STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215197	A. Building B. Wing	03/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fox Chase Healthcare	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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 49815 Based on record review and interview, it was determined that the facility failed to provide documentation whether Residents had an advance directive and/or wished to formulate an advance directive. This was found to be evident for 4 (Resident #27, #28, #54 and #56) out of 4 Residents reviewed for advance directives. The findings include: An advance directive is a legal document that specifies a person's wishes for end-of-life healthcare. It also specifies who should make healthcare decisions on your behalf if you are unable to do so yourself. On 03/04/25 at 12:40 PM the surveyor conducted record reviews of Resident #27, #28, #54 and #56's medical record. During the record review of Resident #27, #28, #54 and #56's medical record, specifically the social services progress notes and assessments, it was revealed that there was no documentation to determine if Residents #27, #28, #54 and #56 had an advance directive and/or determine whether the Residents wished to formulate an advance directive. A MOLST (Medical Orders for Life-Sustaining Treatment) is a standardized form that outlines a patient's medical treatment preferences, including resuscitation and other life-sustaining interventions, ensuring those wishes are respected across all healthcare settings. The surveyor interviewed the Director of Nursing (DON) on 03/05/25 at 10:40 AM. The surveyor asked the DON for documentation of advance directives and offering of advance directive information for Residents #27, #28, #54 and #56. The Director of Nursing (DON) stated that the Residents had a MOLST in the medical charts and that it was the responsibility of the Social Services Director (SSD) for documentation of advance directives. (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Social Services Director (SSD) #9 was interviewed by the surveyor at 02:40 PM on 03/05/25 and asked what the process was for documentation of advance directives. The SSD #9 stated that she was responsible for the documentation of advance directives for the Residents. The surveyor asked the SSD #9 if Residents #27, #28, #54 and 56 had advance directives and/or were offered information to formulate advance directives. The SSD #9 stated that Residents #27, #54 and #56 did not have advance directives and were not asked if they wanted to formulate an advance directive. The SSD #9 stated that she was in the process of providing Resident #28 with the information for formulating an advance directive. The SSD #9 further stated that she was new to the facility but was aware of the expectation for documentation of advance directives which included asking Residents if they had an advance directive and if not, did the Residents wish to formulate an advance directive. At the time of survey exit, no additional information on advance directives was provided by the facility.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 42886 Based on observation and staff interview, it was determined that the facility failed provide a family meeting to discuss grievances regarding the care of a resident. This was evident for1 (Resident #336) of 44 residents reviewed during the recertification survey. The findings include: On 03/3/25 at 9:56AM, the surveyor reviewed a complaint (MD#00201345) from Resident #336's family stating that they requested a family meeting with the facility's social service department regarding grievances regarding inadequate care of Resident #336. The review of the resident's medical record on 03/3/25 at 10:00AM revealed no evidence that the facility social services department provided the resident's family with a family meeting. During a interview with the Director of Nursing (DON) on 03/6/23 at 7:58AM, the DON reviewed Resident #336's medical record and confirmed that the resident's family did not receive the requested meeting.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 42886 Based on medical record review and interview, the facility staff failed to thoroughly investigate a facility reported incident of resident-to-resident abuse. This was evident for 1 (Resident #330) of 44 residents reviewed during survey. The findings include: Review of Residents #330 and Resident #333's facility reported incident (MD 00181638) on 03/6/25 at 10:05AM revealed the Resident #330 alleged that Resident #333 touched his/her private area. Review of the facility investigation documents on 03/6/25 at 10:10AM revealed that the facility was unable to substantiate abuse. Further review of the facility investigation documents revealed that the facility failed to interview other residents and staff members regarding abuse before concluding that the alleged resident-to-resident abuse was unsubstantiated. During an interview with the Director of Nursing on 03/6/25 at 11:00AM, the DON confirmed that the facility failed to thoroughly investigation Resident #330's allegation of abuse

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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** 49815 Based on observation, surveyor record review and facility staff interview, it was determined that the facility failed to accurately code the Minimum Data Set (MDS) assessment for residents, 1) with oxygen usage and 2) with discharge status. This was found to be evident for 2 (Resident #28 and #71) of 2 resident reviewed for accuracy of MDS assessments. The findings include: The MDS (Minimum Data Set) assessment is a standardized tool used to evaluate the health and functional status of Residents in skilled nursing homes (SNFs) in the United States. The purpose is to provide a comprehensive picture of the Resident's physical, cognitive, social and emotional needs; to guide care planning and ensure that Residents receive appropriate services; and to collect data for quality improvement, research and policymaking. 1) On the initial tour of the nursing unit on 03/03/25 at 09:50 AM the surveyor observed Resident #28 with oxygen in use. The surveyor conducted a record review of Resident #28's medical record on 03/04/25 at 11:15 AM and this review revealed that Resident #28 had a physician order for continuous oxygen due to shortness of breath. Further review of the medical record, specifically the progress from notes from 02/08/25 through 02/13/25 revealed documentation that Resident #28 was using oxygen continuously. Review of the MDS (Minimum Data Set) assessment dated [DATE] (Admission - Medicare 5 day) revealed that oxygen was not checked as being used on admission and while a Resident and within the last 14 days. The surveyor interviewed the Director of Nursing (DON) on 03/05/25 at 9:40 AM and asked the DON if Resident #28 used oxygen. The DON stated that Resident #28 used oxygen. The surveyor conveyed to the DON that the MDS assessment dated [DATE] (Admission - Medicare 5 day) did not reflect that Resident #28 uses oxygen, but the progress notes from 2/8/25 through 2/13/25 revealed documentation of continuous oxygen usage for Resident #28. The Director of Nursing (DON) reviewed the MDS and the progress notes for Resident #28 and acknowledged the surveyor. No additional information was provided by the facility at exit. 50502 2) On 3/05/25 at 4:58 PM, a review of Resident #71's medical record revealed a discharge date of [DATE]. The SBAR (Situation, Background, Assessment, Recommendation) summary for the providers dated 12/4/2024 at 11:41 PM indicated, the resident's representative was in the facility and decided to transfer the resident to the hospital at around 10:53pm for further evaluation. A review of the section A of the MDS Discharge Return Not Anticipated assessment with an Assessment Reference Date (ARD) of 12/4/2024 indicated, Discharge Status to Home/Community. On 3/06/25 at 7:41 AM, the Director of Nursing (DON) confirmed that Resident #71 was transferred to the hospital on 12/4/2024. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/06/25 at 4:36 PM, a review of the copy of the MDS assessment with ARD 12/4/24 provided by the facility indicated a Discharge status to hospital. On 3/07/25 at 8:09 AM, in an interview with MDS nurse, she confirmed that Resident #71 was discharged home. The MDS nurse was requested to verify section A of the MDS document received on 03/6/25 against the electronic health record. She confirmed that there was a discrepancy of the 2 MDS assessments with the same ARD and added that 2 nurses completed 2 separate discharge assessments. Which are as follows: 12/4/2024 Discharge Return Not Anticipated (coded discharge to home/community) 12/4/2024 Admission - None PPS /Discharge Return Anticipated (coded discharge to hospital) On 03/07/25 at 12:21 PM, the Nursing Home Administrator(NHA) and the DON were made aware of the inaccurate MDS coding. The NHA stated that she would reach out to the corporate MDS and would make necessary changes. On 03/07/25 at 12:40 PM, the MDS nurse stated that she called the regional MDS nurse and stated that the facility would make the necessary corrections.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50502 Based on record review and interview, it was determined that the facility failed to ensure that a resident was provided with summaries of the baseline care plan. This was evident for 2 (Resident #48 and #8) of 44 residents reviewed for baseline care plan during the recertification survey. The findings include: A baseline care plan must be completed within 48 hours of a resident's admission to the facility and must include the initial goals based on admission orders, physician orders, dietary orders, therapy services, and social services. A summary of the baseline care plan as well as a list of the resident's current medications must be given to each resident. 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. 1) On 03/03/25 at 8:52 AM, Resident #48 stated that he/she has not been involved in any care plan meetings. On 03/06/25 at 8:21 AM, a review of Resident #48's medical record revealed that he/she was readmitted on [DATE]. His/her BIMS (Brief Interview for Mental Status) score was 14, which indicated he/she was cognitively intact. A review of progress notes revealed no supporting documentations that a care plan meeting occurred, and a copy of the baseline care plan summary was provided to Resident #48 and/or the resident representative. On 03/06/25 at 8:35 AM, in an interview with the Social Worker (SW), she described that when scheduling a care plan meeting, the facility notified the residents and the resident representatives either by placing a call or by talking to them personally. She stated that the facility conducted a baseline care plan meeting within 72 hours. She verified Resident #48's medical record for any documentation related to any care plan meetings and confirmed that there were none. On 03/06/25 at 8:42 AM, the Director of Nursing (DON) was made aware of the concern. On 03/07/25 at 11:49 PM, the DON confirmed that the facility had no records of the signature sheet for the baseline care plan meeting that occurred on 3/14/24. 