STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215171	A. Building B. Wing	02/18/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on record reviews and interviews, it was determined that the facility failed to ensure Minimum Data Set (MDS) assessments were accurately coded, including coding related to wander/elopement risk status. This was evident for 2 (Residents #108 and #154) out of 5 residents reviewed for accidents during the recertification survey.The findings include: 1.Resident #108 diagnoses included Vascular Dementia and Depression. A review of Resident #108's clinical record on 2/13/26 at 8:00 AM revealed the quarterly Minimum Data Set (MDS) assessments with Assessment Reference Data (ARD) of 09/30/25 and 12/30/25 were inaccurately coded. Section N0415 (medication is taking) the resident was coded as not receiving an antipsychotic medication in the last 7 days. Further review of Resident#108's clinical record revealed a physician order dated 03/19/25 to administer Aripiprazole (Abilify) daily at bedtime. A review of the resident's Medication Administration Record revealed that Resident #108 had been receiving Aripiprazole (Abilify) daily at bedtime since 03/19/25. The MDS Coordinator #2 was interviewed on 02/13/26 at 8:42 AM and she reviewed the clinical records and confirmed that Aripiprazole (Abilify) was classified as an antipsychotic medication and the MDSs were inaccurately coded. After the surveyor's intervention the MDSs were corrected on 02/13/26. On 02/13/26 at 11:25 AM the Director of Nursing was notified of the findings. Based on record review and interview, it was determined that the facility failed to accurately code the resident's wander/elopement alarm status on the Minimum Data Set (MDS) assessment. This was evident for 1 (Resident #154) of 5 residents reviewed for accidents during the recertification survey. 2. Minimum Data Set (MDS) is a federally mandated comprehensive clinical assessment for all residents of nursing homes certified to participate in Medicare or Medicaid. The data elements (also referred to as items) in the MDS standardize communication about resident problems and conditions within nursing homes, between nursing homes, and between nursing homes and outside agencies. MDS assessments need to be accurate to ensure each resident receives the care they need. Wander guard or alert bracelet is a wandering management system that monitors residents using a wearable bracelet. The system relies on three components: bracelets that residents wear, sensors that monitor doors, and a technology platform that sends real-time safety alerts. When a resident with a bracelet approaches a monitored door, the system alerts. (continued on next page)

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/05/2026 at 1:54 PM, Resident #154 was observed pacing in the hallways. Registered Nurse Unit Manager (RN/UM #4) confirmed that Resident #154 was at risk for elopement and was wearing an alert bracelet. On 2/10/2026 at 12:47 PM, a review of Resident #154's medical records revealed the following: BIMS (Brief Interview for Mental Status) score of 4.0 which indicated severe cognitive impairment. Section G (Elopement) of the Quarterly Risk Evaluation dated 2/25/25, confirmed that Resident #154 was at risk for elopement. Physician's order: Alert bracelet- check function of alert bracelet on right lower extremity every shift, expires 7/2027, # FOBO66 every shift for Check function of alert bracelet on right lower extremity On 2/10/2026 at 3:42 PM, a review of care plan indicated Resident #154 is an elopement risk/wanderer as evidenced by history of attempts to leave facility unattended, impaired safety awareness. Resident wanders aimlessly, Significantly intrudes on the privacy or activities of others. Has a history of removing wander alert bracelet, continue to check daily. However, a review of the Annual MDS assessment with an Assessment Reference Data (ARD) of 10/14/25 revealed that Section P0200 (Alarms), item E (Wander/elopement alarm) was inaccurately coded as 0- Not used. On 2/11/2026 at 9:46 AM, MDS Coordinators #2 and #3 verified the error, and stated that the item should have been coded as 2- Used daily. They stated that the MDS assessment will be modified accordingly. On 2/11/2026 at 10:09 AM, the Director of Nursing (DON) was informed of the concern. On 2/13/2026 at 12:57 PM, MDS Coordinator #2 confirmed that the Annual MDS assessment have been modified to reflect the correct coding.

