

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215200	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/22/2026
NAME OF PROVIDER OR SUPPLIER Brooke Grove Rehab. & Nsg Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 18131 Slade School Road Sandy Spring, MD 20860	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations and interviews, it was determined that the facility failed to ensure the dignity of the residents during meal times. This was evident for 1 (#148) of 3 residents reviewed for dignity during this annual survey. The findings include: On 5/21/2026 at 10:11 AM, the surveyor visited Resident #148 and noted that the resident had not eaten breakfast yet. The surveyor asked Resident #148 if they had had their breakfast. Resident #148 responded that they had not had breakfast and that they were hungry. The surveyor then asked the roommate if they had breakfast already. The roommate answered yes and said that it was around 9 AM when they received their tray. The surveyor then asked the roommate if anyone had come in to feed Resident #148. The roommate responded that she had not seen anyone yet. When the surveyor was leaving the room, the GNA (GNA #18) for the Resident #148 came in with the tray to feed the resident. The Unit Manager (UM #8) was interviewed and asked why the resident had not eaten. UM #8 stated that GNA #18 was working with another resident who had had a bowel movement, and it took GNA #18 a while to assist them. UM #8 was also asked when the food carts come up to the unit. She stated that the carts come up between 8-8:30; then the GNAs deliver the trays to the residents, and the residents who need to be fed are served last. On 5/21/2026 at 11:55 AM, the surveyor notified the NHA of the surveyor's concerns about the resident being fed an hour after the roommate, which is an issue of dignity.		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 215200	If continuation sheet Page 1 of 14

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, record review, and interviews, it was determined that the facility failed to assess a resident's ability to self-administer medication, and to develop and implement a person-centered care plan for safe self-administration. This was found to be evident for 1 (#144) of 32 residents observed during initial screening on the 1st floor rehab units. The findings include: On 5/18/2026 at 10:44AM, during an initial tour of the 1st floor rehab unit, the Surveyor observed Resident #144 in possession of a white paper medicine cup containing multiple pills. The resident stated I like to take my pills slowly, one at a time. The nurse will come back to check on me. Licensed Practical Nurse (LPN) #17 was subsequently seen entering the room. The MDS (Minimum Data Set) is a standardized, comprehensive assessment of a resident's functional, medical, psychosocial, and cognitive status to develop a plan of care based on the resident's individualized needs. On 5/20/2026 at 10:55AM, a review of Resident #144's Minimum Data Set (MDS) comprehensive assessment accepted 4/16/2026 revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 15/15, indicating the resident is cognitively intact with no functional impairment of the upper extremities. Further review of the electronic medical record and care plan failed to reveal documentation that the resident was assessed to safely self-administer medication, and which medications may be safe to self-administer. On 5/21/2026 at 10:28AM, an interview with LPN #17 revealed that Resident #144 receives stool softeners, a probiotic, and Vitamin D in the mornings. The resident likes to take the medications slowly, usually for over an hour. LPN #17 stated that the resident is capable of taking their medications safely and checks in on the resident multiple times to ensure all medication has been taken. On 5/22/2026 at 1:47PM, during an interview conducted with the Director of Nursing (DON), the Surveyor expressed the concern that Resident #144's morning medications were left for self-administration and there was no documentation to verify the resident could safely self-administer medication. The DON informed the Surveyor that residents should be assessed for the capacity to self-administer medication, a physician's order should be in place, and a person-centered care plan should be developed and implemented for safe medication administration. Otherwise, the nurse must observe medication administration and document in the resident's electronic medical record. The DON stated they would review Resident #144's medical record. On 5/22/2026 at 2:29PM, the DON acknowledged these findings and confirmed that Resident #144 would be properly assessed for safe self-administration.		