51790 2) On 03/05/25 at 01:00 PM a record review of Resident #8 ' s 48-hour baseline care plan revealed that there was no signature documented for the Resident or their representative. On 03/07/25 at 09:40 AM, an interview with the Administrator confirmed that she could not locate a signed copy of the baseline care plan nor confirm that the resident and or resident representative received a copy of Resident #8 ' s baseline care plan.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50502 Based on record review and interview, it was determined that the facility failed to develop, implement and update a comprehensive care plan to include 1) smoking, 2) the residents' functional abilities and 3) the residents' use of anti-psychotic medications. This was evident for 2 (Resident #58 and #57) of 44 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. 1) On 03/04/25 at 10:52 AM, a review of the smoking policy dated 10/30/22 and reviewed on 10/27/23 indicated the following: Any resident who is deemed safe to smoke, with or without supervision, will be allowed to smoke in designated areas, at designated times, and in accordance with his/her care plan. All safe smoking measures will be documented on each resident's care plan and communicated to all staff, visitors and volunteers who will be responsible for supervising residents while smoking. Supervision will be provided as indicated on each resident's care plan. If the resident or family does not abide by the smoking policy or care plan, the plan of care may be revised to include additional safety measures. On 03/04/25 at 11:26 AM, a review of Resident #58's smoking assessment dated [DATE], confirmed that he/she was a current smoker and that he/she preferred smoking cigarettes. On 03/04/25 at 12:05 PM, a review of Resident #58's medical record revealed a care plan that was initiated on 11/21/2024, which indicated has coronary artery disease(CAD) related to Hypertension, smoking. The care plan did not specify smoking and was not updated to reflect the interventions related to smoking. On 03/04/25 at 6:46 PM, a review of the Social Worker's progress notes dated 1/7/2025 revealed that Resident #58 is current smoker and has demonstrated noncompliance with the facility's smoking policies. The resident has declined offers for smoking cessation support, including nicotine patches, and does not wish to commit to quitting smoking. Care plans are being implemented and will be revised as needed, however, the smoking care plan was not developed, implemented and revised to reflect the noncompliance to the smoking policy. On 03/05/25 at 8:27 AM, in an interview with the Director of Nursing (DON), she stated that care planning was done by the Interdisciplinary Team (IDT) and that she updated most of the care plans. She was made aware that Resident #58 had no smoking care plan. She confirmed the findings and stated that she would make the necessary changes/ updates to the resident's care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/05/25 at 12:19 PM, the Nursing Home Administrator (NHA) was notified of the concern. On 03/05/25 at 7:16 PM, a review of Resident #58's medical record revealed that a new care plan was added on 03/5/25 related to smoking and non- compliance to smoking policy. 50504 Resident # 57 was admitted to the facility with diagnoses including Vascular Dementia, Mild, with Agitation and Cognitive Communication Deficit 2) On 03/04/25 at 06:18 PM a review of Resident#57's care plan initiated on 10/1/24 stated The resident is (Specify: independent/ dependent on staff etc.) for meeting emotional, intellectual, physical, and social needs r/t (if dependent) Cognitive deficits, Immobility. Goal: The resident will maintain involvement in cognitive stimulation, social activities as desired through review date 4/08/2025. The care plan failed to reveal whether Resident #57 was independent or dependent 3) Further review of resident's medical record revealed that resident was prescribed antipsychotic medication Quetiapine (Seroquel) for agitation and anxiety since September 2024. There was no evidence in the clinical record to show that a care plan was initiated to address the resident's use the anti-psychotic medication. On 03/07/25 at 08:10 AM in an interview, the Unit Manager Staff #2 stated that a care plan was not developed to meet the resident's needs and confirmed that a care plan should have been in place to address the resident's use of antipsychotic medication Seroquel. On 03/07/25 at 08:26 AM the surveyor notified the Director of Nursing of the findings.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49815 Based on record review and interview, it was determined that the facility failed to 1) revise the resident's comprehensive care plan, 2) hold care plan meetings, 3) Reassess the effectiveness of the care plan approaches and 4) have quarterly care plan meetings with the Interdisciplinary Team. This was evident for 5 (Resident #27, #48, #58, #52 and #46) of 44 residents reviewed for care plan timing and revision during the recertification survey. The findings include: An arteriovenous (AV) fistula shunt is a surgical procedure that creates a direct connection between an artery and a vein. This allows blood to flow from the high-pressure artery into the low-pressure vein, increasing blood flow in the vein. AV fistula shunts are primarily used to provide long-term vascular access for hemodialysis, a treatment for chronic kidney disease. According to CMS (Centers for Medicare and Medicaid Services), a care plan meeting is a structured, interdisciplinary conference where staff, residents, and families discuss and review the resident's care plan, ensuring needs are met and goals are achieved. 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. 1) During the initial tour of the nursing unit on 03/03/25 at 08:30 AM the surveyor observed Resident #27 with an AV fistula shunt to the left upper arm. Resident #27 stated that he/she goes to dialysis every Tuesday, Thursday and Saturday. The surveyor conducted a record review of Resident #27's medical record at 11:45 AM on 03/5/25. Review of the medical record revealed that Resident #27 had a care plan for 11 staples in the left forearm area and 10 staples in the left arm fistula site with an initiation date of 10/21/24. The care plan had a revision on date of 01/06/25; however, this problem remained on the care plan and was still on the care plan as of the record review date by the surveyor. An interview was conducted with the Director of Nursing (DON) on 03/10/25 at 9:05 AM. The surveyor conveyed to the DON that Resident #27 had a care plan dated 10/21/24 for staples to the left forearm and the left arm AV fistula shunt with a revision date of 01/06/25, and that this problem was still on the care plan. The DON acknowledged the surveyor. No additional information was provided by the facility at the time of exit. 50502 2) On 03/03/25 at 8:52 AM, Resident #48 stated that he/she has not been involved in any care plan meetings. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/06/25 at 8:21 AM, a review of Resident #48's medical record revealed that he/she was readmitted on [DATE]. His/her BIMS (Brief Interview for Mental Status) score was 14, which indicated he/she was cognitively intact. A review of progress notes revealed no supporting documentations that care plan meetings occurred for Resident #48. On 03/06/25 at 8:35 AM, in an interview with the Social Worker (SW), she described that when scheduling a care plan meeting, the facility notified the residents and the resident representatives either by calling or by talking to them personally. She added that starting March of this year, she started sending meeting notifications. She stated that she scheduled the meeting according to cycle or to the Assessment Reference Date (ARD) of the Minimum Data Set (MDS) schedule and for new admissions, she stated that the facility conducted a baseline care plan meeting within 72 hours. She checked Resident #48's medical record for any documentation related to any care plan meetings and she confirmed that there were none. On 03/06/25 at 8:42 AM, the Director of Nursing (DON) was made aware of the concern. On 03/07/25 at 11:49 PM, the DON confirmed that the facility had no record to prove that care plan meetings were held for Resident #48. 3) On 03/04/25 at 3:05 PM, a review of Resident #58's medical record revealed that he/she was readmitted on [DATE]. Also, the medical record indicated that a care plan was initiated on 11/23/2024 which stated, uses antidepressant medication Seroquel related to Depression, however, the resident was not on Seroquel (a type of medication used to treat mental health conditions.) On 03/05/25 at 8:27 AM, in an interview with the DON, she stated that care planning was done by the Interdisciplinary Team (IDT) and that she updated most of the care plans. She was made aware that the care plan of Resident #48 for psychotropic medication was not updated. She confirmed the findings and stated that she would make the necessary changes/ updates to the resident's care plan. 51491 4) During a telephone interview with the Legal Guardian for Resident #52 on 03/03/25 at 4:08 PM, it was revealed Resident #52 had not attended any recent care plan meetings and the guardian felt a Care Plan meeting could have been beneficial for the Resident. During a review of Medical Records on 03/03/25 at 7:37 PM it was discovered that Resident #52 required total care from the facility and the last Care Plan Meeting was 7/17/24. The attendees for the meeting included the resident, legal guardian, nursing, and activities. During a review of Resident #46 Medical Records on 03/04/25 at 6:27 PM it was discovered that Resident #46 required total care from the facility and the last Care Plan Meeting was 7/31/24. The attendees included the Resident, nursing, rehab, activities, and social services. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Social Worker on 03/05/25 at 9:16 AM she advised she has only been with the facility for 3 months and doesn ' t think care plan meetings are caught up. She reports when the meetings are completed she puts a note in the Social Services electronic medical records. She confirmed Residents #52 and #46 had not had a recent Care Plan Meeting. She reported the staff that would usually attend would include the nurse manager, Director of Nursing, Director of Rehab, and dietician.

