-2 Months. However, a review of Resident #130's active and completed physician orders found no evidence of the Latanoprost medication or treatment being entered or initiated.On 11/21/2025 at 10:25 AM, during an interview Licensed Practical Nurse (LPN #7), he/she stated that when a resident returned from an appointment, the Charge Nurse or Unit Manager would check the consultation note and would notify the attending Physician and the Resident Representative (RP) if there were recommendations. LPN #7 confirmed that the Physician and the RP were not notified, and the order/treatment was not entered and implemented.On 11/24/2025 at 8:45 AM The DON was notified of these concerns.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview and record review, it was determined that the facility failed to provide necessary respiratory care services by failing to label oxygen administration equipment. This was evident for 1 (Resident #163) of 1 resident reviewed for respiratory care during the recertification survey.The findings include: Oxygen therapy is a treatment that provides a person with extra oxygen to breathe in. It is also called supplemental oxygen. A nasal cannula is a thin, flexible tube that delivers oxygen through the nose. A humidifier in oxygen therapy is a device that adds moisture to dry, concentrated oxygen to prevent drying and irritation of a patient's nasal passages, throat, and lungs. These humidifiers typically consist of a bottle filled with water that attaches to an oxygen concentrator. On 11/17/25 at 11:15 AM, Resident #163 was observed receiving oxygen therapy via nasal cannula, however, the oxygen tubing and the humidifier bottle were not labeled with the date they were put into use or the date they should be replaced. On 11/17/2025 at 11:19 AM, the Director of Nursing (DON) was made aware of this finding and verified the observation. On 11/21/2025 at 8:11 AM, a review of the active physician orders indicated 02 (oxygen) at 2LPM (liters per minute) via NC (nasal cannula) continuous every shift for SOB (shortness of breath). On 11/21/2025 at 10:18 AM, during an interview with Licensed Practical Nurse (LPN #7), he/she confirmed that the nurses were expected to change the tubing weekly and the humidifier bottle as needed, and that they were expected to date the equipment when changed.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on clinical record review and staff interviews, it was determined that the facility failed to act upon a clinically significant medication irregularity identified by the consultant pharmacist for residents. This was evident for 1 (Resident #5) out of 5 residents reviewed for medication regimen review during the annual survey.The findings include:On 11/25/25 at 10:02 AM, a review of Resident #5's clinical record revealed a Medication Regimen Review (MRR) dated 8/11/25 that identified a clinically significant drug interaction between Eliquis 5 mg twice daily and Paxlovid. The consultant pharmacist recommended reducing the Eliquis dose by 50% during Paxlovid therapy and continuing the reduced dose for 3 days after the last Paxlovid dose due to increased bleeding risk. The physician response section of the report was blank. Continued review revealed no documentation that the recommendation was addressed by the physician, the nursing staff, or the Director of Nursing (DON). On 11/25/25 at 10:23 AM, a review of Resident #5's August 2025 Medication Administration Record (MAR) revealed that Eliquis 5 mg twice daily was administered as ordered from 8/1/25 through 8/31/25. Further review revealed that Paxlovid was administered beginning on 8/8/25 and continued through 8/13/25. Continued review revealed that the Eliquis dose was not reduced during Paxlovid therapy or for 3 days after the last Paxlovid dose, according to the pharmacist's recommendation. On 11/25/25 at 11:02 AM, a review of the facility's policy titled Medication Regimen Review revealed that urgent or clinically significant medication irregularities are to be communicated to the medical practitioner and the Director of Nursing on the day they are identified. Continued review of the policy revealed that the Director of Nursing or designee is responsible for ensuring that medication irregularity reports are addressed with the medical practitioner in a timely manner that meets the needs of the resident. On 11/25/25 at 11:41 AM, an interview with the DON