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on record reviews and staff interviews, it was determined that the facility failed to provide Medicare beneficiaries with 1) Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage and 2) Notice of Medicare Non-Coverage. This was evident for 1 (#33) of 3 residents selected for Beneficiary Protection Review. The Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage form (CMS-10055) provides information to residents/beneficiaries that services may no longer be covered by Medicare and addresses the resident's liability for payment should they wish to continue receiving the skilled services. The Notice of Medicare Non-coverage form (CMS-10123) informs the beneficiary of his/her right to file an appeal of the decision and the right to an expedited review of Medicare non-coverage of services. 1. On 5/22/26 at 8:23 AM, a review of the SNF Beneficiary Protection Notification Review form (CMS-10055), completed by the facility, indicated that Resident #33 was not provided with the CMS-10055 form. The facility checked the box for the option that states *If NOT issued and should have been: F582. On 5/22/26 at 8:23 AM, the Director of Social Services (DOSS) #4 was interviewed. During the interview, the DOSS #4 indicated that the CMS-10055 form was not provided to Resident #33 although it should have been provided to him/her. 2. On 5/22/26 at 8:23 AM, a review of the Notice of Medicare Non-coverage form (CMS-10123), completed by the facility, indicated that Resident #33 was not provided with the CMS-10123 form. The facility checked the box for the option that states *If NOT issued and should have been: F582. On 5/22/26 at 8:23 AM, the DOSS #4 was interviewed. During the interview, the DOSS #4 indicated that the CMS-10123 form was not provided to resident #33 although it should have been provided to him/her.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on interview and observation, it was determined that the facility failed to ensure a resident's right to a quiet, home-like environment. This was evident for 1 resident (#159) of 4 residents reviewed for safe/clean/comfortable home environment. The findings include: During an interview, on 05/18/26 at 12:35 PM, Resident #159 expressed significant frustration regarding ongoing noise levels that interfered with their ability to have proper rest and sleep. The resident reported that there has been no improvement despite previous complaints, specifically identifying the sound of dragging furniture and staff members laughing, joking, and singing loudly near their room. During the interview on 05/18/26, surveyor personally observed loud conversation and laughing from staff in the hallway that could be heard from within the resident's room. During an interview held on 05/19/26 at 10:49 AM, the Unit Manager #8 noted she was already aware of the concerns raised. She stated that she was to look into the matter further. However, a follow-up interview with Resident #159 on 05/20/26 at 3:50 PM indicated that the noise levels remained unchanged. The resident noted the floor was particularly noisy between 2:00 PM and 3:30 PM due to continued furniture dragging, loud talking, and hand-clapping. Subsequent floor observation, on 5/21/26 at 10:56 AM, confirmed high noise level from staff moving equipment, a fire alarm beeping at the nursing station that had reportedly been ignored for several hours, and Nursing Aide #10 singing loudly in the hallway. Unit Manager #8 was present and stated that the fire alarm will be reset immediately and staff will be instructed to stop creating noise. These findings were shared with the Administrator during a final interview on 05/21/26 at 11:29 AM. The consistently high noise levels do not support the resident's right to a quiet, home-like environment or resident-centered care, which constitutes a deficient practice. He stated that he will follow-up with the staff.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and facility staff interviews, it was determined that the facility failed to ensure the local Ombudsman was notified of resident transfers to the hospital. This was found to be evident for 2 (#9, #10) of 5 residents reviewed for hospitalizations during an annual recertification survey. The findings include: 1. On 5/21/26 at 10:03 AM, the surveyor reviewed Resident #9's BGRNC Hospital Transfer Form 4.0, dated 2/17/26, which indicates that Resident #9 was hospitalized on [DATE] due to an abnormal abdominal x-ray. On 5/21/26 at 11:22 AM, the surveyor reviewed the facility's Admissions/Discharges 2/1/26 to 2/28/26 list that was sent to the local Ombudsman's office via email on 3/3/26, and Resident #9's name was not included on the list for being transferred