STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215211	A. Building B. Wing	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Friends Nursing Home	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)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, it was determined that the facility failed to ensure a homelike environment. This was evident for 13 out of 13 resident rooms reviewed during the survey. The findings include the following: During observation rounds on 05/08/25 at 08:35 AM the following was observed: 1. Resident rooms 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, and 229, bathrooms were observed to have a missing Cove Base around the complete perimeter of the bathroom along with an ½ inch opening between the wall and the floor tiles. 2. The bathroom of room [ROOM NUMBER] black patches of growth appeared at the at the rear base of the toilet extending up from the missing cove base area to about 2 inches up the wall with exposed and peeling paint areas. 3. The floor tiles were stained brown and rust in color near the head of the bed in resident room [ROOM NUMBER]A. 4. There were missing floor tiles with exposed cement flooring observed near the head of the bed in residents' room [ROOM NUMBER]A, 222, and 224A. 5. There was no enclosed space for hanging clothing located in room for resident use in resident room [ROOM NUMBER]A. During a staff interview on 05/08/25 at 10:52 AM the Nursing Home Administrator #02 stated the cove base has been on back order for about a year for several rooms that have been damaged by the flood that occurred about a year ago.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 2. On 5/14/25 at 8:28 AM, record review revealed that the incident took place on 1/14/25 during breakfast. Incident report revealed that Resident #12 experienced second degree burns with 3 clustered blisters to the Left thigh where Resident #12 spilled hot coffee onto themselves. On 1/16/25 the facility started their investigation with staff interviews and with Resident #12 being evaluated for their injuries by wound services. The facility reported the incident to the State Survey Agency on 1/21/25 at 10:32 AM. Further review of the incident showed that the report was not complete within the 5 days as required. Closing of the investigation by the facility was not reported to the State Survey Agency until 1/29/25. On 5/9/25 at 9:30 AM An interview with Administrator #2 and DON was conducted. Administrator #2 confirmed that resident did spill the coffee onto themselves and that corrective action was conducted for the staff member that was responsible for reporting the incident to leadership and education was also given for reporting incidents. Admin #2 was asked for a copy of the facility's investigation report for Resident #12. These deficiencies were discussed with the administrator of the facility prior to and during the exit interview. Based on record review and interviews, it was determined that the facility failed to report an allegation involving serious bodily injury within 2 hours and to complete the facility's investigation within 5 days. This was evident for 2 (Residents #12, #29) out of 3 Facility Incident Reports(FRI) reviewed during the survey. The findings include: 1. On 05/12/25 at 12:55 PM, the facility's investigation report was reviewed. The investigation report revealed that on 2/10/25, Resident #29 was noted to have bruising over his/her right clavicle, shoulder and upper arm. X-rays were obtained at the facility which revealed a displaced fracture of the distal, right, third clavicle and multiple right rib fractures. Resident #29 was interviewed and Resident #29 denied that he/she had a recent fall as well as denied that anyone abused and mishandled him/her. Facility staff assessed, stabilized and transferred Resident #29 to the hospital. The hospital diagnosed Resident #29 with having an acute fracture of the distal, third, right clavicle and fractures of the 5th, 6th, and 7th ribs. The facility's reports also revealed that staff were interviewed, and the staff stated that they observed bruising on the right humerus, ribs and breast. Staff also mentioned that there were no reports about Resident #29 falling or being found on the floor. Also, staff stated that Resident #29 had been observed sleeping on his/her right side, and Resident #29 had been observed walking to the bathroom without calling for assistance. The investigation report also revealed that the facility submitted the initial Facility Reported Incident (FRI) to the Office of Health Care Quality (OHCQ) on 2/11/25 at 11:00 AM and the follow-up Facility Reported Incident was submitted to OHCQ on 2/14/25. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/13/25 at 09:44 AM, the Nursing Home Administrator staff #02 was interviewed. The surveyor mentioned to staff #02 that according to the facility's records, the facility became aware of Resident #29's fractures on 2/10/25; however, the facility did not submit the initial FRI to OHCQ until 2/11/25 at 11:00 AM. Staff #02 stated that the facility staff, who speak Bengali, interviewed Resident #29, and Resident #29 denied falling and being abused. Staff #02 also mentioned that since the injury was of unknown origin and is not abuse, the facility would not have to report the incident to OHCQ within the required two-hour window. On 05/13/25 at 10:22 AM, Resident #29's records were reviewed. The record review revealed that Resident #29 has a Brief Interview for Mental Status (BIMS) Score of a 9/15, which indicates moderate cognitive impairment. Also, the record review revealed that Resident #29 spoke Bengali.