revealed that the consultant pharmacist sends MRR reports via email to the DON, Assistant Director of Nursing (ADON), and Unit Managers. The DON stated that the ADON is responsible for ensuring the recommendations are followed up on. When asked about the clinically significant recommendation for Resident #5 dated 8/11/25, the DON confirmed that the recommendation was not addressed and was not sure why it was missed. On 11/25/25 at 1:15 PM, an interview with the ADON revealed that the pharmacist's recommendations are emailed to the DON, ADON, and unit managers. The ADON stated that unit managers print the recommendations and give them to the provider for review and response. When asked if she was responsible for ensuring recommendations were acted upon, she stated that each unit manager is responsible for their own unit and she only monitors if a unit manager is unavailable.At the time of exit conference, no additional documentation was provided to show that the clinically significant medication recommendation for Resident #5 was reviewed, addressed, or implemented, as required.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview and record review, it was determined that the facility failed to ensure a medication error rate of less than 5% during the medication observation task. This was evident for 4 of 25 medications administered during the observation which resulted in a medication error rate of 16%.The findings include:On 11/20/2025 at 8:52 AM, during the medication administration observation, Registered Nurse (RN #1), crushed the following medications of Resident #90 along with other medications in 2 separate plastics for pill crusher and mixed them in apple sauce:1. 1 tablet of Aspirin 81 mg enteric coated tablet, however the Physician's order indicated that Aspirin was to be administered in a chewable form.2. 1 tablet of Ferrous sulfate delayed release 325 (65 Fe) MG (Ferrous Sulfate) tablet3. 2 tablets of Levetiracetam 750 mg tablet4. 1 tablet of Metformin 500 mg tablet RN #1 stated that Resident #90 preferred to take the medications in powdered form and mixed in apple sauce.On 11/20/2025 at 9:11 AM, while RN #1 was administering the crushed medication mixture, Resident #90 complained of the taste and subsequently vomited immediately after ingestion. RN #1 stated an intent to notify the Physician.On 11/20/2025 at 9:41 AM, in an interview with Licensed Practical Nurse (LPN #6), he/she confirmed that there was no list of do not crush medications on the medication cart. He/she stated that he/she was sure that Aspirin EC (Enteric Coated) is a do not crush medication.On 11/20/2025 at 10:29 AM, RN #5 confirmed that he/she has not seen a list of do not crush medications on the medication carts, however, he/she indicated that bubble packs should indicate the warning. He/she then pulled a blister pack to show a do not crush warning on the pack, such as the Acetaminophen 650 ER (Extended Release) tablet.On 11/20/25 at 11:18 AM, the Director of Nursing (DON) provided a copy of Med that should not be crushed trchealthcare dated April 2025- Resource #410460 from Pharmscript of Maryland confirming that the following medications were not to be crushed with the comments:- Aspirin EC- gastric irritant- Ferrous Sulfate- mucosal irritation- Levetiracetam tablet-bad taste- Metformin- modified releaseA review of the facility's Medication Administration policy indicated the following:a. Section f. Observe the five rights in giving each medication- the right medicineb. Section t. If oral solid medications cannot be given whole, work with the appropriate clinician and the resident /representative to determine the most appropriate method for administering medications which considers the resident's safety needs, medication schedule, preferences and functional ability.On 11/24/2025 at 8:45 AM, the DON was notified of the concerns and acknowledged them.