to the hospital on 2/17/26. On 5/21/26 at 11:30 AM, the surveyor interviewed the Nursing Home Administrator, (NHA #1). During the interview, the surveyor mentioned to the NHA #1 that Resident #9 was not included on the facility's Admissions/Discharges 2/1/26 to 2/28/26 list that was sent to the local Ombudsman's office via email on 3/3/26. The NHA #1 indicated that Resident #9 was not discharged to the hospital, Resident #9 was transferred to the hospital on 2/17/26 and returned back to the facility the next day on 2/18/26; therefore, Resident #9 would not be included on the facility's Admissions/Discharges 2/1/26 to 2/28/26 list that was sent to the local Ombudsman's office via email on 3/3/26. The NHA #1 also mentioned that the facility's Admissions/Discharges list includes resident discharges and resident deaths, not resident transfers to the hospitals. The surveyor mentioned to the NHA #1 that the local Ombudsman's office should be notified of resident transfers to the hospital. The NHA #1 mentioned that he will now include resident transfers to the hospital on the facility's Admissions/Discharges list that is provided to the local Ombudsman's office. Under 483.15(c)(3), Notice of Transfer or Discharge and Ombudsman Notification states that the facility must send a copy of the notice of transfer or discharge to the representative of the Office of the State Long-Term Care (LTC) Ombudsman. 2. On 5/20/2026 at 8:39AM, during a review of Resident #10's electronic medical record, the Surveyor discovered that the resident was transferred to the hospital on 3/5/2026. On 5/22/2026 at 9:07AM, a review of the facility's Discharges 3/1/2026-3/31/2026 report emailed to the local Ombudsman on 4/1/2026 failed to reveal Resident #10's transfer to the hospital on 3/5/2026. During an interview conducted with the Nursing Home Administrator (NHA), the Surveyor (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	confirmed that Resident #10 was omitted from the March report. The NHA stated that the facility had not been including hospital transfers on the monthly reports emailed to the local Ombudsman. The NHA informed the Surveyor that hospital transfers have been added to the monthly report to ensure that moving forward the local Ombudsman is notified of all resident transfers and discharges.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with staff, it was determined that the facility failed to ensure a resident's Preadmission Screening and Resident Review (PASARR) was reviewed after admission to the facility and revised to reflect the resident's current status. This was found to be evident for 1 (#113) of 5 resident PASARR's reviewed during the annual recertification survey. The findings include: The PASARR process requires that all applicants to Medicaid-certified nursing facilities be screened for possible serious mental disorders or intellectual disabilities and related conditions. This initial pre-screening is referred to as PASARR Level I, and is completed prior to admission to a nursing facility. A negative Level I screen permits admission to proceed and ends the PASARR process unless a possible serious mental disorder or intellectual disability arises later. A positive Level 1 screen necessitates an in-depth evaluation of the individual by the state-designated authority, known as PASARR Level II, which must be conducted prior to admission to a nursing facility. PASARR Level II is a comprehensive evaluation by the appropriate state-designated authority and determines whether the individual has MD, ID or a related condition, determines the appropriate setting for the individual and recommends what, if any, specialized services and/or rehabilitative services the individual needs. On 5/19/2026 at 10:39AM, a review of Resident #113's electronic medical record revealed that the resident was admitted to the facility on [DATE] and had diagnoses of but not limited to dementia, hallucinations, anxiety disorder, and major depressive disorder. Further review revealed a PASARR Level 1 dated 4/23/2026, completed by the hospital prior to admission, which failed to identify known or suspected diagnosis of a major mental illness, any signs and symptoms of a major mental illness, and the use of an antipsychotic, mood stabilizing, or antidepressant medication. On 5/20/2026 at 11:16AM, during an interview conducted with the Social Work Director (SW #4) the Surveyor was informed that PASARR Level I screenings are completed by hospital staff prior to admission to ensure the resident is appropriate for placement at the facility. Upon admission, social work staff are responsible for reviewing and updating the PASARR if any inaccuracies are found. The Surveyor expressed the concern that