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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** 37296 Based on record review and interviews, it was determined that the facility failed to ensure that residents who required assistance with Activities of Daily Living (ADL) were 1) provided with showers and 2) properly groomed. This was evident for 3 (Resident #335, #12 and #53) of 44 residents reviewed during the recertification survey. 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. 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 Minimum Data Set (MDS) is a federally mandated assessment tool used to evaluate the health status of residents in nursing homes. The information collected helps nursing home staff identify health problems and develop individual care plans for residents. 1) A review of MD00210657 from October 2024 revealed an allegation that Resident #335 only had two showers in four months since their admission in July 2024. A review of the MDS, with an assessment reference date of 08/02/24, revealed that Resident #335 needed maximal assistance with showers. On 03/03/24 at 8:32 AM, the surveyor requested the shower task sheet for July 2024 to October 2024 for Resident #335. On 03/4/24 at 10:06 AM, an interview with the Director of Nursing (DON) revealed she was able to provide documentation of showers for Resident #335 for 09/11/24 and 9/18/24. The surveyor reviewed the concern regarding the facility's failure to ensure that a resident needing assistance with ADLs was receiving regularly scheduled showers. 50504 2) On 03/03/25 at 09:03 AM the surveyor observed Resident #12 sitting on his/her bed with fingernails on both hands approximately 1/2 inch long. The resident's fingernails were visibly dirty with a dark substance under them. The resident's right thumb nail appeared broken with jagged edges. On 03/04/25 at 01:00 PM a second observation by the surveyor revealed the Resident# 12's fingernails remained uncut and dirty. The resident stated he/she needed assistance to trim his/her fingernails. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/05/25 at 07:24 AM the surveyor reviewed the Resdent #12's care plan which was initiated on 9/23/19. The care plan stated Resident #12 is at risk for decreased ability for ADL self-care performance r/t Schizophrenia, Extra-pyramidal/movement disorder. On the care plan there was an intervention which stated BATHING/SHOWERING: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. 3) On 03/03/25 at 11:07 AM the surveyor observed Resident #53 sitting in a wheelchair in the dining room. The resident's fingers on both hands were contracted and bent towards his/her palms. Resident #53's fingernails were approximately 1/2 inch long and visibly dirty with a brown substance under the fingernails. On 03/05/25 at 10:14 AM a review of Resident #53's MDS annual assessment dated [DATE], Section GG revealed that the resident was dependent on staff for ADls. On 03/06/25 at 10:35AM in an interview with Staff #11, the surveyor expressed concern regarding the condition of Resident #12 and Resident #53 fingernails. The surveyor accompanied Staff #11 to both residents' rooms where the findings were confirmed. Staff #11 stated that there was no schedule for cutting the residents' fingernails and that it was the responsibility of the Geriatric Nursing Assistants to ensure the residents' fingernails were clean and trimmed. Staff #11 stated, there is room for improvement On 03/06/25 at 10:46 AM the Director of Nursing was notified of the surveyor's findings.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide activities to meet all resident's needs. 50504 Based on observations, record review and interview, it was determined that the facility failed to implement an ongoing resident centered activities program designed to meet the interests and support the physical, mental and psychological well-being of each resident. This was evident for all residents. The findings include: On 03/04/25 at 11:00AM and 03/05/25 at 10:40AM, the surveyor observed residents sitting in the hallways, sitting in the dining room areas without supervision, and walking around common areas in the nursing units. The surveyor observed no forms of activities or engagement in the units, the dining room, nor in the common areas. On 03/05/25 at 8:11AM a review of the list of the facility's key personnel, which was provided to the surveyor by the Administrator, revealed that the position of Activities Director was vacant. On 03/05/25 at 1:04PM the surveyor interviewed Activities Assistant, Staff # 8 who stated that she was employed by the facility from September 2024 on a part-time basis for 20 hours per week including every other weekend. Also, there was another part-time activities staff who work on alternate weekends. Staff #8 stated that the Activities Director resigned in November 2024 and since then, the facility had not filled the position. Further, on her days off, Thursdays and Fridays, there is no activity staff available to engage the residents in activities. The facility does not maintain an activity participation log and activities are not documented. Activities are not provided for residents who stay in their rooms and need one-on-one interaction with the activity staff. On 03/06/25 at 8:18AM in an interview, the Administrator stated that a new Activities Director was hired and would assume duties on March 17th, 2025. The Administrator confirmed that since the Activities Director left in November 2024, no formal activities were provided for the residents when the part time assistants were off two days per week and there was no full-time activities staff. Further, no activities were provided for vulnerable residents who require 1:1 visit. The Administrator started the truth is, I do not have the staff. The Administrator stated that she experienced difficulties filling the position of Activities Director and she reached out to her corporate office for an Interim Activities Director but was not successful in obtaining one.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 49815 Based on observations, medical record reviews, and interviews, it was determined the facility failed to 1) document the delivery of daily wound care to a resident with a pressure ulcer and 2) implement recommendations made by the wound care team to treat pressure ulcers. This was evident for 2 (Resident #28 and #23) of 2 residents evaluated for pressure ulcer care. The findings include: A pressure ulcer, also known as a bed sore or decubitus ulcer, is a localized area of skin damage that develops when prolonged pressure or shear forces disrupt blood flow to the tissues resulting in damage to the underlying tissue. Pressure ulcers are staged based on their severity from Stage I (area of persistent redness), Stage II (superficial loss of skin such as an abrasion, blister, or shallow crater), Stage III (full-thickness skin loss involving damage to subcutaneous tissue presenting as a deep crater) or Stage IV (full thickness skin loss with extensive damage to muscle, bone or tendon). 