

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215197	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER Fox Chase Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 2015 East-West Highway Silver Spring, MD 20910	
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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on record review and interviews it was determined the facility staff failed to develop and implement a system to ensure accurate accountability of controlled substances by 1) failing to have a system to accurately identify staff reconciling and signing out controlled substances upon receipt, shift audits and administration; 2) failing to identify a discrepancy in the controlled substance inventory; and 3) failing to maintain accurate record keeping, when controlled substances were removed from the inventory. This was evident for 1 (Resident #1) of 5 residents reviewed during the complaint survey. The findings include: A controlled substance is a drug or chemical whose production, use, and possession are strictly regulated by the government because it carries a risk of abuse, misuse, and physical or psychological dependence. Governments place these chemicals into five categories, called schedules, based on their medical use and danger level: Schedule I: High abuse risk and no safe, accepted medical use. Schedule II: High abuse risk, but with accepted medical uses. Schedule III-V: Lower abuse risks with accepted medical uses and decreasing levels of danger. Proper handling of controlled substances requires strict adherence to security, accurate recordkeeping, and safe disposal protocols. Accurate recordkeeping includes: Real-time logs: Record every receipt, administration, transfer, or dose change immediately. Shift audits: Conduct physical inventory counts during every staff change or shift rotation. Discrepancy reporting: Investigate and log any count mismatch right away. The facility staff utilized Medication Monitoring Control Records - forms that reflected the supply of each controlled substance provided by the pharmacy. Spaces were provided on the form for the staff administering the medication to document their name, date, time, amount given, and the number of tablets remaining of each medication in the corresponding medication blister card. 1) Resident #1's medical record was reviewed on 7/21/26 at 12:45 PM during review of Facility Reported Incident #3056055 and complaint #3056055. The record revealed Resident #1 had physician orders for: Alprazolam (Xanax) [a Schedule IV controlled substance] 0.5 mg (milligrams) 1 tablet 4 times/day for anxiety, and 1 mg every night for anxiety; and Oxycodone HCl (hydrochloride) [a Schedule II controlled substance] 30 mg by mouth every 4 hours for Chronic Pain. Resident #1's paper record contained numerous completed Medication Monitoring Control Record forms. The entries in the column designated for the name of the person who administered the medication contained illegible, unidentifiable handwritten signatures and initials. It failed to clearly identify the name and title of the person who administered the medication. Further review of the record failed to reveal a staff signature page or other means to identify the handwritten signatures/names/initials. Review of the June 2026 Controlled Drug-Controlled Substance Record for Cart #2 revealed handwritten signatures of the oncoming and off going licensed nurses responsible for counting and reconciling the controlled substances at the change of each shift. There was no identification of the signatures of the nurses who conducted the counts and reconciliation of the (continued on next page)		

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	controlled substance records. The surveyor requested a copy of a staff signature identification list on 7/21/26 at 12:52 PM. On 7/21/26 at 2:07 PM the Chesapeake Unit Manager (UM) Registered Nurse (RN) #4 and the Potomac UM RN #5, provided a list identifying the electronic medical record (EMR) usernames of the staff. It did not identify the handwritten signatures. Upon further inquiry they indicated the facility did not have a way to identify staff signatures/initials and acknowledged the surveyor's concern. 2) Further review of Resident #1's medical record on 7/23/26 at 8:00 AM revealed a Medication Monitoring Control Record [#15] for Resident #1 for Alprazolam tablets 0.5 mg give 1 tablet four times daily for anxiety. The date received was 05/12/2026 The amount received indicated 24 with a line through it and 23 written beside it with 1 set of unidentified initials. There was no indication that a second person reconciled the amount received and verified the discrepancy. The final line in the sequence of signed out tablets was dated 6/7/26 9 pm. The form reflected 4 tablets remaining in the corresponding blister card. There was no documentation to indicate the disposition of the 4 remaining tablets from the blister card. On 7/23/26 at 3:10 PM the surveyor observed the medication cart containing Resident #1's medication with Licensed Practical Nurse (LPN) #6 and UM #5. LPN #6 was asked to reconcile Resident #1s controlled medications with the surveyor. The reconciliation was done twice and failed to reveal a blister card containing the 4 tablets of Alprazolam 0.5 mg as reflected on the Medication Monitoring Control Record [#15]. 3) However, on 7/23/26 at 3:10 PM the reconciliation with LPN #6 revealed: -Resident #1's Alprazolam 0.5 mg [Card #98B] Control Sheet indicated 12 tablets remained, the blister card contained 10 tablets. 2 tablets were unaccounted for. LPN #6 indicated that she did not sign off the 9 AM or 1 PM doses that she administered.-The Control Sheet for Pregabalin (Lyrica) 225mg [Card #103B] indicated 29 tablets remained. However, 28 tablets were in the blister card. 1 tablet was missing. LPN #6 indicated that she did not sign off the 9 AM dose that she administered.-The Control Sheet for Oxycodone 30 mg [Card#101A] indicated there should have been 7 tablets remaining, the blister card contained 5 tablets. LPN #6 indicated she did not sign off the doses she administered at 9 AM and 1 PM.LPN #6 signed off each dose from the corresponding control logs at that time. When asked when medications should be signed off she stated, when I give them. UM #5 was present and immediately made aware of the above concerns. The Administrator was made aware of the missing controlled medications on 7/23/26 at 4:10 PM and began an investigation. An interview was conducted with the facility's clinical pharmacy consultant #7 on 7/24/26 at 2:33 PM. He indicated that a team which included a pharmacist and a nurse among other disciplines came to the facility close to every month. They conducted reviews/audits which included but were not limited to: Med storage including audits of controlled drugs and narcotic sheets (Control Sheets). Medication carts were opened and audited and included checking for correct counts, and double locks. When asked if there was a policy/procedure for signing out controlled medications, he indicated that it was more of a facility responsibility. He was asked if there was a policy/procedure related to how the medication monitoring control records should be utilized. He stated, we are a vendor, we don't write policy but have input into the facility's policy, but it's up to the facility to have a policy/procedure. The Director of Nursing (DON) was made aware of the above findings on 7/28/26 at 1:20 PM.		