Resident #113's PASARR failed to identify the resident's indicators for mental illness, including diagnoses of dementia, hallucinations, anxiety disorder, and major depressive disorder. SW #4 stated that they would look into the Surveyor's concern. On 5/22/2026 at 1:30PM, a review of Resident #144's PASARR documentation provided by SW #4 confirmed inaccurate documentation of resident status. The facility failed to ensure the PASARR was reviewed after admission and revised, as needed, to reflect the resident's current status, which should have prompted further evaluation to determine if the resident required any specialized services. After a discussion with SW #4, in the presence of the Nursing Home Administrator (NHA #1), SW #4 acknowledged the Surveyor's concern and stated that they would submit a new PASARR for Resident #144. On 5/22/2026 at 2:49PM SW #4 provided the Surveyor with a copy of Resident #144's updated PASARR submission for review by [Company].		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observations, record review, and interviews with resident and staff, it was determined that the facility failed to administer medication in a timely manner and according to professional standards of practice. This was found to be evident for 1 (#133) of 32 residents observed during the initial tour of the 1st floor rehab unit. The findings include: On 5/18/2026 at 1:00PM, during an interview with Resident #133, the Surveyor was informed that his/her medications were frequently given late, particularly during the evening shift (3:00PM-11:00PM). On 5/21/2026 at 2:18PM, a review of Resident #133's Medication Administration Report (MAR) revealed that medications were administered as ordered by documentation of a check mark, unless otherwise noted. On 5/21/2026 at 2:39PM, a review of Resident #133's Medication Admin Audit Report from 4/29/2026 through 5/21/2026 revealed: -5/2/2026 Olmesartan Medoxomil Oral Tablet 40 MG and Labetalol HCl Oral Tablet 200 MG scheduled at 8:00PM, administered at 10:21PM, and documented at 10:21PM. -5/5/2026 sulfasalazine Oral Tablet 500 MG scheduled at 5:00PM, administered at 8:11PM, and documented at 8:11PM. -5/5/2026 Pancreatic enzymes scheduled at 5:30PM, administered at 8:11PM, and documented at 8:11PM. -5/6/2026 Labetalol HCl Oral Tablet 200 MG, Gabapentin Oral Capsule 100 MG, Olmesartan Medoxomil Oral Tablet 40 MG, Tenapanor HCl Oral Tablet 50 MG scheduled at 8:00PM, administered at 10:28PM, and documented at 10:29PM. -5/7/2026 Gabapentin Oral Capsule 100 MG, sulfaSALazine Oral Tablet 500 MG, Labetalol HCl Oral Tablet 200 MG, MiraLax Oral Packet 17 GM, Lysine Oral Tablet 1000 MG, and Lidocaine External Patch 5 % scheduled at 8:00AM, administered at 10:14AM, and documented at 10:15AM. -5/9/2026 Tenapanor HCl Oral Tablet 50 MG scheduled at 8:00PM, administered at 22:55PM, and documented at 10:56PM and Gabapentin Oral Capsule 100 MG scheduled at 8:00PM, administered at 10:54PM, and documented at 10:56PM. -5/10/2026 Olmesartan Medoxomil Oral Tablet 40 MG and Labetalol HCl Oral Tablet 200 MG scheduled at 8:00PM, administered at 10:52PM, and documented at 10:52PM. -5/14/2026 Labetalol HCl Oral Tablet 200 MG and Olmesartan Medoxomil Oral Tablet 40 MG scheduled at 8:00PM, administered at 12:19AM, and documented at 12:19AM. -5/16/2026 HydrALAZINE HCl Tablet 25 MG, Tenapanor HCl Oral Tablet 50 MG, Labetalol HCl Oral Tablet 200 MG, and Olmesartan Medoxomil Oral Tablet 40 MG scheduled at 8:00PM, administered at 10:11PM, and documented at 10:13PM. -5/20/2026 Tenapanor HCl Oral Tablet 50 MG, Labetalol HCl Oral Tablet 200 MG, and Olmesartan Medoxomil Oral Tablet 40 MG scheduled at 8:00PM, administered at 10:16PM, and documented at 10:16PM. On 5/22/2026 at 9:20AM, during an interview with Resident #133, the Surveyor was informed that he/she had not received his/her morning medications, most being due at 8AM. On 5/22/2026 at 2:29PM, during an interview conducted with the Director of Nursing (DON), the Surveyor was informed that the expectation is for medication to be administered within 1 hour before or 1 hour after their prescribed time, unless otherwise specified. The Surveyor informed the DON that Resident #133 expressed the concern that his/her medications were frequently given late, especially during the evening shift. A review of the resident's Medication Admin Audit report from 4/29/2026 through 5/21/2026 confirmed instances where medications were administered well over the facility's 1 hour timeframe. The DON stated that the resident's concern would be addressed and his/her medical record would be reviewed. The Nursing Home Administrator was informed of these findings.		