

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215171	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/30/2024
NAME OF PROVIDER OR SUPPLIER Montcare at Potomac		STREET ADDRESS, CITY, STATE, ZIP CODE 10714 Potomac Tennis Lane Potomac, MD 20854	

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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>47200</p> <p>Based on observation, interview, and record review it was determined the facility failed to ensure the call bell device was within reach of a resident (Resident #28). This was evident for 1 out of 34 facility residents observed by the surveyor during initial tours during the facility's recertification survey.</p> <p>The findings include:</p> <p>On 9/19/24 at 9:52AM the surveyor observed Resident #28 laying in their bed, repeatedly gesturing and pointing to their head. When the surveyor attempted interview of the resident and inquired as to if they had a call bell device to ask for staff assistance, the resident was observed looking around their bed for the call bell device. At this time, the surveyor observed the call bell cord was plugged into the wall and was laying draped over top of the resident's wheelchair with the call device located behind a pillow situated on the wheelchair parked next to the resident's bed, not within reach of the resident. Upon further observation, the surveyor noted this was a tap style type of call bell device.</p> <p>On 9/19/24 at 9:52AM the surveyor requested for a dual observation with Unit Manager #21, who accompanied the surveyor to the room of Resident #28 and observed and acknowledged the surveyor's concern. The surveyor observed Unit Manager #21 retrieve the call bell from the resident's wheelchair and secure it within reach of the resident. The resident was observed to have the ability to utilize/press the call bell. Upon interview of Unit Manager #21, they confirmed the call bell was not within reach of the resident, and confirmed their expectation was for residents to have their call bell within reach.</p> <p>On 9/25/24 at 10:44AM upon review of the medical record, the surveyor observed the following intervention was listed on the careplan of Resident #28: Reinforce need to call for assistance.</p>

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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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>43096</p> <p>Based on a medical record review and staff interview, it was determined that the facility failed to ensure that the physician documented a resident's discharge in the medical record. This was identified for one (Resident # 152) of three residents reviewed for discharge during the recertification/complaint survey.</p> <p>The finding includes:</p> <p>On 9/23/24 at 10:51 AM, the surveyor reviewed Resident #152's medical record for system-selected closed record review. The review revealed that a progress note written by a Licensed Practical Nurse (LPN #10) on 8/23/24 documented that Resident #152 was discharged home. Also, the facility had a form named My Transition Home, which was reported by LPN #10 about Resident #152's discharge. However, there was no documentation from the physician regarding Resident #152's discharge.</p> <p>During an interview with the facility attending physician (Staff #4) on 9/24/24 at 10:07 AM, Staff #4 stated that they should document residents' discharge in the electronic medical records system within 30 days of discharge.</p> <p>On 9/30/24 at 8:10 AM, the surveyor reviewed Resident #152's medical records again to verify whether the resident had discharge documentation from the physician within 30-day window. There was no record from the physician.</p> <p>In an interview with the Director of Nursing (DON) on 9/30/24 at 11:30 AM, the surveyor shared concerns regarding residents' discharge records from a physician. She validated the concern.</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>42507</p> <p>Based on medical record review and staff interview it was determined the facility failed to notify the resident/resident representative (RP) in writing of a transfer/discharge of a resident along with the reason for the transfer. This was evident for 2 (#136, #70) of 4 residents reviewed for hospitalization during a recertification/complaint survey.</p> <p>The findings include:</p> <p>1) During an initial screen of Resident #136 on 9/18/2024 at 9:18 AM, the resident stated that s/he was sent out to the hospital on 7/31/2024 for shortness of breath.</p> <p>On 9/24/2024 at 12:15 PM a review of nurses' progress notes and change in condition documentation dated 8/1/2024 at 22:15 (10:15 PM) revealed Resident #136 was sent to the ER (emergency room) via 911 on 8/1/2024 for further evaluation and treatment of shortness of breath, weakness, and hypotension (low blood pressure).