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on medical record review, interviews, and observations it was determined that the facility failed to create, revise and update the resident's care plan in a timely fashion. This was evident for 1 (#48) of 4 resident care plans reviewed during the survey. The findings include: A care plan is used to summarize a person's health conditions, specific care needs, and current treatments and outlines what needs to be done to plan, assess, and manage care. Care plans are developed, reviewed, and/or revised by the interdisciplinary team (IDT) after the completion of a comprehensive MDS assessment (Admission, Annual, Quarterly, Significant Change) to help to evaluate the effectiveness of the resident's care while in the facility. A comprehensive care plan is developed and revised by the interdisciplinary team to address a resident's individualized physical functioning for example. On 05.08.25 at 08:30 AM the surveyor observed Resident # 48 in bed with white knit tube stockings extending from the bilateral contracted hands up to the upper arms. The resident was non-verbal with surveyor at the time of the observation. During an interview with the DON, it was determined that this resident required maximum assistance with eating meals and drinking fluids and was not wearing hand splints. On 05.09.25 at 12:30 PM the surveyor reviewed the electronic medical record and determined that there was no care plan present that addressed the use of hand splints for Resident #48 or occupational therapy (OT) interventions related to Resident #48's limited range of motion. On 05.13.25 at 08:50 AM the surveyor interviewed the Director of Rehabilitation, staff #14. The surveyor asked if the occupational (OT) staff had participated in any care plan meetings with the interdisciplinary team since March 26, 2025. Staff # 14 stated that there were no OT rehab. Staff #14 had participated in the creation of a care plan for Resident #48 that referenced the bilateral hand orthotics/splints. Staff #14 stated that the current air pump style splint is new and experimental for the resident and therefore there was no order for this specific type of splint. Additionally, staff #14 stated that she had not participated in creating a care plan with nursing staff regarding the hand splints. On 05.13.25 at 13:45 the surveyor reviewed the hard copy occupational therapy (OT) evaluation and plan of treatment notes for Resident #48. The document indicated that Resident #48 was certified for occupational therapy services from 03.25.25 through 05.19.25. One of the diagnoses described was contractures of bilateral hands and wrists. The OT notes documented a short-term goal of patient will tolerate bilateral hand orthotics without skin changes for four hours to maintain joint alignment and to prevent skin breakdown. As of 05.14.25 at 12:15 PM the facility failed to provide evidence that the interdisciplinary team which included nursing had created a care plan reflecting the occupational therapy goals for Resident #48 related to the use of bilateral hand and wrist orthotic splints.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on medical record review, interviews, and observations it was determined that the facility failed to revise and update the resident's care plan in a timely fashion. This was evident for 1 (#48) of 4 resident care plans reviewed during the survey. The findings include: A care plan is used to summarize a person's health conditions, specific care needs, and current treatments and outlines what needs to be done to plan, assess, and manage care. Care plans are developed, reviewed, and/or revised by the IDT after the completion of a comprehensive MDS assessment (Admission, Annual, Quarterly, Significant Change) to help to evaluate the effectiveness of the resident's care while in the facility. A comprehensive care plan is developed and revised by the interdisciplinary team to address a resident's individualized physical functioning for example. The Minimum Data Set (MDS) 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 05.08.25 at 08:30 AM the surveyor observed Resident #48 in bed with white knit tube stockings extending from the bilateral contracted hands up to the upper arms. The resident was non-verbal with surveyor at the time of the observation. During an interview with the DON it was determined that this resident required maximum assistance with eating meals and drinking fluids and was not wearing hand splints. On 05.09.25 at 12:30 PM the surveyor reviewed the electronic medical record and determined that there was no care plan present that addressed the use of hand splints for Resident #48 or occupational therapy (OT) interventions related to Resident #48's limited range of motion. On 05/12/25 at 01:24 PM during an interview with DON while observing Resident #48 in bed with white stretch cloth sock dressing from hand to elbows the surveyor asked if the resident should have hand and/or wrist splints on during certain times of the day and had occupational therapy made any recommendation. The surveyor also