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, it was determined that the The facility failed to provide on-going personalized activities to meet the resident's physical, mental, and psychosocial needs. This was evident for 2 (#15 , #7) of 5 residents reviewed for the personalized activities during an annual survey. The findings include:1.Observation, on 05/18/26 at 1:00 PM and 3:15 PM Resident #15 was in their room dozing off while sitting in the wheel chair. There was no evidence that the activity staff provided any one-to-one interaction, personalized activities, or any device/materials offered for the resident to use.Further interview, it was noted that Resident #15 attended group activities occasionally. However, this resident expressed a desire for more suitable options, specifically focus on creativity.A record review conducted on 05/19/26 indicates that the resident was admitted to this facility on 05/20/17. Their diagnoses include schizoaffective disorder, depression, hypoxia, and diverticulitis. According to Activity Staff #20's plan, this resident was able to make needs known and resident's care plan included in-room engagement and individual discovery five to six times per week.On 05/20/26 at 11:10 AM an interview was conducted with Activity Director #7 who stated that Activity staff were doing daily in-room visits for residents do not come out of their rooms. She stated that the one to one visit is expected daily and document on their daily logs.On 05/20/26 at 3:19 PM Record Review of Resident #15's Daily one to one visit logs found:-April visits- 4/9, 4/11, 4/12, 4/13, 4/18, 4/20 (19%)-May the first 3 weeks visits- 5/1, 5/4, 5/7, 5/8, 5/11, 5/14 (30%) 2.On 05/18/26 at 12:47 PM, Resident #7 was observed, no activity staff present and falling asleep while sitting up in the bed twice during a three-hour observation period. A room check confirmed that no self-stimulation activities materials or devices were present. This resident's verbal language skills are limited, they are able to effectively communicate their needs by answering yes and no questions. This resident indicated Yes for getting out of bed for activities and No that no activity staff visit.Record review on 05/20/26 at 10:02 AM, Resident #7 was admitted on [DATE]. medical diagnoses include Dementia, Right Rib Fracture, Cellulitis, Pulmonary Embolisms (PEs), Heart Failure (HF), and Acute Kidney Failure (AKF). Activity plan dated 04/13/26 indicated that this resident will participate in-room engagement, and individual discovery for 5-6 times per week.On 05/20/26 at 11:10 AM an interview was conducted with Activity Director #7 who stated that Activity staff were doing daily in-room visits for residents do not come out of their rooms. She stated that the one to one visit is expected daily and document on their daily logs.On 05/20/26 at 3:19 PM Record Review of Resident #7's Daily one to one visit logs found:- April visits- 4/8, 4/9, 4/10, 4/15, 4/18, 4/19, 4/22, and 4/24 (25%)- May for the first 3 weeks visits- 5/12, 5/13, and 5/15 (14%)On 05/21/26 at 11:29 AM, an interview was conducted with the Administrator who discussed the facility's activity program. It was determined that the activity staff failed to implement a daily one-to-one activities program that adequately meets the physical, mental, and psychosocial activity needs of the residents. Specifically, the following issues were discussed:- A low number of one-to-one visits for residents- A lack of self-stimulatory devices and materials provided for resident use.The Administrator mentioned that he would follow up with the Activity program staff.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review it was determined the facility failed to ensure post-surgical care recommendations were timely implemented and monitored according to professional standards. This was evident for 1 (#176) of 2 Residents reviewed for accidents during the facility's recertification survey. The findings include: On 5/18/26 at 8:52 AM the surveyor observed Resident #176 laying in bed wearing a neck brace with facial injuries present. Review by the surveyor on 5/20/26 at 12:05PM of the nursing admission assessment documentation present on Resident #176's medical record dated 5/12/26 revealed the following information: S/P fall with diagnosis of C2 cervical fracture, wear a hard collar. On 5/20/26 at 12:11PM the surveyor conducted a review of Resident #176's hospital Discharge summary dated [DATE] which documented the following information: 1.) Resident #176 had a fall prior to their hospital admission which resulted in a cervical fracture and a cervical subluxation, 2.) A recommendation made by Resident #176's orthopedic surgeon post-surgery for their hard neck collar to be worn until their outpatient follow up appointment to occur within