</p> <p>On 9/24/2024 at 12:50 PM, surveyor requested and received from the VP of Clinical Services (Staff #23), copies of the change in condition form dated 8/1/2024. She stated that she could not locate any written notification of the reason for transfer to the hospital on 8/1/2024. However, she added that the reason for transfer to the hospital was noted in the change in condition form that was given to the surveyor.</p> <p>On 9/25/2024 at 9:20 AM an interview was conducted with Licensed Practical Nurse (LPN #10).</p> <p>Regarding written notification of reason for transfer to the hospital, LPN #10 stated that the reason for transfer was documented in the transfer form that was included in the paperwork (transfer packet) sent with the resident to the hospital. She stated that the residents were notified verbally of the reason for transfer to the hospital. LPN #10 added that family members/RP were notified of reason for transfer verbally in person if they were present in the building, and if they were not present, they were notified over the phone. She confirmed that she has not given in writing the reason for transfer to the hospital to any resident and/or their RP.</p> <p>On 9/30/2024 at 11:35 AM, in an interview with the Director of Nursing (DON), surveyor shared concerns regarding written notification of resident and/or their RP of reason for transfer/discharge to the hospital. She did not provide any documentation that Resident #136 and/or their RP was notified in writing the reason for transfer to the hospital on 8/1/2024.</p> <p>37296</p> <p>2) Review of the medical record for Resident #70 revealed the resident was transferred to an acute care facility on 8/19/2024. There was no documentation found in the medical record that the resident, and or the resident's responsible party was given written notice why the resident was transferred to the hospital in a language and manner that they understand.</p> <p>(continued on next page)</p>		

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/20/24 at 11:27 AM the Administrator was made aware there was no documentation found in the medical why the resident was transferred to the hospital in a language and manner that they understand and confirmed the findings. The Administrator provided the surveyor a plan of correction to include the reason for transfer to an acute care facility.		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47200</p> <p>Based on record review and interview it was determined the facility failed to ensure a resident (Resident #81) received a recommended specialist follow up appointment after a hospitalization . This was evident for 1 out of 4 residents reviewed for hospitalization during the facility's recertification/complaint survey.</p> <p>The findings include:</p> <p>On 9/24/24 at 12:49PM the surveyor conducted a review of the medical record for Resident #81 which revealed the resident was discharged after hospitalization on [DATE] and during their hospitalization the resident was seen by urology for a cystoscopy with right ureteral (tube that carries urine from the kidneys to the bladder) stent placement (small plastic tube inserted into the ureter to keep the urine pathway open). Review of the resident's hospital discharge summary revealed they needed to have a follow up outpatient appointment with urology after their hospital discharge, and further stated the ureteral stent was temporary and that the urologist office was to be called for scheduling of the outpatient ureteroscopy with laser lithotripsy.</p> <p>Further review of subsequent hospitalization documentation for the resident revealed they had been hospitalized again on 1/18/24 with discharge diagnoses which included a complicated urinary tract infection. The hospital discharge summary dated 2/6/24 revealed the following information: Urinary tract infection with gross hematuria, right ureteral stent extensively coiled upon itself within central collecting system and proximal ureter on CT (computed tomography: scan of the body), presented with uti suspected secondary to right ureteral stent causing gross hematuria and uti. Stent placed in July 2023; patient seemed to never follow up with urology. Documentation on the discharge summary documented the resident underwent a cystourethroscopy with laser (urologic procedure) on 1/23/24 and a right retained ureteral stent and right nephrolithiasis (solid material or stones formed in the urinary tract) was removed at that time.</p> <p>On 9/24/24 at 12:49PM the surveyor requested documentation of all urology consults/appointments for the resident from July of 2023 through 1/18/24 from the Director of Nursing (DON).