1) During the initial tour of the facility at 08:20 AM on 03/03/25 the surveyor observed Resident #28 lying in bed on a specialized pressure-relieving air mattress. Resident #28 stated that the air mattress provided relief for the wound on the back. The Medication and Treatment Administration Record (MAR/TAR) is a record used to keep track of every dose of medication or treatment that a Resident is administered. The MAR and TAR includes key information about the Resident's medication and treatment including the name, dose taken, special instructions and date and time. The surveyor conducted a record review of Resident #28's medical record on 03/04/25 at 12:59 PM. The review of the medical record revealed that Resident #28 had a physician order for daily treatment for a wound on the sacrum (buttock). Further review of the medical record, specifically the February 2025 and March 2025 treatment administration record (TAR), revealed that there was no documentation that the daily wound treatment was being provided to Resident #28 by the nursing staff. At 09:40 AM on 03/05/25 the surveyor interviewed the Director of Nursing (DON) and asked the DON if Resident #28 had a pressure ulcer on the sacrum. The DON stated yes. The surveyor conveyed to the DON that there was a physician order for daily treatment of the sacral wound but there was no documentation on the February 2025 and March 2025 MAR/TAR that the wound care was provided. The Director of Nursing (DON) reviewed the MAR/TAR for Resident #28 and acknowledged that there was no documentation on the February 2025 and March 2025 MAR/TAR for the daily treatment of the sacral wound. The DON stated that the physician order must have not transferred to the MAR/TAR for wound care and that she would take care of this. 51491 2) During an interview with Resident #23 on 03/03/25 at 10:53 AM he/she reported having pressure ulcers and said They are not getting better. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevalon Boots wrap around the foot and ankle. They have a cushioned bottom that floats the heel off the surface of the mattress, helping to reduce pressure. The Boot stays in place for continuous pressure relief. During a Medical Record review on 03/03/25 at 7:42 PM it was revealed that Resident #23 had unhealed pressure ulcers present upon his/her admission on 12/23/24. A nursing progress note dated 12/23/24 showed there was a Deep Tissue Injury to the Resident ' s right heel, a Stage 3 pressure ulcer to the left buttock, and a Stage 3 pressure ulcer to the right buttock. Further review showed Resident #23 had been seen by a Wound Care Provider once a week from 01/10/25 to 03/06/25. Each Progress note from the Wound Care Provider documented, Wound care was discussed with staff at the time of the visit, and The patient continues on an alternating air/low air loss mattress for pressure redistribution. Ensure settings are maintained at an appropriate level based on the patient ' s needs and body habitus and Float heals while in bed with use of Prevalon Boots. During an interview with Licensed Practical Nurse (LPN) #25 on 03/10/25 at 10:10 AM, it was discovered that the Resident does not have any Prevalon boots or an air mattress because there is no order for them. The LPN stated the Doctor or Nurse Practitioner would put an order into the computer for them to be provided. During an interview with Geriatric Nursing Assistant (GNA) #13 on 03/10/25 at 10:52 AM she advised the Resident does not have any boots to wear in the bed and confirms the mattress is not an air mattress. During an observation with LPN #25 and the Maintenance Director, on 03/10/25 at 11:00 AM they confirmed the mattress is a standard mattress and not an air mattress. During an interview with the Director of Nursing (DON) on 03/10/25 at 11:02 AM she reported the resident should have the Prevalon boots and an air mattress as recommended in the Wound Care Progress notes. She advised the order should be placed when the wound care provider tells the nurses and the nurse would put the order into the Resident ' s chart. During an observation on 03/10/25 at 12:05 PM the Maintenance Director had removed the standard mattress and was replacing it with an air mattress.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 50504 Based on observation, record review and interview, it was determined that the facility failed to provide the prescribed treatment for limited mobility. This was evident for 1 (Resident #53) of 1 resident reviewed for positioning and mobility during the recertification survey. The findings include: A splint is a medical device that stabilizes part of the body and holds it in place. Healthcare providers use them to protect and support the body after an injury or to treat certain health conditions On 03/03/25 at 11:07 AM the surveyor observed Resident # 53 sitting in a wheelchair in the dining room. The resident's fingers were contracted on both hands and bent towards his/her palms. Resident #53's fingernails were approximately 1/2 inch long and visibly dirty with brown substance under the fingernails. The resident was not wearing a splint on either hand. The resident stated that his/her contractures were caused by arthritis of the hands. On 03/05/25 at 10:14 AM a review of Resident #53's clinical record revealed an active physician's order dated 01/12/24 which stated R hand splint - h/o scleroderma with severe R hand pain. No directions specified for order. A review of Resident #53's Medication Administration Record and Treatment Administration Record (MAR/TAR) revealed no evidence of the Right-hand splint, ordered by the physician, ever being applied to the resident's right hand. The surveyor also noted that there was no clarification of the order to indicate specific directions for the use of the Right-hand splint. On 03/06/25 at 10:35 AM in an interview Staff#11 confirmed that a physician order for a Right-hand splint was documented in the Resident #53's clinical record. However, she was unaware of the order because it was not transcribed on to the MAR/TAR. Staff #11 accompanied the surveyor to the Resident #53's room, looked at both hands and confirmed the surveyor's findings. 03/06/25 at 10:46 AM the Director of Nursing was notified of the findings.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. 42886 Based on medical record review and staff interview, it was determined that the facility failed to provide adequate management of a resident's Intravenous antibiotic schedule. This was evident for 1 (Resident #324) of 44 resident reviewed during the recertification survey. The findings include: A review of Resident #324's medical records on 03/04/25 at 12:26PM revealed that the resident was ordered Intravenous (IV) antibiotics once a day for 6 weeks from 1/19/23 to 03/18/23 to prevent infection. Further review of resident 324's medical record on 03/04/25 at 12:40PM revealed that the resident was seen by Maximed Associates Inc on 02/01/23 to ensure that the IV antibiotics were affective at preventing infection. Maximed Associates recommended that the resident be given an MRI (a type of diagnostic test that creates detailed images of structures and organs in the body) one week prior to completing the IV antibiotics to determine if the resident needed to prolong IV antibiotics administration. Continued review of Resident #334's medical record on 03/04/25 at 1:00PM revealed that there was no evidence that the resident received the MRI prior to completing the IV antibiotics treatment on 03/04/23. An interview with the Director of Nursing (DON) on 03/04/23 at 1:15PM confirmed that Resident #324 should have received the MRI prior to completing the IV antibiotics treatment on 03/04/23. The DON also confirmed that the facility failed to provide Resident #324 with an MRI necessary for his/her IV antibiotic treatment.