two weeks post discharge with the orthopedic surgeon. On 5/20/26 at 12:16PM the surveyor reviewed Resident #176's census history which revealed they were admitted to the facility on [DATE]. Review by the surveyor of the May 2026 Medication and Treatment Administration Record revealed that the following order for the neck brace was not instituted until 5/19/26: Patient is to wear Aspen neck collar brace on at all times for C2 cervical fracture every shift. Surveyor review on 5/20/26 at 1:17PM of Resident #176's baseline care plan revealed the Resident's neck brace/collar was not identified by the facility on that document. On 5/20/26 at 1:17PM the surveyor shared concerns regarding the baseline care plan of the Resident with the facility Administrator and conducted an interview of them. During the interview, the surveyor inquired as to why the neck brace was not identified on the baseline care plan as an immediate care need for Resident #176 in which it was noted their admitting diagnoses included cervical fracture and cervical subluxation and the Resident was status-post surgical intervention, to which they replied: I will review this and get back to you, all care will not be listed on a baseline care plan. On 5/20/26 at 1:22PM the surveyor observed a communication document present in the medical record of Resident #176 dated 5/16/26 at 2:35PM from the facility to the on-call provider which documented the following information: Patient has a cervical brace that s/he is reporting is uncomfortable and bothering her/him, and S/he is requesting for a doctor to evaluate her/him and see if maybe they can alter the brace. Review by the surveyor of the provider's response documented the following information on 5/16/26 at 2:51PM: Pls (please) have PT (physical therapy) see patient for brace adjustment if indicated and also schedule follow up visit with the specialist that recommended her/his neck brace. On 5/20/26 at 1:26PM the surveyor conducted an interview of the Director of Nursing (DON) at which time they stated regarding Resident #176's neck brace: Yes it wasn't mentioned in the baseline care plan. The DON further stated to the surveyor: The Unit Manager did care planning which mentioned neck brace on at all times. The DON was observed by the surveyor pointing to the intervention of the neck brace on a paper copy of the Resident's care plan. The surveyor observed that the intervention was dated as not having begun until 5/19/26. When the surveyor inquired to the DON as to when the care plan intervention for the neck brace began, they stated: 5/18th or 5/19th, s/he had it on at all times though, there is communication, they (the Resident) had a concern about it. The surveyor asked the DON if they agreed with this surveyor that a Resident who is to wear a neck brace at all times should have a medical order present for that care being delivered, at which time the DON did not answer the surveyor's question and (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Brooke Grove Rehab. & Nsg Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 18131 Slade School Road Sandy Spring, MD 20860	
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated: Let me get the Unit Manager. At this time, the surveyor shared concerns. On 5/21/26 at 8:04AM the surveyor shared concerns and conducted an interview of the facility's Administrator who acknowledged and confirmed understanding of the surveyor's concerns. The Administrator discussed multiple failures which occurred regarding the care of the Resident which included the following information: The Resident (#176) was admitted on a Friday, the admitting nurse, the supervisor, the night shift should be checking that the care and orders are correct, therapy was supposed to see them even on the weekend and ensure orders for the neck brace, the same nurse worked over the weekend, and Monday the Unit Manager was present, the order was not instituted until Monday, over the weekend the Resident had an issue with the brace. The Administrator reported he believed the neck brace was being utilized, although there is a failure with documentation for that. The Administrator agreed with this surveyor that orders were not timely in place and confirmed that orders surrounding a neck brace should be in place right away. On 5/21/26 at 9:04AM the surveyor conducted an interview of the DON who stated: The admissions/supervisor nurse missed a step, s/he didn't see the recommendation and didn't put the order in on admission. At this time, the surveyor shared concerns with the DON who acknowledged the concerns and an interview of Admissions Nurse #12 was requested. On 5/21/26 at 9:12AM the surveyor conducted an interview of Admissions Nurse #12 who stated regarding