</p> <p>Review of the medical record by the surveyor on 9/24/24 at 12:53PM of the Attending Physician #4's progress note dated 7/23/23 revealed the following information was documented: Obstructive uropathy: Notes: Patient status post cystoscopy with stent placement, patient was noted to have mild hematuria post stent, patient will need to follow up with urology, overall patient appears to be doing well and denies any dysuria or urinary frequency. No further documentation regarding scheduling or follow up with the urology specialist could be found by the surveyor in the medical record between the date of the first hospitalization and subsequent hospitalization . The surveyor additionally noted that the resident had documented urinary symptoms and treatments that further occurred at times leading up to the 1/18/24 hospitalization .</p> <p>On 9/25/24 at 9:50AM the surveyor conducted an interview with Unit Manager #21 who observed the appointment calendar at that time and was unable to see any appointment having been scheduled for the urology follow up in question. During the interview, Unit Manager #21 asked for Unit Secretary #24 to check if any appointments had been made for the resident for the urology follow up appointment.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/25/24 at 10:00AM the surveyor conducted an interview with the Assistant Director of Nursing #22 who reported to the surveyor that they could not recall if the resident had the appointment or not.</p> <p>On 9/25/24 at 10:07AM the surveyor conducted an interview with the DON who confirmed there was no consult in the medical orders for the resident to see the urology specialist.</p> <p>On 9/25/24 at 12:10PM the surveyor conducted an interview with Attending Physician #4 who reported to the surveyor several reasons as to why the appointment had not occurred, however, it was confirmed with Physician #4 that there was no documentation that could be found in the medical record that further discussed the recommended follow up urology appointment after their written progress note on 7/23/23.</p> <p>On 9/26/24 at 11:41AM Unit Manager #21 confirmed with the surveyor that Unit Secretary #24 was unable to find any documentation regarding the facility having made any attempts to schedule the follow up urology appointment. At this time, the surveyor shared their concern with Unit Manager #21 and they acknowledged and confirmed understanding of the concern.</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>51128</p> <p>Based on medical record review, policy review, and staff interview, it was determined that the facility failed to monitor and evaluate residents' weight gain and notify the physician. This was evidenced by 1 (Resident #145) out of 3 residents reviewed for nutrition during the recertification/complaint survey.</p> <p>The findings include:</p> <p>A review of Resident #145's medical record on 9/25/24 at 09:48 AM revealed that the resident was receiving tube feedings upon admission. Resident #145's body weight was documented as 80 pounds on 8/25/24 and 93.4 pounds on 9/13/24, which was a 16% weight gain within 19 days.</p> <p>Further review of a progress note written by Staff # 25 (Dietitian-former) dated 9/13/24 at 2:33 PM revealed that 80 lbs (pound) is the recorded weight upon admission on 8/25/24 and is awaiting further weights to determine loss, gain or stability since admission. She also wrote that the resident was awaiting weekly weights 4X (times four).</p> <p>On 9/25/24 at 11:10AM, an interview was conducted with the Registered Nurse (RN #8) about the process of obtaining weight and communicating the results. She stated that the Geriatric Nursing Assistants (GNAs) and nurses obtained residents' body weights. RN #8 explained that the weight was done by mechanical lift or scale, which would be documented monthly or weekly (if there was a specific order). When the GNA obtained weights, they were given to the nurse, who documented them in the electronic medical record (EMR). If there was a gain/loss of weight, the physician and dietitian were notified, and information was documented in the EMR.</p> <p>On 9/25/24 at 11:32 AM, a review of the weight monitoring policy under the compliance guidelines stated that weight can be a useful indicator of nutritional status. Significant unintended changes in weight (loss or gain) or insidious weight loss (gradual unintended loss over a period of time) may indicate a nutritional problem. under the documentation section of the policy, it states that the physician should be informed of a significant change in weight and may order nutritional interventions.</p> <p>On 9/25/2024 at 12:31 PM, an interview with the Director of Nursing (DON) confirmed that resident #145's weight was 80 pounds upon admission, and the next weight was 93.4 pounds on 9/13/24. The DON further explained that parameters were in place to notify the physician if there was a weight gain or loss of 3-5 pounds.</p> <p>On 9/25/24 at 1:10 PM, an interview with Staff #9 (Dietitian) stated that a resident's weight gain was a concern for the dietitian. She said the facility would review the weight formula with the physician when it was reported. The residents' conditions would also be reviewed, and interventions would be implemented. In addition, if a resident was underweight upon admission and weight gain was expected, it was still required to document their weight changes.