inquired whether the nursing staff ensured that the resident had the bilateral hand and wrist splints in place as recommended by the occupational therapy. The DON stated that the nursing department was responsible for applying the splints to the resident's bilateral hand and wrist. Resident #48's bilateral hand/wrist splints were located by the DON in the bedside table. On 05.13.25 at 08:20 AM the surveyor interviewed the DON regarding the status of the resident's hand splint. The DON stated that the OT staff had just started working with the resident. Also, the DON stated that the nursing staff had been using rolled washcloths in the resident's hands. The surveyor and the DON reviewed the electronic medical records with the surveyor to verify that the care plan did not include information regarding the resident's hand/wrist splints. The DON agreed that any interventions related to treating the resident's hand contractures should have been included in a care plan for Resident #48 and updated as the occupational therapist interventions changed. The DON was not able to show the surveyor a care plan related to the resident's use of hand/wrist splints since the OT interventions were initiated on 03.05.25 and continued through 05.14.25. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05.13.25 at 08:50 AM the surveyor interviewed the Director of Rehabilitation, staff #14. The surveyor asked if the OT staff had participated in any care plan meetings with the interdisciplinary team since March 26, 2025. Staff # 14 stated that no, the rehabilitation staff had not participated in care plan meetings. Staff #14 stated that the current air pump style splint is new and experimental for the resident and therefore there was no order for this specific type of splint. Additionally, staff #14 stated that she had not participated in creating a care plan with nursing staff regarding the hand splints. On 05.13.25 at 11:28 AM a further review of the electronic medical record reveal the annual MDS, including section GG0115, functional limitation in ROM, bilateral hand, arm was completed and signed on 05.07.25. The facility failed to update and revise the care plan to address the resident's individual needs for the potential/actual use of bilateral hand/wrist splints/orthotics. This deficient practice was reviewed with the administrative staff during the exit conference on 05.14.25.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on observations, family and staff interviews, and record review, it was determined that the facility failed to manage pain for residents who require such services consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This was evident for 1 (Resident #56) out of 28 residents observed during the survey. The findings include: On 5/08/25 at 2:00 PM Resident #56 was observed lying on their left side in bed complaining that it is burning. Surveyor spoke with resident's son who stated that when s/he urinates s/he says it burns and s/he doesn't like to be wet. Resident's son continued to state that s/he complains of pain all the time but I called for the GNA already. She's coming to change him/her. On 5/13/25 at 9:10 AM Resident #56 was observed lying on left side in bed screaming of pain. Resident was encouraged to use the call bell. Resident did hit the button but stated that s/he was scared no one would come. RN #18 came into the room within 3 minutes and asked the resident how could she help him/her. Resident #56 continued to scream in pain. RN #18 stated that she will bring pain medication. RN #18 was asked what the resident was getting for pain. She stated that Resident #56 is on scheduled Tylenol and Tramadol 25 mg as needed. Nurse #18 was then asked when was the last time that the resident received the Tramadol. RN #18 reviewed the chart and stated that the last time the resident received Tramadol was on 5/10/25. Resident #56 continued with screams that could be heard in the hallway. RN #18 was asked if this typical behavior for the resident to be calling out in pain. RN #18 stated that he/she only works one day a week but she has been the nurse before and noted that the resident is always in pain unless his/her family is visiting. RN #18 was asked, what did she think she should do for the pain as the resident's nurse. RN #18 replied that she was going to speak with the doctor about what they can do to better manage the resident's pain, maybe change the resident's Tramadol order from PRN to a standing order. On 5/13/25 at 12:15 PM Review of the Care Plan for Resident #56 revealed: Resident #56 is at risk for pain related to limited physical mobility and presence of sacral wound. Resident #56 will verbalize pain relief 0/10 scale through the review date. Administer pain medication as per ordered. Give 1/2 hour before treatments or care. Evaluate the effectiveness of pain interventions. Monitor/document for side effects of pain medication. Observe for constipation; new onset or increased agitation, restlessness, confusion, hallucinations, dysphoria; nausea; vomiting; dizziness and falls. Report occurrences to the physician. Monitor/record/report to Nurse resident complaints of pain or requests for pain treatment. Offer pain medication prior to wound care. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/13/25 at 12:50 PM, observation was made again of the resident. Resident #56 was sleeping comfortably in bed with wedges under his/her knees and pillows on both sides. Resident's family member was sitting with the resident at the bedside and stated that they were very satisfied with this nursing home, and that they take very good care of Resident #56. Surveyor asked the family member about resident's pain and if they thought that they were managing the pain for the resident. The family member replied that the resident has pain but it comes and goes; stated that they could manage the pain a little better and that the doctor had called today in reference to the resident's Tramadol order being changed to every 8 hours instead of PRN for better management of the pain.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the main kitchen tour and staff interviews, it was determined that the facility failed to store, monitor, and serve food in accordance with professional standards for food service safety. This deficient practice has the potential to affect all residents in the facility. The findings include the following: During the initial kitchen tour with the Culinary Director (Staff #06) on 05/08/25 at 08:00 AM, the following was observed: 1. The temperature logs for 7 out of 7 refrigerators observed were incomplete for 05/07/25 Evening and 05/08/25 Morning. 2. In the walk-in freezer, nine 3-gallon size Hershey's Ice Cream Premium tubs were observed sitting on the floor. 3. In the walk-in refrigerator, 1 gallon container each of [NAME] Thousand Island salad dressing and Ken's Asian Sesame dressing had a handwritten date on the lid. There was no expiration or used by date on either container. During the follow-up kitchen visit on 05/13/25 at 08:45 AM the Surveyor conducted temperature reviews with the Culinary Director #06 utilized the facility thermometer and performed the cold foods temperature testing at the Deli Holding Station and refrigerator below the Deli Holding station which revealed temperatures above 41°F for the following: 1. The deli holding station refrigerator thermometer read to be at 41.7 °F 2. A package of yellow cheese read to be at 43.1 °F 3. A bag of hard-boiled eggs read to be at 42.6 °F. 4. A package of turkey read to be at 44.0 °F. 5. A package of hot dogs from within the refrigerator read to be at 42.6 °F. These findings were discussed with the administrator prior to and during the exit conference.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, it was determined that the facility failed to: 1) maintain Infection Prevention & Control based on when and how isolation should be used for a resident. This was evident for 1 resident (#54) out of 20 residents reviewed during survey; 2) conduct an annual review of its Infection Prevention and Control Program (IPCP) and update their program, as necessary. This was evident during a review of the facility's Antibiotic Stewardship Program policy and procedures for infection control. The findings include: The findings include the following: 1. Enhanced Barrier Precautions are used as an infection control intervention that uses targeted gown and glove use during high-contact resident care activities in nursing homes to reduce the transmission of multidrug-resistant organisms (MDROs). During observation rounds on 05/08/25 at 08:44 AM there was a Enhanced Barrier Precautions sign posted on the door of resident room [ROOM NUMBER]. There was no indication to which resident within the room that the precautions applied to. During a staff interview on 05/08/25 at 08:47 AM with GNA, staff #09 stated that she did not know which resident within the room that the enhance barrier precautions were for. During resident medical record review on 05/08/25 at 10:00 AM revealed resident (#54) had diagnosis of a facility-acquired stage IV pressure ulcer requiring enhanced barrier precautions. 2. On 5/13/25 at 10 AM, surveyor asked Administrator #2 for a copy of their Antibiotic Stewardship policy which the Administrator returned immediately with a copy. Review of the policy revealed that it was last revised on August 2018 and should be reviewed in August 2019. The Admin #2 was asked if she had any documentation that the policy has been reviewed annually. Admin #2 stated that that's one of the things that I need to work on is updating PolicyStat where all the policies are. She then stated that she would get back to the surveyor with any information she could find. Admin #2 returned at 2:18 PM with an updated copy of the policy for review. Admin #2 stated that she did not have any documentation that the policy was updated since August 2018, but she was able to update the policy in PolicyStat. The new revised date is May 2025 and the next review date is May 2026.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, it was determined that the facility failed to ensure that essential equipment to be in safe operating condition. This was evident for 2 out of 13 resident rooms reviewed during the survey. The findings include the following: During observation rounds on 05/08/25 at 08:35 AM the Surveyor observed the call bell box hanging from wall with blue wires exposed in resident rooms [ROOM NUMBERS]. During an observation round and staff interview on 05/08/25 at 10:50 AM the Nursing Home Administrator #02 stated the maintenance team provides repairs to the call boxes when they are dislodged, and I will have maintenance look at it right away.