the neck brace for Resident #176: Unfortunately I missed that part, it was human error, I had six admissions that day, new patients, and in the process I was rushing and put in all the orders- I missed the one for the neck brace. On 5/22/26 at 3:47PM the surveyor reviewed Resident #176's May 2026 Medication and Treatment Administration Records which documented their orthopedic follow up appointment was scheduled for 5/28/26. Further review of the May 2026 Medication and Treatment Administration Record revealed that the following medical orders were implemented on 5/19/26: 1.) Patient is to wear Aspen neck collar brace on at all times for C2 cervical fracture every shift, 2.) Monitor Aspen neck collar brace every shift and prn and check for skin breakdown, monitor for any potential complications such as skin breakdown, discomfort, or improper use, if 'Y' (yes) notify provider and document every shift, 3.) Monitor bruising around the right eye every shift and report any changes to MD/NP every shift for skin care, 4.) Monitor laceration to forehead q (every) shift until resolves, notify provider if site worsens every shift. Concerns were again reviewed by the survey team with the facility Administrator and various facility staff during the facility's exit conference on 5/22/26.		

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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. Based on medical record review and interview it was determined the facility failed to ensure medication order parameters were followed and ensure a resident was free from unnecessary medication. This was evident for 1 (#178) of 5 Residents reviewed for unnecessary medications during the facility's recertification survey. The findings include: Surveyor review of Resident #178's medical record on 5/22/26 at 12:57PM revealed a May 2026 Medication Administration Record showing the following medication order with parameters:-Aldactone Oral Tablet 25MG, Give one tablet by mouth in the afternoon for CHF (Congestive Heart Failure), Hold for systolic bp (blood pressure) <110 or diastolic bp <60, start date 4/24/2026 1600, d/c (discharge) date 5/21/2026, 2048. Further surveyor review of the May 2026 Medication Administration Record revealed documentation showing that Aldactone medication was administered outside these parameters on 5/14/26, with a documented blood pressure of 115/50 by Nurse #13. On 5/22/26 at 1:20PM the surveyor conducted an interview of the facility's Administrator and shared the concern and offered opportunity for them to provide any further documentation relating to the concern. On 5/22/26 at 1:29PM the surveyor shared the concern with the facility's Director of Nursing (DON) who stated: I will look into this. During an interview conducted by the surveyor on 5/22/26 at 1:41PM the DON stated: (Nurse #13) did not follow the parameters, I looked at the original order, the medication administration record and blood pressure parameters and this was outside the parameters that were given. At this time, the DON confirmed with this surveyor that the medication was given to Resident #178. Concerns were again reviewed by the survey team with the facility Administrator and various facility staff during the facility's exit conference on 5/22/26.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, record review, and interviews with staff it was determined that the facility failed to maintain food temperature logs and store food and drinks in a manner that maintains professional standards of food service safety. This practice has the potential to affect residents who eat the food and receive thickened drinks prepared in the facility's main kitchen and satellite kitchens located on rehab floor #1 and #2. The findings include: 1. On 5/18/2026 at 8:00AM, during a tour of the main kitchen, the Surveyor observed the tray line of food being plated and trays prepared to serve residents on the long-term care unit. On 5/18/2026 at 8:25AM, an observation of the food temperature log binder failed to reveal food temperatures recorded for: -5/16/2026 breakfast and lunch-5/17/2026 breakfast and lunch-5/18/2026 breakfast. On 5/18/2026 at 8:26AM, the Surveyor's findings were confirmed by Executive Chef #14. During an interview, the Surveyor was informed that to ensure proper food temperatures before serving residents, food temperatures are taken while the food is on the food table and then recorded in the binder for each meal service. Education will be provided to dietary staff. 