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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. 49815 Based on observation, record review and interview, it was determined that the facility failed to follow appropriate respiratory care and services. This was found to be evident in 1 (Resident #28) of 1 resident reviewed for respiratory care and services during the recertification survey. The findings include: On tour of the Nursing Unit on 03/03/25 at 09:50 AM the surveyor observed Resident #28 with oxygen in use. Further observation revealed an oxygen cannula in the Resident's nostrils and an oxygen humidifier bottle and oxygen tubing attached to the oxygen concentrator without a date on the tubing and without a date on the humidifier bottle. The surveyor interviewed Resident #28's Nurse #5 on 03/04/25 at 12:42 PM. The surveyor asked Nurse #5 what the expectation was for dating and labeling oxygen tubing and oxygen humidifier bottles. Nurse #5 stated that the oxygen tubing and the humidifier bottle were to be labeled and dated by the night shift. Nurse #5 observed the oxygen tubing, and the oxygen humidifier bottle not dated for Resident #28, and Nurse #5 stated that she would take care of it. The surveyor conducted a record review of Resident #28's medical record on 03/05/25 at 7:15 AM. The medical record review revealed that Resident #28 had current physician orders for oxygen and an order to change the oxygen tubing every 7 days on the night shift. Further review of the medical record revealed that Resident #28 had a care plan for oxygen therapy related to respiratory illness. In addition, the surveyor reviewed the facility's oxygen administration policy and procedure dated 10/31/21 that was provided by the Director of Nursing (DON). The policy guidelines were to change the oxygen tubing/cannula weekly and as needed, and to change the oxygen humidifier bottles when empty or every seventy-two hours. The surveyor interviewed the Director of Nursing (DON) on 03/05/25 at 09:40 AM and reviewed Resident #28's oxygen usage. The surveyor asked the DON what the expectation was for dating/labeling of oxygen tubing and oxygen humidifier bottles when Residents use oxygen. The DON stated that the oxygen tubing and oxygen humidifier bottles were to be changed/labeled weekly. The surveyor conveyed to the DON that Resident #28 had oxygen in use and the oxygen tubing, and the oxygen humidifier bottle were not dated/labeled. In addition, the surveyor conveyed to the DON that Nurse #5 was notified and observed the oxygen tubing and the oxygen humidifier bottle not dated/labeled for Resident #28. At the time of survey exit, no additional information was provided on respiratory care and oxygen usage by the facility.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 51790 Based on record review and interview, it was determined that the facility failed to ensure annual performance evaluations and skill assessments were completed. This was found to be evident for 2 (#3 and #6) of 5 Geriatric Nurse Assistants (GNAs) reviewed for Sufficient and Competent Nurse Staffing. The findings include: On 03/07/25 at 11:54 AM, a record review of employee files showed that GNA #3 did not have an annual performance evaluation in her chart. It was also found that there was not a skills competency assessment completed for GNA #6. During an interview on 03/10/25 at 8:41 AM conducted with the Administrator, she confirmed that based on GNA #3 ' s hire date, she should have an annual performance completed in her file. It was also confirmed by the Administrator that GNA #6 should have a record of a skills competency assessment completed. The Administrator explained that she would check with the Director of Nursing (DON) to locate these records, and report back if anything was found. On 03/10/25 at 10:00 AM, this surveyor received written confirmation from the Administrator that there were not any records found for a performance evaluation for GNA #3 nor a skills competency assessment for GNA #6.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. 50504 Based on record review and interview, it was determined that the facility failed to monitor the behaviors of residents receiving anti-psychotropic medications. This was evident for 1 (Resident #57) of 1 resident reviewed for Dementia care. The findings include: Psychotropic medications are drugs that affect the brain and central nervous system, altering mood, thoughts, perceptions, and behaviors. They are primarily used to treat mental health conditions, such as anxiety, depression, schizophrenia, and bipolar disorder. Resident # 57 was admitted to the facility with diagnoses including Vascular Dementia, Mild, with Agitation and Cognitive Communication Deficit On 03/04/25 at 6:18PM a review of Resident #57's active medication orders revealed that the resident was placed on anti-psychotic medication Quetiapine (Seroquel) for anxiety on 09/11/24 and for agitation at bedtime from 09/27/24. Further review of Resident#57's clinical record revealed no evidence that the resident's behaviors were monitored, neither was there a physician order or a care plan to address the resident's behaviors. On 03/05/25 at 11:33 AM, a review of the facility's Psychotropic Medication Use policy revealed that Drugs in the following categories are considered psychotropic medications and are subject to prescribing, monitoring and review requirements specific to psychotropic medications: a. Antipsychotics b. Antidepressants c. Antianxiety d. Hypnotics On 03/07/25 at 08:10 AM in an interview, the Unit Manager Staff #2 stated that all residents on anti-psychotropic medications are monitored by the facility for behaviors to assess the effectiveness of the medications and care plans are initiated. Staff#2 checked the electronic health record of Resident #57 and confirmed that the resident's behaviors were not monitored, and a care plan was not initiated for anti-psychotic medication use. On 03/07/25 at 08:26 AM the surveyor notified the Director of Nursing of the findings.

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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** 50502 Based on record review and interview, it was determined that the facility failed to provide adequate behavior monitoring for resident on psychotropic medications. This was evident for 1 (Resident #58) of 4 residents reviewed for unnecessary medications during the recertification survey. The findings include: Psychotropic medications are drugs that affect the brain and central nervous system, altering mood, thoughts, perceptions, and behaviors. They are primarily used to treat mental health conditions, such as anxiety, depression, schizophrenia, and bipolar disorder. On 03/04/25 at 3:05 PM, a review of Resident #58's medical record revealed that he/she was readmitted on [DATE]. His/her BIMS (Brief Interview for Mental Status) was completed on 02/17/25 with a score of 15/15 which indicated that he/she was cognitively intact. A review of Resident #58's active physician orders revealed that he/she was on the following psychotropic medications: 1. Aripiprazole Oral Tablet 2 MG (Aripiprazole) Give 2 mg by mouth one time a day for depression. 2. Clonazepam Oral Tablet 0.5 MG (Clonazepam) Give1 tablet by mouth at bedtime for anxiety. 3. Duloxetine HCl Oral Capsule Delayed Release Sprinkle 20 MG (Duloxetine HCl) Give 1 capsule by mouth one time a day for depression/suicide ideation. Give together with 60mg to equal 80mg. 4. Duloxetine HCl Oral Capsule Delayed Release Sprinkle 60 MG (Duloxetine HCl). Give 60 mg by mouth one time a day for suicidal ideation. 5. Escitalopram Oxalate Oral Tablet 20 MG (Escitalopram Oxalate) Give 20 mg by mouth one time a day for major depressive disorder. 6. Lisdexamfetamine Dimesylate Oral Capsule 40 MG (Lisdexamfetamine Dimesylate) Give 1 capsule by mouth one time a day for depression. 7. Trazodone HCl Oral Tablet 50 MG (Trazodone HCl)Give 1 tablet by mouth at bedtime for depression. On 03/05/25 at 7:59 AM, in an interview with Licensed Practical Nurse (LPN #1), he/she confirmed that the facility had no tools or processes for behavior monitoring for residents on psychotropic medications. On 03/05/25 at 8:36 AM, during an interview with the Director of Nursing (DON), she stated that the facility had behavior monitoring tool in the Treatment Administration Record (TAR). However, after she reviewed the electronic medical record of Resident #58, she confirmed that there was no evidence that behavior monitoring was provided. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/05/25 at 11:33 AM, a review of the facility's Psychotropic Medication Use policy revealed that Drugs in the following categories are considered psychotropic medications and are subject to prescribing, monitoring and review requirements specific to psychotropic medications: a. Antipsychotics b. Antidepressants c. Antianxiety d. Hypnotics On 03/06/2025 at 7:56 AM, a review of Resident #58's new physician orders revealed that, after surveyor intervention, a behavior monitoring every shift was written on 03/05/2025 at 4:47 PM.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 51491 Based on observations, interviews, and record reviews it was determined that the facility failed to ensure medications were properly stored and labeled. This was evident for 2 of 2 medication carts observed for medication storage. The findings include: During an observation of the Potomac Hall medication cart on 3/04/25 at 11:39 AM with Licensed Practical Nurse (LPN) #5 it was revealed to contain expired medications. The following medications were found: Oxycodone 5 mg Tablets had expired on 12/05/24 for Resident #25. Two boxes of Albuterol Sulfate Inhalation Solution vials 0.083% 2.5mg/3mL had expired February 2025 for Resident #36. During an observation of the Chesapeake Hall medication cart on 03/04/25 at 1:59 PM with LPN #1 it was revealed to contain expired, unrefrigerated, and undated open medications. The following medications were found: An Insulin Lispro Injection 100 unit/mL vial is unopened, not dated, or refrigerated for Resident #11. A Lantus Solostar 100 unit/mL pen is opened with no opening date for Resident #11. A Basaglar Injection 100 unit pen is unopened, not dated or refrigerated and the packaging says to refrigerate for Resident #45. Percocet Tablets 5-325mg expired on 7/10/24 for Resident #40. Percocet Tablets 5-325 mg expired on 2/12/24 for Resident #40. During an interview with the Director of Nursing (DON) on 03/04/25 at 2:39 PM she advised the expectations for medications are that nurses should remove them from the cart when they are expired, or the resident is discharged . She added Insulin should be kept in the refrigerator until ready to be used and then dated when removed per policy. During a review of the Storage of Medications Policy on 03/05/25 at 10:32 AM it identified Nursing staff as being responsible for maintaining medication storage. The policy stated, Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed and it advised medications requiring refrigeration are stored in a refrigerator in the drug room. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the Discarding and Destroying Medications Policy on 03/06/25 at 09:24 AM, it stated Disposal of controlled substances must take place immediately (no longer than three days) after discontinuation by the resident.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. 51790 Based on interview and record review, it was determined that the facility failed to ensure that residents who require dental services on a routine basis receive the recommended dental service in a timely manner. This was evident in 2 (Resident #9 and #12) of 2 residents reviewed for Dental services. The findings include: 1) On 03/03/25 at 04:50 PM during an interview with Resident #9 ' s family member, he/she reported that during the most recent care plan meeting it was discussed that Resident #8 had not seen a dentist in about a year ago. The family member reported that he/she recalled the social worker reported to him/her that an appointment had been made for the dentist to visit Resident #9. However, he/she still did not know when that appointment would be. According to the Centers for Medicare and Medicaid Services, the definition of care planning is Establishing a course of action with input from the resident (resident ' s family and/or guardian or other legally authorized representative), resident ' s physician and interdisciplinary team that moves a resident toward resident-specific goals utilizing individual resident strengths and interdisciplinary expertise; crafting the ' how ' of resident care. A care plan meeting/conference should involve the resident and/or the resident ' s representative if they wish, and the interdisciplinary team. On 03/04/25 at 12:09 PM, a record review of Resident #9 showed a Care Plan Meeting Note for a Care Conference that was held on 06/05/24. It stated, resident's RP [representative] requested for a dental appointment for this resident. On 03/04/25 at 12:38 PM, an interview with the Social Worker was conducted. During the interview, it was confirmed that if a request for services, such as dental, is brought up during care plan meetings, it is the responsibility of the nurse in attendance to follow up with scheduling such services. During an interview conducted on 03/04/25 at 12:48 PM with Registered Nurse (RN) #11, it was confirmed that the nurses attending the care plan meetings are responsible for contacting the doctors to set up appointments. She explained that the nurse would call the doctors, and the doctor would place an order for the needed service, such as dental. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/04/25 at 01:01 PM, an interview with the Unit Manager #2 was conducted, in which we discussed the process for residents getting services, such as dental. She reported that once a resident stated to the nurse that they need a specific service, the process is that a nurse would notify the physician, the physician would then assess the resident and put in a consult to be seen by a dentist (or whatever service is needed). The nurse would then see the (dental) consult in the resident ' s chart, then she would go into a shared drive with HealthDrive services and put in the information to request that this resident required dental services. She explained that HealthDrive is a company that provides services such as dental, podiatry, and ophthalmology to residents, on a twice a month basis. She further explained that the next time HealthDrive would visit the facility, that HealthDrive would then have a list of the residents and the services that they need (such as: dental, podiatry, ophthalmology, etc). On 03/04/25 at 01:38 PM, a record review of HealthDrive List from June 2024 to March 2025 showed there was not a dental consult for Resident #9. On 03/06/25 at 08:22 AM an interview was conducted with the Social Worker. She reported that she is in attendance to the care plan meetings, ensures the attendance sheet is filled out, and writes the notes for the meeting. She reported that she believed she was in attendance for Resident #9 ' s last care plan meeting and had taken notes. At this time, documents were requested for Resident #9 ' s most recent care plan meeting attendance sheet and the notes for that meeting. On 03/06/25 at 09:11 AM, a record review of Resident #9 ' s most recent care plan meeting attendance sheet for 02/20/25 showed that Resident #9 ' s family member/resident representative was in attendance for this meeting. The notes for this meeting stated, wants Dental *chewing issue. On 03/06/25 at approximately 10:00 AM, during an interview with the Social Worker it was communicated that there was a concern that Resident #9 had not received dental services, though it had been discussed during two separate care plan meetings, for 06/05/24 and 02/20/25. 50504 2) On 3/03/25 at 9:10AM during an interview Resident #12 stated that he/she had not seen a dentist and would like dentures. On 03/5/25 at 7:24AM a review of the resident's clinical record revealed an active physician order dated 2/24/21 which stated Annual Dental Exam every 12 months starting 21st day for dental exam. Further review of Resident #12's clinical record failed to reveal the resident was seen by a Dentist. On 03/06/25 at 11:30 AM in an interview with the surveyor, the Director of Nursing (DON) was asked about the process for ensuring dental appointments were kept. The DON stated that after a physician's order is obtained, the Charge Nurse would make the necessary arrangements for the resident to be seen by a dentist. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor informed the DON that a review of the resident's clinical record failed to reveal that Resident #12 was seen by a dentist in keeping with the physician's order. The DON reviewed the electronic record and gave the surveyor documentation of a visit by the Resident #12 to the dentist on 10/12/22. The document stated that the resident was not seen by the dentist because the appointment was due on 3/24/23. The DON informed the surveyor that the document was the only record she could find in the resident's electronic record regarding the resident's appointment. However, she would arrange for Resident #12 to see a dentist.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 50502 Based on observation and interview, it was determined that the facility failed to ensure that food was delivered to residents at an appropriate and palatable temperature. This was evident for 1 out of 1 observation of test tray temperatures. This practice has the potential to affect all residents who eat food prepared by the facility. The findings include: On 03/04/25 at 11:57 AM, the surveyor conducted a lunch tray line observation and requested the Certified Dietary Manager (CDM) to include a test tray on the last cart that was going to the unit. Six dietary aids were observed preparing a total of 4 meal carts. The first cart was brought out to the dining room and the last cart was completed at 12: 34PM. On 03/04/25 at 12:38 PM, the surveyor and the CDM followed the last cart that was brought out to the unit to conduct the test tray. The cart was parked in one area in the hallway while the nursing staff were walking back and forth to the cart and to the residents' rooms until the last tray was distributed at 12:55 PM. The CDM proceeded to test the food on the test tray using the facility's food thermometer. The temperatures were as follows: Potato-134.6 F Carrots-134.7 F Chopped steak-136 F Dessert: pudding-48.5 F The CDM was informed of the concern and confirmed that the facility was expected to serve hot food items at 135 F and 41 F for cold food items. On 03/05/25 at 8:05 AM, during an interview with Licensed Practical Nurse Staff #1, she stated that the nursing staff were expected to distribute the meal trays as soon as the meal carts were brought to the floor. On 03/05/25 at 8:45 AM, the Director of Nursing was made aware of the food temperature concern.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50502 Based on observation and staff interview, it was determined that the facility failed to store and label food item to maintain the integrity of the specific item. This was evident during the initial tour of the kitchen. This deficient practice has the potential to affect all residents. The findings include: On 03/03/25 at 8:13 AM, the surveyor conducted an initial tour of the kitchen with the assistance of the Certified Dietary Manager (CDM). The surveyor observed 1 large carton (approximately 0.5 gallon) of an opened lactose free milk inside the kitchen refrigerator. The carton had a letter R and 2/12/25 written on it using a black permanent marker, however, it did not contain any label as to when the item was opened and when the contents should have been used. The CDM stated that for dairy food items, the facility had 7 days to discard the item from the time it was opened. He confirmed the carton had no label and took it out from the refrigerator and discarded it in the trash bin. On 03/03/25 at 9:00 AM, the CDM followed the surveyor on the unit and verified that letter R meant received and indicated that the milk was received on 02/12/25. The surveyor informed the CDM that the carton had no date when the milk was actually opened. On 03/05/25 at 8:45 AM, the Director of Nursing (DON) was made aware of the concern.