</p> <p>On 9/25/24 at 1:15 PM, upon further review of the Resident #145's medical record, there was no weight tracking found, and no documentation of communication between nursing, dietician, provider and resident's family member concerning the resident's weight gain.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/30/24 at 11:30 AM, the surveyor shared the concern with the DON, and the DON validated the concern.</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>49409</p> <p>Based on observations, record reviews, and resident and staff interviews, it was determined that the facility failed to evaluate and manage residents' pain consistently. This was evident for one resident (# 97) of four residents who were reviewed for pain during the recertification/complaint survey.</p> <p>The findings include:</p> <p>Resident #97 was at the facility receiving short-term rehab. A record review conducted on 09/20/24 at 8:30 am revealed that resident #97 had a BIMS score of 0/15 on admitted d 08/26/24, indicating severe cognitive impairment. BIMS stands for Brief Interview for Mental Status, a standardized assessment tool to evaluate a patient's cognitive function. One of Resident #97's diagnoses was Chronic pain syndrome.</p> <p>During an interview with the family member of Resident #97 on 9/20/24 at 09:13 AM, she/he stated that the resident has been in pain frequently despite getting pain medication.</p> <p>During an interview with the Geriatric Nursing Assistant (GNA), staff # 27, on 09/30/24 at 09:47 AM, revealed that resident #97 was in pain when staff moved her/him during care and always grimaced with pain.</p> <p>During an interview with the Licensed Practical Nurse (LPN), staff # 26 on 09/30/24 at 9:53 am, she/he stated that she/he reviews the pain medication parameters prior to administering pain medication as needed.</p> <p>On 09/24/24 at 10:19 AM, a record review revealed that resident # 97's pain was not managed consistently. Resident #97 had an order written on 08/26/24 to document his/her pain score, stating Pain Score every shift on a scale of 0-10 0 = no pain 1-3 = mild pain 4-6 = moderate pain 7-10 = severe pain every shift for Pain. Medication orders (as needed) did not have parameters to correspond with pain scores:</p> <p>Acetaminophen Oral Solution (Acetaminophen) Give 20.3 ml via PEG-Tube every 4 hours as needed for Pain</p> <p>Morphine Sulfate Oral Solution 20 MG/5ML, Give 2.5 ml via PEG-Tube every 4 hours as needed for Pain.</p> <p>oxyCODONE HCl Oral Tablet 5 MG, Give 5 mg via G-Tube every 4 hours as needed for Abdominal pain.</p> <p>Further review of Resident #97's Medication Administration Record (MAR) revealed that the resident received:</p> <p>On 09/23/24 at 8:47 AM Acetaminophen 20.3 ml via PEG tube for Pain Level 2,</p> <p>On 09/10/24 at 4:49 PM oxyCODONE HCl Oral Tablet 5 mg via PEG tube for pain level 5,</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>42507</p> <p>Based on medical record review and interview, it was determined the facility staff failed to follow physician orders by administering as needed (PRN) pain medication outside the prescribed parameters. By failing to follow the prescribed parameters for the medication administration, the resident was given an unnecessary medication. This was identified for 1 (#203) of 5 residents reviewed for unnecessary medications during a recertification/complaint survey.</p> <p>The findings include:</p> <p>On 9/23/2024 at 11:54 AM, review of Resident #203's medical record revealed the resident was admitted to the facility in September 2024 with medical diagnosis that included but not limited to other specified disorders of muscle, infection and inflammatory reaction due to cardiac valve, pneumonia, type 2 diabetes mellitus, presence of cardiac pacemaker, and spondylosis lumbar region (osteoarthritis of the spine).</p> <p>On 9/23/2024 at 12:04 PM, review of physician orders revealed an active order with a start date of 9/3/2024 for Tramadol HCL tablet 25 mg, give 25 mg by mouth every 4 hours as needed for Moderate Pain. Further review of the orders revealed active orders for: Pain Score every shift on a scale of 0-10, 0 = no pain 1-3 = mild pain 4-6 = moderate pain 7-10 = severe pain every shift for Pain dated 9/3/2024.</p> <p>On 9/23/2024 at 12:29 PM, review of Resident #203's Medication Administration Record (MAR) for September 2024 was completed. Staff documentation revealed PRN Tramadol HCL 25 mg was given outside ordered parameters for Moderate pain level (4-6) on the following dates:</p> <p>On 9/6/2024 - for pain score 0 at 0620 (6:20 AM) and</p> <p>On 9/23/2024 - for pain score 2 at 1153 (11:53 AM).