

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215211	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/08/2024
NAME OF PROVIDER OR SUPPLIER Friends Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 17340 Quaker Lane 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>43648</p> <p>Based on record review, facility document review, interview, and facility policy review, the facility failed to report an allegation of abuse to the state survey agency within two hours for 1 (Resident #6) of 3 residents reviewed for abuse.</p> <p>Findings included:</p> <p>A facility policy titled, Abuse Policy, revised 07/2024, revealed, [The facility name] follow the 7 components of abuse prevention, to include 7. Reporting and Response: Any suspicion of abuse MUST be reported to administrative staff immediately. (If you do not report and it is discovered you were aware; you are considered as guilty as the person committing the abuse). According to the Elder Justice Act: abuse that does not result in serious bodily injury needs to be reported within 24 hours. Any abuse that results in serious bodily (broken bones, severe wounds, death) and sexual abuse must be reported within 2 hours of knowledge. Reports may be made to the state and local law enforcement. The facility has 5 days to complete an investigation and report findings to the state. The policy revealed, [The state survey agency] shall be notified immediately by fax or email on the appropriate state form as to the nature of the allegation and the names of the resident(s) and individual(s) involved. (Within 24 hours) Within 2 hours where if [sic] the suspected crime/injury results in serious bodily injury.</p> <p>Resident #6's Admission Record indicated the facility admitted the resident on 01/04/2024. According to the Admission Record, the resident had a medical history that included diagnoses of dissection of the carotid artery, nontraumatic subarachnoid hemorrhage, hypertension, and anxiety disorder.</p> <p>An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/09/2024, revealed Resident #6 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS revealed the resident required partial/moderate assistance from staff with toileting hygiene, showers/bathing, and lower body dressing. Per the MDS, the resident required partial/moderate assistance from staff with going from sitting on the side of the bed to lying, from lying to sitting on the side of the bed, from sitting to standing, with chair/bed-to-chair transfers, and with toilet transfers.</p> <p>Resident #6's care plan revealed a focus area, initiated 01/05/2024, that indicated the resident was at risk for skin breakdown related to immobility. Interventions directed staff to turn and reposition the resident routinely (initiated 01/05/2024).</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #6's Progress Notes revealed an Incident Note, dated 01/05/2024 at 11:51 AM and electronically signed by Staff Identifier (SI) #18 (the previous Assistant Director of Nursing), that revealed Resident #6 reported physical abuse to a physical therapist. The note indicated that the resident provided descriptions of a male and female who were, in my room last night, I was sitting on my bed and the [description of female] hit me on my right arm four times very hard and told me to scoot, scoot up in bed. The note indicated that the resident's family member was in the room and stated that Resident #6 called them the previous night and told them that a female hit the resident on the arm. The note indicated that SI #27 (the Nurse Practitioner) was made aware of the allegation.</p> <p>A Facility Reported Incidents Initial Report Form, dated 01/05/2024, indicated that Resident #6 reported to a therapist during an occupational therapy session on 01/05/2024 that they were struck four times by a staff member the previous night. The document indicated that staff became aware of the incident on 01/05/2024 at approximately 6:00 PM and SI #1 (the Administrator) was notified of the allegation at 6:00 PM. The document indicated that the state survey agency was notified of the abuse allegation on 01/05/2024 at 8:00 PM, over eight hours after SI #18 documented the Incident Note.</p> <p>During an interview on 11/07/2024 at 2:45 PM, SI #1 stated she was notified of the allegation of abuse on 01/05/2024 after 6:00 PM, after she had left the facility. She stated that she filed the initial report by 8:00 PM. She stated that if the resident reported the allegation at around noon, the staff should have notified her at that time and the initial report filed within two hours.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>20960</p> <p>Based on interview, record review, and facility policy review, the facility failed to ensure a physician's order for medicated eye drops was followed and the eye drops not administered until after surgery for 1 (Resident #3) of 3 residents reviewed for medications. Resident #3 had eye drops ordered to be administered three times daily for seven days after surgery, and the eye drops were administrated prior to the surgery.</p> <p>Findings included:</p> <p>A facility policy titled, Administering Medications, revised January 2024, indicated, Medications are administered in accordance with prescriber orders, including any required time frame.</p> <p>An Admission Record indicated the facility admitted Resident #3 on 03/24/2018. According to the Admission Record, the resident had a medical history that included diagnoses of dementia and cataracts.</p> <p>An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/02/2024, revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 7, which indicated the resident had severe cognitive impairment.</p> <p>Resident #3's care plan included a focus area, revised 05/14/2024, that indicated the resident had a history of cataracts. Interventions directed staff to arrange consultations with eye care practitioners as required (revised 10/15/2024) and to monitor, document, and report any acute eye problems (created 02/05/2024).</p> <p>A physician's order, dated 07/07/2023, indicated Resident #3 was to be administered prednisolone (a corticosteroid)/Moxifloxacin (an antibiotic) ophthalmic 1-0.5% solution, one drop into the right eye three times a day for seven days after surgery. The order start date was 07/13/2023, and the order end date was 07/20/2023.</p> <p>Resident #3's July 2023 Medication Administration Record (MAR) contained the transcription of an order, started 07/13/2023, for prednisolone/Moxifloxacin ophthalmic solution 1-0.5% one drop in the right eye three times a day for one week after surgery. The MAR indicated Resident #3 was administered the eye drops three times a day from 07/13/2023 through 07/19/2023 by staff including Staff Indicator (SI) #5 (the Assistant Director of Nursing) and SI #19 (a licensed practical nurse).</p> <p>A Current Summary Medication/Fluid Error Event, record for Resident #3, dated as entered 07/23/2023, indicated that Resident #3 received eye drops (prednisolone/Moxifloxacin 1- 0.5% ophthalmic solution) due to an order placed on 07/12/2023 that should have been discontinued when Resident #3 did not have surgery. The record indicated eye drops were given in error from 07/12/2023 through 07/19/2023.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/07/2024 at 12:12 PM, SI #19 stated Resident #3 had orders for eye drops prior to their surgery and after the surgery occurred. SI #19 stated Resident #3 did not have the surgery, and the order was never discontinued or changed. SI #19 stated she had administered the eye drops, as the order was on the MAR. SI #19 stated she did not know the surgery had never occurred until the previous director of nursing called her and brought it to her attention. SI #19 stated she should not have administered the eyes drops when she did because the surgery never happened.</p> <p>During an interview on 11/07/2024 at 1:39 PM, SI #5 stated she had been off work, and Resident #3 was scheduled for cataract surgery and had orders for eye drops after the surgery was completed. SI #5 stated when she returned to work, she did not know that Resident #3 had never had the surgery, and she administered the eye drops thinking the surgery had occurred. SI #5 stated the eye drops were administered even though Resident #3 did not have the surgery. SI #5 stated she only found out about the error when the previous director of nursing told her after the eye drops had been administered.</p> <p>During an interview on 11/08/2024 at 10:20 AM, SI #2 (the Director of Nursing) stated she started employment after the medication error, but was made aware of the issue. SI #2 stated Resident #3's orders were not followed but should have been. SI #2 stated the expectations were for all nurses to follow the orders as they were written.</p> <p>During an interview, on 11/08/2024 at 10:49 AM, SI #1 (the Administrator) stated staff should not have administered the eye drops.</p>		