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. Based on interview, record review and observation, it was determined that the facility failed to provide dental services for residents. This was evident for 2 (Resident #13 and #122) of 2 residents reviewed for dental services during the recertification survey.The findings include: 1) During an interview with a family member for Resident #13 on 11/18/2025 at 5:43 PM he/she reported that the resident has had problems with his/her teeth and had not had any dental care. During a review of medical records for Resident #13 on 11/20/2025 at 10:26 AM it revealed that he/she had a history of dementia and was dependent on staff for care. A change in condition communication form dated 11/21/2023 was found which reported that the nurse had found Resident #13 chewing on his/her tooth that came off and the nurse noted the resident is cognitively impaired. During further review of Resident #13 medical records it was discovered that an order was placed on 11/21/23 that ordered a Dental consult secondary to his/her tooth that came out and discontinue order when consult is completed. During continued review of the medical records for Resident #13 it was found that the order for the dental consult was signed off in the Treatment Administration Record everyday from November 22, 2023 – December 31, 2023, everyday from January 1, 2024 through December 31, 2024 and everyday from January 1, 2025 through May 27, 2025. The order was discontinued on 5/27/2025. During additional medical record review it revealed that there was no documentation of a dental consult being requested or completed for Resident #13. During an interview with the Director of Nursing (DON) on 11/21/2025 at 9:26 AM she advised that referrals for consults should be completed within 24 hours and can be completed by the nursing staff. She reported the documentation for a dental consult being requested or being completed should be in the Resident's medical records. She agreed that the order for Resident #13 to have a Dental consult should have been completed. During an interview with the DON on 11/21/25 at 1:31 PM she confirmed that there was no documentation of a dental consult referral being sent or a dental consult being completed for Resident #13 During a review of the facility's Dental Services Policy it stated, The facility will assist the resident in: A: Obtaining routine Dental Services B: Obtaining 24 – hour Emergency Dental Services C: Obtaining services to the resident to meet the needs of each resident D: Making appointments. 2) Resident #122 was admitted to the facility in May 2024 and received Hospice services until July 2024 when he/she was discharged to Long Term Care. The resident's diagnoses included Alzheimer's (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Disease, Adult Failure to Thrive and Cognitive Communication Deficit. On 11/18/25 at 9:16AM during initial rounds the surveyor observed the resident with broken teeth that were blackish/greyish in color along with other teeth that were similarly discolored. The resident could not tell whether he/she had seen a dentist since admission to the facility. On 11/20/25 at 7:15 AM a review of Resident #122 clinical record revealed that upon admission to the facility on 5/31/24 the resident was assessed and the documentation on the Nursing admission Evaluation Form -V6, Section 3B 4 Oral Status stated Obvious or likely cavity or broken natural teeth. There was no evidence in the clinical record indicating that the resident was evaluated by a dentist while he/she resided in the facility. The surveyor noted an active physician order dated 5/31/24 which stated Consults: Audiology, Dental, Optometry, Ophthalmology and /or Podiatry as needed. Further review of the clinical record revealed that between September 2025 and November 2024 the resident had a weight loss of 16.6 lbs., and the weight loss was addressed by the Dietitian. On 11/21/2025 at 8:50 AM during an interview the Unit Manager #11 stated that a dentist visits the facility quarterly and dental services are scheduled routinely and as needed depending on the resident's condition. Unit Manager #11 reviewed the clinical record and confirmed that there was no record to show that the resident was seen by a dentist. The Unit Manager accompanied the surveyor to Resident #122's room and, after observing the resident's teeth and confirming the surveyor's findings stated, I do not know why (resident) did not see the Dentist. During an interview on 11/21/25 at 9:17 AM the Director of Nursing (DON) was notified of the surveyor's concerns regarding the Resident #122's dental care. The DON reviewed the clinical record and stated the resident should have been evaluated by a dentist and that she would conduct a further review of the records. Later, 11/21/25 at 11:45AM the DON informed the surveyor that the records confirmed the resident was not evaluated by a dentist.