</p> <p>On 9/23/2024 at 12:32 PM, Surveyor reviewed Resident #203's September 2024 MAR with the Director of Nursing (DON). She verified and confirmed that the 25 mg Tramadol was given inappropriately on the days/times when the resident's pain score was below 4 (ordered parameters not followed). DON stated that sometimes the residents may request a particular pain med, and the nurses would give it without paying attention to the orders. However, she indicated that she was going to review the nurses' notes and follow up with surveyor for explanation why the Tramadol was administered for pain score of 0 and 2 respectively.</p> <p>On 9/25/2024 at 7:52 AM, in a follow up interview with the DON, she stated that she identified the nurses who administered the above Tramadol without following the ordered parameters and have started providing one-on-one education to them. DON further stated that they were working on harmonizing the pain scale throughout the facility and educating staff on following ordered parameters during PRN med administration.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42507</p> <p>Based on observation and interview it was determined facility staff failed to 1) safely store a resident's medication (Resident #42), and 2) dispose of expired medications and dressing supplies. This was evident on 2 of 3 nursing units observed during a recertification/complaint survey.</p> <p>The findings include:</p> <p>1) On 9/25/24 at 9:45 AM, during Medication Administration observation on the 2nd floor Unit for Resident #134 by Registered Nurse (RN # 8), surveyor observed a labeled plastic bag with a pill in it on the floor by the trash can close to the resident's bedside table. Surveyor showed RN #8 the plastic bag containing the pill, and she (RN #8) immediately picked it up. Upon exiting the room, surveyor requested to see what was in the plastic bag. RN #8 stated she threw it in the trash can in the resident's room. Surveyor asked RN #8 to go retrieve the bag. RN #8 went into the room and brought the plastic bag that she had picked from the floor and identified it as Atenolol 50 mg tab belonging to Resident #134's roommate (Resident #42). Surveyor verified that it was an unopened tab of Atenolol 50 mg (expiration date [DATE]) labeled for Resident #42.</p> <p>On 9/25/2024 at 9:50 AM, surveyor shared her observation with the 2nd floor Unit Manager (UM # 12), who took the medication and stated he was going to follow up.</p> <p>On 9/25/2024 at 12:31 PM, Surveyor reviewed with the Director of Nursing (DON) findings during med administration observation: Regarding the Atenolol found on the floor in the residents' room, DON stated that they took a picture of the plastic bag with the med in it and sent to their pharmacy (Geri Script) for verification. DON stated that the pharmacy did not recognize the plastic bag labeled with the Atenolol and stated that it was not from them. She added that the pharmacy did not send single dose /individual packet of any medication to the facility, they send blister packs that contain multiple doses. However, DON stated that Resident #42 was not currently on Atenolol and she (DON) was going to follow up with the resident's daughter to find out if they brought him/her any medications.</p> <p>On 9/26/2024 at 8:23 AM, the Divisional Director of Quality Assurance (Staff #11) provided the surveyor with documentation from their pharmacy that the Atenolol 50 mg tablet was not supplied by them. She stated that the medication might have been in the resident's personal belongings because s/he came from the hospital. However, when asked how the medication ended up on the floor by the roommate's section of the room, Staff #11 stated that she did not know.</p> <p>2) On 9/27/2024 at 11:40 AM, 1st Hallway medication cart (cart #22) was reviewed for medication storage and labeling in the presence of Registered Nurse, RN #19: Surveyor found in the bottom drawer of the med cart one bottle of Pro-Stat 15 g of Protein (floor stock) that expired on 7/26/2024. RN #19 verified and confirmed the finding and immediately removed the bottle from the cart.</p> <p>On 9/27/2024 at 11:52 AM, observation was made of the treatment cart on the 1st floor unit in the presence of RN #15: The following expired and unsterile dressing supplies were found:</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Montcare at Potomac		STREET ADDRESS, CITY, STATE, ZIP CODE 10714 Potomac Tennis Lane Potomac, MD 20854	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>a) One (1) sealed/unopened bottle of Iodoform Packing Strip (1 inch) that expired on 6/4/2024. RN #15 verified the expiration date and confirmed that it was expired. She immediately removed it from the cart.</p> <p>b) One (1) pack of Xeroform Petrolatum dressing 5x9 inch cut opened and the remaining dressing inside exposed. RN #15 confirmed that the dressing in the opened pack was no longer sterile and should not be in the treatment cart and immediately removed it.</p> <p>On 9/30/2024 at 11:31 AM, the medication storage carts observations were reviewed with the Director of Nursing (DON). DON stated she was going to follow up.