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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 comprehensive care plan regarding the use of a nebulizer. This was evident for 1 (Residents #1) of 41 residents reviewed for care planning during the recertification survey.The findings include: A care plan is a guide that addresses the unique needs of each Resident. It is used to plan, assess, and evaluate the effectiveness of the Resident's care. The care plan consists of focus, goal and interventions. A nebulizer is a medical device that converts liquid medication into a fine mist, allowing it to be inhaled directly into the lungs through a mouthpiece or face mask.On 2/5/2026 at 1:55 PM, during the initial tour of the facility, a nebulizer machine with unlabeled tubing was observed on Resident #1's nightstand.On 2/11/2026 at12:43 PM, a review of the active physician orders confirmed the following: NEBULIZER - Change nebulizer mask and nebulizer tubing weekly every night shift every Monday, Saturday. NEBULIZER - Change nebulizer mask and nebulizer tubing weekly every night shift every Saturday. Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML (Ipratropium-Albuterol) 1 vial inhale orally via nebulizer every 6 hours as needed for Shortness of breath/Emphysema.On 2/11/2026 at 1:09 PM, a review of care plan revealed no evidence that a care plan has been initiated to address the use of a nebulizer treatment.On 2/13/2026 at 10:22 AM, the Director of Nursing (DON) confirmed that the care plans were generated upon admission and updated by the Unit Manager or Minimum Data Set (MDS) Coordinator. She acknowledged the findings and concerns identified during this survey.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, clinical record reviews and interviews, it was determined that the facility failed to review and revise care plans to meet the specific needs of the residents. This was evident of 3 (Residents #4, #111 and #91) out of 41 residents reviewed for care plan timing and revision during the recertification survey. The findings include: 1. On 02/11/26 at 11:32 AM, a review of Resident #4's clinical record revealed that the resident was prescribed Triamterene-HCTZ 37.5-25 mg 1capsule by mouth once a day for Hypertension on 10/17/24. The resident was administered the medication from 10/17/24 until 12/24/24 when it was discontinued. Further review revealed an active Care Plan for Resident #4 with focus Resident is on diuretic therapy (HCTZ) r/t hypertension. Goal Resident will be free of any discomfort or Adverse side effects of diuretic therapy through the review date. Revised on 12/16/24 with Target date 03/21/26. The care plan had not been revised to reflect the medication was discontinued on 12/24/24. In an interview on 02/12/2026 at 10:03 AM the Unit Manager Staff #7 stated that when a medication was discontinued the care plan pertaining to that medication was also discontinued. Unit Manager Staff #7 reviewed the clinical record and confirmed that HCTZ was discontinued on 12/24/24 but the care plan remained active. I will resolve the care plan. The surveyor noted that Unit Manager Staff #7 resolved the care plan on 02/12/26 after the surveyor's intervention. On 02/12/2026 at 11:53 AM the Surveyor informed the Director of Nursing of the concerns and findings. 2. 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. The care plan consists of focus, goal and interventions. According to CMS (Centers for Medicare and Medicaid Services), in long-term care facilities, care plans should be reviewed and updated at least every 90 days, or more frequently if a resident's condition changes significantly. ADL is a term used collectively to describe fundamental skills required to independently care for oneself, such as eating, bathing, and mobility. 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. On 02/05/2026 at 1:24 PM, Resident #111 was observed with long fingernails. A review of the Quarterly MDS with an Assessment Reference Date (ARD) of 11/07/25 indicated no impairment in range of motion, but a functional status of Dependent for personal hygiene. (Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity.) (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/05/2026 at 1:32 PM, Resident #91 expressed frustration regarding untrimmed fingernails, noting that staff had been notified multiple times. The resident's fingernails were observed extending approximately half an inch beyond fingertips. A review of the Quarterly MDS (ARD 11/25/25) indicated impairment in upper and lower extremities, with a functional status of Dependent for personal hygiene. On 2/06/2026 at 8:51 AM, the Registered Nurse/Unit Manager (RN/UM #4) was notified of the findings and stated that one of the residents had behaviors which were indicated in the care plan. On 2/12/2026 at 9:08 AM, a review of the following care plans for both residents revealed that revisions were only initiated after surveyor intervention: Resident #111's care plan indicated resistive to care related to Anxiety and Dementia. Revised on 2/6/26 to include The resident may resist care such as bathing, dressing, hygiene, nail care, turning and positioning. Encourage the resident to accept daily ADL care such as bathing, dressing, grooming, hygiene, nail care and repositioning. Resident #91's care plan indicated has an ADL Self Care Performance Deficit related to physical limitation due to left sided weakness/comorbidity and is at risk for skin alterations. Revised on 2/6/26 to include May need encouragement to accept ADL care such as grooming, hygiene, dressing, nail care. If patient refuses ADL care such as bathing, grooming, hygiene, nail care report to assigned nurse to provide encouragement and education. Due to patient's preference, will attempt to have licensed staff provide nail care and as needed. 2/13/2026 at 10:22 AM, the Director of Nursing (DON) confirmed that care plans were generated upon admission and updated by the Unit Manager or MDS Coordinator. She acknowledged the specific findings and concerns identified during this survey.