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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. Based on observations and interviews, it was determined that the facility failed to maintain 1) Food service equipment in a manner that ensures sanitary food service operations and 2) Proper sanitation for the storage of food on the nursing units. This was evident during the initial tour of the kitchen and on 1of 3 nursing units observed for food storage and sanitation.The findings include:1. On 11/17/25 at 7:59 AM during an initial tour of the kitchen with the Certified Dietary Manager (CDM), the surveyor observed on the wall outside the walk-in refrigerator a temperature log which stated 36 degrees 11/17/25 AM. The surveyor observed that the thermometer inside the refrigerator was broken and not functioning. When asked how the temperature was verified when the thermometer was broken, the CDM stated that the temperature could have been recorded before the thermometer was broken. The thermometer was replaced. Later at 8:30AM the refrigerator's temperature revealed 39 degrees Fahrenheit.The log on the wall outside the walk-in freezer read -1 degree 11/17/25 AM. There was no thermometer visible inside the freezer. The CDM said the thermometer might have been caught behind the boxes in the freezer. Dietary Aide #9 was asked to look for the thermometer. He located a broken thermometer on the floor of the walk-in freezer. The surveyor did not observe any thawing of food or build-up of ice. The CDM stated that she will immediately replace the thermometer. After the thermometer was replaced another check at 9:00AM revealed a temperature of 10 degrees Fahrenheit. In an interview conducted on 11/17/25 at 9:15 AM the CDM, who was with the surveyor during the observations, confirmed the findings and stated that she would educate the staff to ensure that thermometers in the freezer and refrigerator were visible and in working condition. 2. On 11/19/25 at 8:25AM the surveyor conducted an observation of the nourishment refrigerator on the 1st floor in the presence of Unit Manager Staff #20. Inside the refrigerator were: one 3 cup white plastic container with a red cover containing spaghetti and ground meat with no name, no date and labeled Rm#122B; one white unlabeled shopping bag containing a black dotted lunch box. The lunch box contained 2 plastic containers with rice, 1 packet brownie, 1 packet of popcorn, and 16oz bottle of water. None of the items inside the lunch box was dated or labeled. In an interview the Unit Manager Staff #20 stated that the nourishment refrigerator is used by the residents. When food items are received it is labeled with the date received, the resident's name and room number. After 72 hours the food item is discarded. The unit manager stated that she did not know to whom the unlabeled items belong and the date they were put in the refrigerator. The unlabeled and undated items were removed from the refrigerator.On 11/19/25at 9:00 AM the surveyor reviewed the facility's policy on Storage of Resident Food. Section II (C) stated Staff will date the container when food or beverages are brought into the facility and discard food when non-safe. Reheat foods only once then discard.On 11/19/25 at 9:32 AM in an interview the Director of Nursing stated that she was notified by the Unit Manager of the surveyor's findings and that the items should have been labeled and discarded after 72 hours if not used.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215146	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FT Washington Rehabilitation and Wellness Center	12021 Livingston Road Fort Washington, MD 20744

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 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. Based on record reviews and interviews, it was determined that the facility failed to provide a therapy screening for 1 (Resident #17) of 28 residents reviewed for therapy services during the annual survey.The findings include:During a review of medical records for Resident #17 on 11/21/2025 at 9:02 AM it was discovered that the Resident had mobility difficulties and a history of falls. A change in condition form dated 9/29/2025 revealed that the Resident was found on the floor laying on his/her back after an unwitnessed fall.During a continued review of medical records it was revealed that there was a Nursing Referral to Therapy form completed on 9/30/2025 as a result of Resident #17 having an Unwitnessed fall.During further record review it was discovered that no therapy assessment or evaluation had been completed on Resident #17 after the fall and the nursing referral.During an interview with Therapy Manager #17 on 11/21/2025 at 2:56 PM she reported that the nurses can use the Therapy Notification Referral if they see any kind of decline or concerns with the residents. She advised the goal to complete screening after a therapy referral was 48 hours. She reported Resident #17 was not currently receiving therapy and that he/she should have had a therapy screening after the Therapy Referral request was submitted. During an interview with Therapy Manager #17 on 11/24/2025 at 8:22 AM she confirmed no screening was completed after the therapy referral was made and it should have been completed. During an interview with the Administrator on 11/25/2025 at 1:43 PM he reported that the facility Interdisciplinary Team does well following up with falls and if the referral was made to therapy, it should have been followed up on.