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37296</p> <p>Based on medical record review and interview it was determined the facility staff failed to maintain the medical record in the most complete and accurate form for Resident (#70). This was evident for 1 of 54 residents selected for review during the recertification/complaint survey.</p> <p>The findings include:</p> <p>A medical record is the official documentation for a healthcare organization. As such, it must be maintained in a manner that follows applicable regulations, accreditation standards, professional practice standards, and legal standards. All entries to the record should be legible and accurate.</p> <p>On 9/23/24 at 10:30A, the surveyor reviewed Resident #70's medical record. The review revealed that Resident was discharged to acute care on 8/19/24 and readmitted to the facility on [DATE].</p> <p>Resident #70's physician's orders on 4/20/2024 Cleanse stage 4 sacrum pressure injury with NSS, pat dry apply calcium alginate with silver and cover with foam every day.</p> <p>Further review of Resident #70's Electronic Medical Record and Treatment Administration Record did not reveal wound care management on 8/1, 8/7, 8/12, 8/13 and 8/18/2024.</p> <p>The Treatment Administration Record for the month of September did not reveal wound care management on 9/2, 9/3, 9/8, 9/10, 9/12, 9/18, and 9/20/2024.</p> <p>On 9/23/24 at 11 AM, the Director of Nursing confirmed the findings.</p>		

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NAME OF PROVIDER OR SUPPLIER Montcare at Potomac		STREET ADDRESS, CITY, STATE, ZIP CODE 10714 Potomac Tennis Lane Potomac, MD 20854	

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51128</p> <p>Based on medical record review and staff interview, it was determined that the facility failed to provide education regarding the benefits and potential side effects of the influenza and pneumococcal vaccine. This was evidenced for 1 (Resident #29) of 5 residents reviewed for Influenza and Pneumococcal Immunizations records during the recertification/complaint survey.</p> <p>The findings include:</p> <p>Pneumococcal vaccine helps prevent pneumococcal disease, which is any type of illness caused by streptococcus pneumonia bacteria. The Centers for Disease Control and Prevention (CDC) recommends a pneumococcal vaccine for ages [AGE] years or older and adults 19 through [AGE] years old with certain medical conditions or risk factors. (Centers for Disease Control and Prevention- vaccines and preventable disease)</p> <p>Flu is a contagious disease that spreads around the United States every year, usually between October and May. Anyone can get the flu, but it is more dangerous for some people. Infants and young children, people [AGE] years and older, pregnant people, and people with certain health conditions or a weakened immune system are at the greatest risk of flu complications. Influenza (Flu) vaccines can prevent influenza. (Centers for Disease Control and Prevention- vaccines and preventable disease)</p> <p>On 9/26/24 at 11:49 AM, the surveyor reviewed the medical records of 5 randomly selected residents for immunization. The review revealed that Resident #29 had been residing at the facility since March 2020.</p> <p>Further review of Resident #29's record revealed that the resident refused influenza vaccine in 2020. There was no documentation for the influenza vaccine in 2021. The documentation for the influenza vaccine in 2022 showed that the resident refused it. However, there was no evidence to support the resident receiving education on the vaccine's risks and/or benefits. There was no documentation for the influenza vaccine in 2023.</p> <p>During an interview with the Infection Control Preventionist (Staff # 22) on 09/30/24 at 10:25 AM, she stated that the facility provided influenza education yearly to all residents, which should be documented in the Electronic Medical Record.</p> <p>On 9/26/24 at 12:30 PM, the surveyor reviewed Resident #29's pneumococcal immunization record. The documentation for the pneumococcal vaccine for 2020 revealed that the resident refused. There was another documentation in March 2024 stating that Resident #29 refused the vaccine. However, there was no evidence to support the resident receiving education about the vaccine's risks and/or benefits.</p> <p>During an interview with Staff #22 on 9/30/24 at 10:25 AM, she stated that the facility offered the pneumococcal vaccine and educated residents who had refused it quarterly and yearly about its risks and/or benefits.</p> <p>(continued on next page)</p>

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/30/24 at 11:30 AM, the surveyor shared the concern with the Director of Nursing (DON) regarding providing residents education about immunization risks and/or benefits. The DON validated the concern.		