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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. Based on observation, interview and record review, it was determined that the facility failed to provide necessary personal hygiene to dependent residents. This was evident for 2 (Residents #111 and #91) of 5 residents reviewed for Activities of Daily Living (ADLs) during the recertification survey.The findings include: ADL is a term used collectively to describe fundamental skills required to independently care for oneself, such as eating, bathing, and mobility. 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. On 02/05/2026 at 1:24 PM, Resident #111 was observed with long fingernails. A medical record review showed a (Brief Interview for Mental Status) BIMS score of 15.0 which indicated intact cognition and a Quarterly MDS with an Assessment Reference Date (ARD) of 11/07/25 indicating no impairment in range of motion, but a functional status of Dependent for personal hygiene. (Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity.)On 02/05/2026 at 1:32 PM, Resident #91 expressed frustration regarding untrimmed fingernails, noting that staff had been notified multiple times. The resident's fingernails were observed extending approximately half an inch beyond fingertips. A medical record review showed a BIMS score of 15.0 (intact cognition) and a Quarterly MDS (ARD 11/25/25) which indicated impairment in upper and lower extremities, with a functional status of Dependent for personal hygiene.On 2/06/2026 at 8:32 AM, a follow-up visit confirmed that both residents still had overgrown fingernails.On 2/06/2026 at 8:40 AM, during an interview with Geriatric Nurse Assistant (GNA #1), he/she stated that staff were expected to provide ADL care, including nail trimming, and must notify the assigned nurse if a resident refuses.On 2/06/2026 at 8:51 AM, the Registered Nurse/Unit Manager (RN/UM #4) was notified of the findings, and the Director of Nursing (DON) was informed at 9:27 AM and acknowledged the 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 observations, record reviews and interviews, it was determined that the facility failed to provide residents with necessary respiratory care services consistent with professional standards. This was evident for 3 (Resident #28, #4 and #1) out of 4 residents reviewed for respiratory care during the recertification survey.The findings include:1.On 02/06/26 at 8:53 AM the surveyor observed Resident #28 in bed receiving oxygen via nasal canula at 2 liters per minute. The oxygen tubing and humidifier bottle were not labeled to indicate when they were changed. On 02/06/26 at 10:45 AM a review of Resident #28's clinical record revealed physician orders as follows: Oxygen at 2L per minute continuously Q Shift - Start Date 12/19/25 Oxygen tubing - change and date tubing, respiratory bag and humidified water (if applicable) weekly, every night shift every Sat. Please date tubing, date the respiratory bag for storage and date the humidified water bottle if applicable Start Date: 08/30/25 On 2/06/26 at 12:43 PM in an interview LPN #9 stated that oxygen tubing and humidifier bottles were changed weekly on the night shift and labeled. She accompanied the surveyor to Resident #28's room and confirmed that the oxygen tubing and humidifier bottle were not labeled to indicate the date they were changed. The staff member stated I do not know when they were changed On 02/06/26 at 12:53 PM Unit Manager Staff #7 also accompanied the surveyor to the resident's room and confirmed that the oxygen tubing and humidifier bottle were unlabeled. 2. Resident #4 was observed lying in bed on 02/06/26 at 7:45 AM with oxygen in use at 2 liters per minute via nasal cannula. The resident's Humidifier bottle was dated 02/01/26 and the nasal cannula was undated. The facility's Oxygen Administration Policy dated 03/20/24 and revised on 02/14/25 stated on Page 2 (5c) as follows: Nurse responsibilities: Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated. Change humidifier bottle when empty, weekly, or as recommended by the manufacturer. On 02/06/26 at 12:48 PM a review Resident #4's clinical record revealed a physician order for Oxygen as follows: O2 at 2 Liters via nasal cannula as needed for Pulse Ox < 92% as needed for sats <92%. Order Date: 01/02/26 The clinical record failed to reveal an order to change the oxygen tubing and the humidifier bottle. On 02/06/2026 at 12:53 PM in an interview, Unit Manager Staff #7 stated that it was the practice of the facility to have oxygen tubing and humidifier bottles changed weekly and documented in the residents' Treatment Administration Record (TAR). Unit Manager Staff #7 checked the clinical record and confirmed there was no order to change Resident #4's oxygen tubing, I will put in the order now. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/06/2026 at 1:41 PM the Director of Nursing was notified of findings and stated that Resident # 4's clinical records had been updated to include the order. 