2. On 5/18/2026 at 8:00AM, during a tour of the main kitchen, the Surveyor observed the following concerns in the main refrigerator: -Coleslaw to be discarded 5/16/2026-Pureed prep to be discarded 5/17/2026-Shrimp to be discarded 5/15/2026 The following concerns in the hydration refrigerator: -Sysco Imperial Thickened Orange Juice, with instructions on the carton to discard 7 days after opening, labeled 4/18-4/28. -Sysco Imperial Thickened Cranberry Juice, with instructions on the carton to discard 7 days after opening, labeled 4/18-4/28 The following concerns in the pantry: -Container of a white powdery substance opened to air on a shelf-A large, mobile food storage container (gallons) containing a white powdery substance with no label-Another large, mobile food storage container (gallons) containing a white powdery substance with no label-A large, mobile food storage container (gallons) containing a tan crumb substance with a clear, unlabeled, 1 gallon storage bag of a white powdery substance inside the large container on top of the tan crumbs. On 5/18/2026 at 8:45AM, during an interview and tour of the kitchen, Executive Chef #14 acknowledged and confirmed the Surveyor's findings. The expired food and drink items were discarded. Staff #14 stated that the expectation is for expired food and drink items to be discarded timely, food and drink items should be labeled appropriately with open and discard dates, and food items should be stored to avoid contamination. On 5/19/2026 at 11:35AM, during a tour of the satellite kitchen on the 1st floor rehab unit, the Surveyor observed the following concerns: -Sysco Imperial Thickened Apple Juice opened with no label-Sysco Imperial Thickened Lemon-flavored water opened with no label. On 5/19/2026 at 11:53AM, during a tour of the satellite kitchen on the 2nd floor rehab unit, the Surveyor observed the following concerns: -Silk Almond milk opened with no label-Sysco Imperial Thickened Cranberry Juice, Thickened Lemon-flavored water, Thickened Apple Juice, and Thickened Orange Juice, with instructions on the carton to discard 7 days after opening, labeled 5/9/2026. On 5/19/2026 at 12:10PM, during an interview with the Interim Certified Dietary Manager (CDM) #15, in the presence of Staff #14 and General Manager (GM) #16, the Surveyor discussed the findings from 5/18/2026 and the findings during a tour of the satellite kitchens on the 1st floor and 2nd floor rehab units. CDM #15 acknowledged the Surveyor's findings and stated that an in-service education will be completed for all dietary staff regarding labeling, storage, and disposal of food and drink items.		

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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 that facility failed to maintain proper infection prevention and control practices. Specifically, the laundry service area was not maintained in a sanitary manner, failing to provide an environment free of cross-contamination. This was evident by the whole laundry service areas observed during an annual survey. The findings include: A tour of the laundry service area was conducted on 05/21/26 at 2:25 PM, the following issues were observed in the service area: - A personal iPad in a small old shopping bag was left on a side table in the washing room.- The top shelves of the dryer room were filled with staff's personal belongings, food and drinks.- A makeshift eating area was set up within the dryer room. During an Interview, on 05/21/26 at 2:35 PM, the Housekeeping Director #19 stated that all laundry staff has designated personal items lockers which he declared that there should be no personal items in the Laundry service area. He confirmed that the makeshift eating area was an oversight. During an interview on 05/21/26 at 4:39 PM, the Administrator acknowledged that laundry staff's personal items were stored throughout the laundry service area and an eating area found in the dryer room. He agreed that these findings constitute deficiency concerns. To address this, he stated that all personal items will be removed immediately, and staff will receive re-education on regulations/policy. A follow-up tour of the laundry service area on 5/22/26 at 12:59 PM was conducted. During the tour, three drink cups were found hidden behind a sewing machine belonging to Laundry Tech #10. When Housekeeping Director #19 addressed it, Laundry Tech #10 expressed it was ridiculous referring to the policy prohibiting drinks in the laundry service area. Housekeeping Director #19 provided immediate corrective actions to remove all the drinks. During a final interview on 5/22/26 at 1:38 PM with the Administrator and a review of the findings, the Administrator agreed that the non-cooperative behavior of the laundry staff is unacceptable. This is particularly concerning as the Director had provided education on laundry service regulations and policies the day prior. He recognized the pattern as a significant practice concern.		