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. 42783 Based on review of Administration documents and interviews it was determined that the facility failed to obtain a Transfer agreement to the local hospitals. This was found to be evident for 1 out of 1 Dialysis Agreement document reviewed during the Extended Survey. The findings include: A written agreement outlines the arrangements between an End Stage Renal Dialysis (ESRD) facility and a nursing home. The agreement establishes a connection between both entities and fosters accountability that is vital to patient health and the success of the care plan. The ESRD facility should collaborate with the nursing home to develop and implement protocols for the delivery of dialysis services, and to the extent possible, ensure that nursing home dialysis patients are provided with the same standard of care as dialysis patients receiving treatments in a dialysis facility. During a review of the Administration documents conducted on 03/06/25 at 11:09 AM, it was determined that there was not a Dialysis Agreement within the documents provided. During an interview conducted on 03/06/25 at 12:05 PM, the Administrator stated that she was unable to locate the Dialysis Agreement but was actively searching and would let this surveyor know if she was able to locate it. During a phone interview conducted on 03/12/25 at 1:04 PM, the Administrator advised she had reached out to the Dialysis Service Provider Fresenius however she had not received an agreement. She further stated that she was currently in the process of working with Davita Dialysis to obtain an agreement.

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F 0843 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have an agreement with at least one or more hospitals certified by Medicare or Medicaid to make sure residents can be moved quickly to the hospital when they need medical care. 42783 Based on review of Administration documents and interviews it was determined that the facility failed to obtain a Transfer agreement to the local hospitals. This was found to be evident for 1 out of 1 Transfer Agreement document reviewed during the Extended Survey. The findings include: A nursing home transfer agreement with a local hospital ensures smooth and timely transfers for residents needing hospital care, including medical information exchange and a plan for emergency situations. During a review of the Administration documents conducted on 03/06/25 at 11:09 AM, it was determined that there was not a Transfer Agreement with the local hospitals within the documents provided. During an interview conducted on 03/06/25 at 12:05 PM, the Administrator stated that she was unable to locate the Transfer Agreement but was actively searching and would let me know if she was able to locate it. During a phone interview conducted on 03/12/25 at 1:04 PM, the Administrator advised she had reached out to the local hospitals to obtain a Transfer Agreement however she had not received a response yet.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. 50385 Based on record reviews and interviews, the facility failed to maintain an effective QAPI program that addresses the deficient practices in the facility. This was evident during the revisit recertification survey. The findings include: On 5/29/2025 at 12:00 PM, a review of the facility ' s Plan of Correction and credible evidence for the deficiencies found during the annual recertification survey was reviewed. In the plan of correction and credible evidence for multiple citations, there was missing evidence to support the compliance of multiple deficiencies including F578, F623, F695, F699, F711, F744, F812, F842, F880, and F883. On 5/29/25 at 12:15 PM, After review of the 34 cited Federal regulations and 2 cited State regulations from the annual recertification survey ending on 3/10/2025, 10 Federal regulations (F578, F623, F695, F699, F711, F744, F812, F842, F880, and F883) were recited as noncompliant. On 5/29/2025 at 12:38 PM, an interview was conducted with the facility ' s Director of Nursing (DON) and Nursing Home Administrator (NHA). When asked who was in charge of the facility ' s QAPI committee and program, they stated that no one person was in charge but that there was a QAPI committee that met to discuss the facilities issues and performance improvement. When asked how they were tracking to ensure that the facility was in compliance with the plan of correction from the annual survey, they stated that initial and follow up audits were conducted. The survey team expressed concern with the QAPI committee ' s inability to provide documentation that would reflect the implementation of the facility ' s plan of correction for the deficiencies cited in the annual survey. The survey team discussed the 10 Federal regulations that were going to be recited due to the facility's current noncompliance.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 50504 Based on record review and interview, it was determined that the facility failed to have an Infection Preventionist (IP) participate in the facility's Quality Assessment and Assurance (QAA) committee meetings. This was evident in 9 of the 11 months of attendance records reviewed for the Quality Assurance Improvement Program. The findings include: The Quality Assessment and Assurance (QAA) committee is responsible for identifying and addressing quality deficiencies, developing and implementing corrective actions, and monitoring the effectiveness of those actions to ensure quality care and quality of life for residents. On 03/07/25 at 10:41AM a review of the monthly QAA sign-in sheets from January 2024 through September 2024 failed to reveal that an IP participated in the facility's QAA meetings. The dates of the meetings were 1/23/24, 02/20/24, 03/19/24, 04/23/24, 05/28/24, 06/25/24, 07/23/24,08/20/24, and 09/24/24. On 03/08/25 at 1:06PM in an interview, the findings were brought to the Administrator's attention. The Administrator reviewed the sign-in sheets and stated that she believed one of the QAA committee members was an IP. On 03/08/25 at 1:30PM the Director of Nursing (DON) informed the surveyor that she served as IP from April 2024 to September 2024 and attended the QAA meetings. The surveyor requested DON's IP credentials from the Administrator. The Administrator failed to provide DON's IP credentials at the time of exit on 03/10/25.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 49815 Based on observation, interview, and record review it was determined the facility failed to use appropriate infection control practices for 1) conducting ongoing surveillance for infections and 2) urinary catheter maintenance and ensuring that staff observed appropriate practices for enhanced barrier precautions during a high contact care for residents with indwelling urinary catheters and with pressure ulcer. This was found to be evident on the tour of the laundry department, during a record surveillance for infections and for 3 (Resident #48, #58 and #272) of 44 residents reviewed for infection control during the recertification survey The findings include: 1) On 03/05/25 at 06:56 AM the surveyor toured the laundry department in the basement of the facility with the Environmental Services Director (EVSD) #16 and the Laundry Aide #17. During this tour of the laundry department with EVSD #16 and Laundry Aide #17 the surveyor observed the following: staff personal items in clean laundry area (coat on chair, water bottle, bottle of tea and coffee cup on folding table), cardboard box of socks directly on the floor in clean laundry area, and a small refrigerator with staff personal items in the clean laundry area. Additionally, in an area directly adjacent to the clean and dirty laundry rooms the surveyor observed the following: cardboard box of personal protective equipment on top of a linen cart against a water pipe, 4 plastic bags of personal clothing directly on the floor and personal clothing in a barrel next to a maintenance paint cart. The EVSD #16 acknowledged the surveyor and stated, thank you for bringing these concerns to my attention and that he would take care of these concerns. The surveyor at 07:55 AM on 03/05/25 conveyed to the Nursing Home Administrator (NHA) several of the findings that were observed in the laundry department. On follow-up to the laundry department at 08:15 AM on 03/05/25 the surveyor observed the EVSD #16 and the laundry aide #17 addressing the identified concerns from the initial tour of the laundry department. On 03/05/25 at 09:15 AM the surveyor reviewed the Infection Prevention & Control Program dated 2001 and the Surveillance for Infections Policy which was dated 2001 and revised 2017. At 09:45 AM on 03/05/25 in an interview with the Director of Nursing (DON) and the Infection Preventionist (IP) #2 who were responsible for the Infection Control Program, specifically the surveillance for infections revealed that the facility did not have a system in place for conducting ongoing surveillance for infections. Additionally, there was no documentation for gathering surveillance data, data collection and recording, calculating infection rates, and interpreting surveillance data for the year 2024. The surveyor asked the DON and IP for monthly infection surveillance for the 3 months (January, February and March) of 2025. The DON stated that she was working on that but was unable to print the reports. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On follow-up interview with the Director of Nursing (DON) at 03:00 PM on 03/06/25 the surveyor asked again for the monthly infection surveillance for 2025. The DON presented the surveyor with a 2-page computer generated list of Residents with antibiotic orders for the past year totaling 16 orders and a 1-page written log titled monthly infection surveillance for this year (2025) totaling 7 infections which was incomplete. The surveyor asked the DON for the monthly infection surveillance for 2024, and the DON acknowledged that there were no monthly infection surveillance logs for 2024. No further information was provided by the facility at the time of exit. 50502 2) An indwelling urinary catheter is a thin, flexible tube inserted into the bladder through the urethra to collect and drain urine. It remains in place for an extended period, typically days or weeks. Per Centers for Disease Control (CDC), Enhanced Barrier Precautions (EBP)are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). 2a) On 3/03/25 at 9:01 AM, the catheter drainage bag of Resident #48 was observed on the floor. Licensed Practical Nurse (LPN #1) was made aware and confirmed that the drainage bag should be off the floor. On 3/03/25 at 9:08 AM, an EBP sign was observed posted outside Resident #48's room, however, there was no cart for Personal Protective Equipment (PPE). LPN #1 confirmed that the EBP sign was for foley catheter use and that he/she had not seen the PPE cart. On 3/06/25 at 6:50 PM, a review of Resident #48's medical record revealed a care plan initiated on 5/11/2023 which indicated Indwelling Catheter: Neurogenic bladder, however, the active physician orders revealed no evidence that an EBP order was written. 2b) On 3/03/25 at 9:32 AM, a review of Resident #58's active physician orders revealed an order written on 11/20/2024 which read, Maintain foley or suprapubic catheter for Neurogenic bladder. The care plan that was initiated on 11/21/2024 also indicated has Indwelling Catheter for Neurogenic bladder, however, Resident #58 had no EBP order, no EBP sign and no PPE cart outside his/her room. On 3/03/25 at 9:40 AM, the Unit Manager (UM) stated that the facility is expected to put up EBP signs and ensure that PPE carts were placed outside the residents' rooms when caring for residents with indwelling medical devices and wounds. The UM was notified that Resident #48 had no PPE cart outside the room and Resident #58 had no PPE cart as well as no EBP sign. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/03/25 at 9:44 AM, Geriatric Nurse Assistant (GNA #3) was observed placing a PPE cart outside Resident #48's room. He/she stated that if there was an EBP sign outside the room, he/she would only wear mask and gloves when providing close contact care to the residents, however, he/she added that he/she would wear gown, gloves and mask if a contact isolation (a medical practice used to prevent the spread of infections that can be transmitted through direct or indirect with a patient or environment) sign was up. On 3/03/25 at 9:47 AM, the UM was observed putting up an EBP sign outside the room of Resident #58. On 3/03/25 at 10:26 AM, in an interview with Resident #58, he/she confirmed that the staff were not wearing gown when giving direct contact care to him/her. He/she added that the nursing staff would only wear gloves and sometimes would wear masks. 2c) On 3/3/2025 at 9:27 AM, the surveyor observed no EBP sign and PPE cart outside Resident #272's room. On 3/03/25 10:03 AM, the UM was observed putting up an EBP sign and PPE cart outside Resident #272's room. The UM confirmed that the EBP sign was for Resident #272's wounds. On 3/06/25 at 9:40 AM, a review of the wound visit dated 3/6/25 confirmed that Resident #272 had a stage 3 pressure ulcer to the buttocks which resolved on 3/6/25 and a surgical wound of the right groin. On 3/06/25 at 10:40 AM, a review of the active physician orders revealed treatment to the wounds, however, an EBP order was not written. On 3/07/25 at 7:55 AM, in an interview with GNA #13, he/she stated that when an EBP sign was posted outside the resident's room, it meant that the resident was on oxygen and that the staff should put on gloves and mask when care was being given to the resident. He/she added that only when a resident was on contact isolation, that's when the nursing staff were expected to wear gown. On 3/07/25 at 8:24 AM, in an interview with LPN #1, he/she stated that when residents were placed on EBP for wounds and urinary catheters, nursing staff were expected to wear PPE, such as mask, gown and gloves when providing care. On 3/07/25 at 8:31 AM, in an interview with the Director of Nursing (DON), she stated that per the facility's policy, residents who had feeding tubes, wounds , foley catheters should be placed on EBP. She added that once the residents were identified, the nursing staff put up EBP signs and placed PPE carts outside the residents' rooms. The DON was made aware of the concerns. On 3/07/25 at 10:37 AM, a review of the facility's EBP policy indicated the following: Gloves and gown are applied prior to performing the high contact resident care activity. EBPs are indicated for residents with wounds and indwelling medical device. Staff are trained prior to caring for residents on EBPs. (continued on next page)

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 03/10/2025
NAME OF PROVIDER OR SUPPLIER: Fox Chase Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE: 2015 East-West Highway Silver Spring, MD 20910	

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Signs are posted in the door or wall outside the resident room indicating the type of precautions and PPE required. PPE is available outside the resident rooms. Residents, families and visitors are notified of the implementation of EBPs throughout the facility.

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 03/10/2025
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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 49815 Based on record review and facility staff interviews, it was determined that the facility failed to provide documentation that Residents were offered the pneumococcal vaccine. This was found to be evident in 3 (Resident #27, 54 and 56) of 5 Residents reviewed for pneumococcal immunization. The findings include: The surveyor conducted record reviews of Resident #27, 54 and 56's medical records on 03/05/25 at 08:50 AM. Reviews of the medical records revealed that Residents #27, 54 and 56 lacked up to date documentation of the pneumococcal immunization. The MDS (Minimum Data Set) assessment is a standardized tool used to evaluate the health and functional status of Residents in skilled nursing homes (SNFs) in the United States. The purpose is to provide a comprehensive picture of the Resident's physical, cognitive, social and emotional needs; to guide care planning and ensure that Residents receive appropriate services; and to collect data for quality improvement, research and policymaking. Further review of the medical records on 3/6/25 at 9:10 AM of Resident #27, 54 and 56 revealed that the Residents had a recent MDS assessments completed which indicated that the pneumococcal vaccination was not up to date, not received and not offered. Resident #27 had an MDS assessment completed 12/20/24 and the MDS indicated that the pneumococcal vaccine not received, state reason not offered. Resident #54 had an MDS assessment completed 01/28/25 and the MDS indicated that the pneumococcal vaccine not received, state reason not offered. Resident #56 had an MDS assessment completed 12/05/25 and the MDS indicated that the pneumococcal vaccine not received, state reason not offered. The surveyor interviewed the Director of Nursing (DON) and the Infection Preventionist (IP) on 03/06/25 10:45 AM and asked what the expectation was for the documentation of the pneumococcal vaccination. The DON stated that the documentation of the pneumococcal vaccination was in the Resident's medical record. The surveyor stated that the informed consent sheets and the immunization records for the pneumococcal vaccinations were incomplete for Resident #27, 54 and 56. In addition, the surveyor stated that review of the recent MDS assessments for Residents #27, 54 and 56 indicated that the pneumococcal vaccinations were not up to date, were not received and were not offered. The surveyor reviewed Resident #27, 54 and 56's medical records specifically the pneumococcal vaccination informed consent forms with the Infection Preventionist (IP) at the nursing unit on 03/06/25 at 12:50 PM. The review revealed that Resident #27 did not have an informed consent form in the medical record, Resident #54's informed consent form indicated Resident cannot sign due to confusion dated 11/30/23, and Resident #56's informed consent form indicated Resident cannot sign due to confusion dated 2/23/24. The Infection Preventionist (IP) acknowledged that Resident #27 did not have an informed consent form and Resident #54 and #56's pneumococcal vaccination informed consent forms indicated that Residents cannot sign due to confusion. The surveyor requested a copy of these informed consent forms. At the time of survey exit on 03/10/25 no additional information for pneumococcal immunization was provided by the facility.