3. A nebulizer is a medical device that converts liquid medication into a fine mist, allowing it to be inhaled directly into the lungs through a mouthpiece or face mask. On 2/5/2026 at 1:55 PM, during the initial tour of the facility, unlabeled nebulizer machine tubing and suction catheter were observed on Resident #1's nightstand. On 2/06/2026 at 8:50 AM, during an interview with Registered Nurse/ Unit Manager (RN/UM #4), he/she stated that respiratory equipment must be dated and changed according to facility protocol. On 2/6/26 at 9:27 AM, a review of Nebulizer policy (reviewed 1.1.25 and revised 2.2.25) indicated: Care of equipment: Item #8 Change nebulizer tubing weekly. On 2/11/2026 at12:43 PM, a review of the active physician orders confirmed the following: NEBULIZER - Change nebulizer mask and nebulizer tubing weekly every night shift every Monday, Saturday. NEBULIZER - Change nebulizer mask and nebulizer tubing weekly every night shift every Saturday. Suction as needed for excessive secretion every 1 hours as needed for excessive secretion On 2/13/2026 at 10:22 AM, the Director of Nursing (DON) was notified of the findings and acknowledged the concerns.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews, it was determined that the facility failed to ensure a resident received medication according to the physician's orders. This was evident for 1 (Resident #31) of 6 residents reviewed for unnecessary medications.The findings include:On 02/09/2026 at 8:15 AM Resident #31 was observed sitting in a wheelchair at nurse's station with a bandage over the left eye and bluish discoloration with swelling on the face. The resident said I fell.A review of the resident's clinical record on 02/15/2026 at 6:40 PM revealed that Resident #31 fell on [DATE] then again on 02/08/26 and was transferred to the Emergency Room.Further review of the clinical record revealed that the facility requested a pharmacy review of Resident #31's medications due to the resident's falls. On 02/09/26, the Pharmacy Consultant provided the facility with several recommendations. One recommendation was to decrease the dosage of the resident's medication, Gabapentin. A review of the resident's Medication Administration Record revealed that the resident had been receiving Gabapentin 100mg twice a day from 01/11/26.On 02/11/26 the attending physician reviewed the pharmacy recommendations and wrote an order as follows Decrease Gabapentin to 100 mg Q D. The facility failed to act on physician's order and continued to give the resident Gabapentin 100mg twice a day.During an interview on 02/17/26 at 10:54 AM the Unit Manger #7 reviewed the resident's clinical record and confirmed that the resident was receiving Gabapentin twice a day and that the physician's order was not implemented. The Unit Manager stated that she would address the issue immediately.The Director of Nursing (DON) was notified on 02/17/2026 at 11:15 AM of the surveyor's concerns and stated that she would look into the matter. Later at 11:40 AM the DON stated that she had no comment. On 02/17/2026 at 11:45 AM the surveyor was given copies of documents to show that the physician was notified and Resident #31's medication, Gabapentin, was decreased to 100mg once a day.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Number of residents sampled: Number of residents cited: Based on observation, interviews, and review of facility policy, the facility failed to ensure opened insulin pens were labeled with the date opened as required by policy. This was evident in 1 of 5 medication carts observed during the annual survey. The findings include: On 2/11/26 at 10:42 AM, during a random observation of a medication cart on the Medbridge Unit (1st floor), the surveyor observed two opened insulin pens for Resident #48 stored in the top drawer without an opened date documented on either pen.In an interview on 2/11/26 at 10:45 AM, RN Unit Manager #6 confirmed that both insulin pens were opened and did not contain an opened date label.In an interview on 2/11/26 at 10:51 AM, the Director of Nursing stated that once insulin pens are opened, they are expected to be labeled with the opened date.In a follow-up interview on 2/11/26 at 11:23 AM, RN Unit Manager #6 stated that the facility discarded the opened insulin pens and reordered new pens for Resident #48 because staff could not determine when the pens were opened as the opened date was not documented.On 2/11/26 at 11:57 AM, review of the facility's policy titled Insulin Pen, revised 1/31/24, revealed that insulin pens must be labeled with the resident name and the date opened. The policy further revealed that if the label is missing, the pen will not be used and a new pen must be ordered. The policy also states that insulin pens should be discarded after 28 days or according to the manufacturer's instructions.The findings were discussed with the Director of Nursing.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation and interviews, it was determined that the facility failed to ensure appropriate infection prevention and control practices were followed. This was evident for 1 of 1 observation in the laundry room.The findings include:On 02/09/2026 at 8:20 AM during rounds in the laundry room, the surveyor observed Staff #12 removing clean linen from a dryer and placing them in a bin. In the process of removing the linen, a cream-colored blanket fell on the floor. Staff #12 picked up the blanket and placed it in the bin containing clean linen. After the surveyor voiced concern Staff #12 said I am sorry, I should not do that. At 8:35 AM, Supervisor Staff #13 arrived in the laundry room and the surveyor in an interview informed the supervisor of the findings. Supervisor Staff #13 communicated with Staff #12 who confirmed the findings in the presence of the surveyor. Supervisor Staff #13 stated that she would address the issue as Staff #12 was educated on infection control practices and should not have put the blanket in the bin with other clean linen.On 02/10/2026 at 7:04 AM the Administrator was notified of the findings in the laundry room.