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. Based on surveyor observation, interview and record review it was determined the facility staff failed to implement measures as per the resident's Plan of Care and standards of nursing practice to promote dignity for a resident with an indwelling urinary catheter. This was evident for 1 (Resident #5) of 5 residents reviewed during the complaint survey. The findings include: During a tour of the facility on 7/28/26 at 11:45 AM the surveyor observed Resident #5's bedroom door was open. From the hallway, the surveyor observed Resident #5 lying in bed, a urinary catheter bag containing a moderate amount of urine was lying on the floor beside the foot of the bed. The surveyor knocked on the door however Resident #5 appeared to be asleep and did not answer. Review of Resident #5's medical record on 7/28/26 at 12:48 PM revealed a plan of care created 11/21/24 for Indwelling Catheter; and 3/2/26 for Indwelling suprapubic catheter. The interventions/tasks included but were not limited to: Apply dignity bag to cover the urine bag q (every) shift; and Position catheter bag and tubing below the level of the bladder and away from entrance room door. Another observation was made at 1:00 PM on 7/28/26. Resident #5 was in bed, and the uncovered urinary catheter bag was in the same location, visible from the hallway. A Licensed Practical Nurse (LPN #2) was standing at a medication cart in the hallway and confirmed she was the nurse providing care for Resident #5. When asked who was responsible for providing urinary catheter care she explained that the aides and the nurses empty and maintain the urinary bags. She was shown and confirmed that Resident #5's urinary bag was uncovered and visible from the hallway. When asked if the facility utilized dignity bags or other privacy covers for the urinary drainage bags, she explained that the bags utilized by the facility were made with a panel that prevented the contents of the bag from being visible. She obtained a new bag to show the surveyor. She explained that Resident #5 returned from a recent urology appointment several days prior, where his/her urinary drainage bag was changed to the current bag which did not include a dignity cover. She was unable to explain why the facility staff did not cover the bag upon the resident's return to the facility. The Director of Nursing (DON) was made aware of the concern on 7/28/26 at 1:20 PM.		

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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 interview it was determined the facility staff failed to implement standard infection control measures for a resident with an indwelling urinary catheter. This was evident for 1 (Resident #5) of 5 residents reviewed during the complaint survey. The findings include: During a tour of the facility on 7/27/26 at 11:05 AM Resident #5 was observed propelling his/her motorized wheelchair from the hallway near the nurses' station toward the Administrator's office. A urinary catheter drainage bag was lying on the foot pedals between Resident #5's feet. The drainage tubing was dragging on the floor between the foot pedals. During an observation on 7/28/26 at 11:45 AM Resident #5's bedroom door was open. From the hallway, the surveyor observed Resident #5 lying in bed, a urinary catheter drainage bag containing a moderate amount of urine was lying on the floor beside the foot of the bed facing the door and was visible from the hallway. The surveyor knocked on the door however Resident #5 appeared to be asleep and did not answer. Another observation was made on 7/28/26 at 1:00 PM. Resident #5 was in bed, and the urinary catheter drainage bag was in the same location on the floor visible from the hallway. Licensed Practical Nurse (LPN) #2 was standing at a medication cart in the hallway a few doors away. She confirmed she was the nurse providing care for Resident #5. LPN #2 indicated that the nurses and the aides were responsible for emptying the urinary drainage bags and caring for the urinary catheters. She was shown Resident #5's urinary drainage bag and confirmed it was not acceptable for the drainage bag to be on the floor per infection control standards. She indicated that it must have fallen. She was made aware that the surveyor observed the bag lying on the floor in the same location at 11:45 AM. LPN #2 again indicated that the drainage bag should not have been on the floor. She indicated that the plastic hook for hanging the bag was broken/missing and staff were using an exam glove to tie the drainage bag to the bed frame. The Director of Nursing (DON) was made aware of the above findings and acknowledged the concerns on 7/28/26 at 1:20 PM.		