STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215234	A. Building B. Wing	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carriage Hill Bethesda	5215 Cedar Lane Bethesda, MD 20814

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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 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. 49815 Based on observations and interviews it was determined that the facility failed to ensure the dignity of the residents as evidenced by the nursing staff not knocking on resident room door before entering resident room, and nursing staff not wearing a name tag. This was found to be evident for 2 (Resident #35 and #58) out of 3 residents reviewed for dignity and resident rights. The findings include: During an interview with Resident #35 on 1/8/2025 at 10:05 AM the surveyor observed the Geriatric Nursing Assistant (GNA) #15 enter Resident #35's room without knocking on the resident room door. The surveyor interviewed GNA #15 and asked what the expectation was when entering a resident room. GNA #15 stated that staff were to knock on the resident room door prior to entering the resident room. GNA #15 acknowledged that she did not knock on Resident #35's door before entering the room and that she was sorry that she did not knock on the resident door. During the tour of Nursing Unit 2 at 12:55 PM am on 1/13/2025, the surveyor observed Geriatric Nursing Assistant (GNA) #17 in the hall at the food delivery cart outside of Resident #58's room. The surveyor observed that GNA #17 did not have a name badge visible on her person. The surveyor interviewed GNA #17 and asked what the expectation was for wearing a name tag in the facility. GNA #17 stated that all staff were to wear a name tag in the facility. GNA #17 later observed at the elevator with a piece of tape applied to her uniform with her name written on the piece of tape. The Nursing Home Administrator (NHA) and the Director of Nursing (DON) were notified of staff not wearing a name tag and staff not knocking on resident room door at the time of exit.

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42783 Based on observations, staff interview and record review, it was determined that the facility failed to ensure a homelike environment for residents and accommodate the needs of residents. This was found to be evident for 8 (Resident #209, #210, #212, #213, #215, #216, #217, and #357) out of 15 Residents reviewed for homelike environment and accommodation of needs. The findings include: 1) During random observations conducted on 01/15/25 at 11:29 AM, the Surveyors observed multiple environmental concerns in resident rooms. The following were observed: a. room [ROOM NUMBER] stained ceiling tiles in the bathroom and by the window, b. room [ROOM NUMBER] no bathroom call bell pull cord and a hole in the wall behind bed A, c. room [ROOM NUMBER] wall paper had peeled from the bathroom wall, d. room [ROOM NUMBER] no bathroom call bell pull cord and a plastic bag that covered the smoke detector, e. room [ROOM NUMBER] no bathroom call bell pull cord, f. room [ROOM NUMBER] ceiling tile stained in resident room above resident bed, and e. room [ROOM NUMBER] no bathroom call bell pull cord. During a tour of the facility conducted on 01/16/25 at 8:12 AM, the Nursing Home Administrator (NHA) and Surveyors observed resident rooms 209, 210, 212, 213, 215, 216, and 217. The NHA acknowledged the stained ceiling tiles, hole in the wall, missing bathroom call bell pull cords and a plastic bag that covered the smoke detector. The NHA pulled a chair underneath the smoke detector in Resident room [ROOM NUMBER] and removed the plastic bag that covered the smoke detector. During an interview conducted on 01/16/25 at 8:26 AM, the NHA stated that he would have an audit conducted of all resident rooms for environmental concerns. 50502 2) On 1/08/25 at 8:31 AM, Resident #357 was observed lying in bed on an air mattress. He/she stated that he/she had difficulty sleeping since 1/6/2025, the night of his/her admission. He/she added that he/she felt miserable because the mattress was very uncomfortable causing his/her back to hurt. According to Resident #357, he/she already informed the nurse on 1/7/2025 and he/she was told that the facility will replace the mattress today. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/09/25 at 8:51 AM, Resident #357 was again observed lying on the air mattress. He/she claimed that he/she was told that the air mattress would be replaced with a regular one on 1/8/2025, but it never happened. He/she again expressed to the surveyor that the air mattress was very uncomfortable, and he/she had a hard time sleeping. The surveyor notified Unit Manager (UM #13) at 9:00 AM. On 1/09/25 at 9:02 AM, a record review of the physician orders revealed no evidence that the air mattress was ordered by the physician. On 1/14/25 at 9:20 AM, in an interview with the Assistant Director of Nursing (ADON), she stated that the managers conducted rounds in the morning and talked to the residents, especially the new admissions, and addressed the issues right away. The ADON was made aware that Resident #357 requested for the air mattress to be removed because it was causing discomfort and inability to sleep, however, it took 3 days for the facility staff to address the concern. On 1/16/25 at 12:30 PM, the Nursing Home Administrator (NHA) and the Director of Nursing (DON) were notified of the concern.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50502 Based on observation, interview and record review, it was determined that the facility failed to complete comprehensive MDS (Minimum Data Set) assessments within the required timeframe. This was evident for 6 (Resident #4, #6, #11, #71, #94, and #405) out of 34 Residents reviewed for resident assessments during the annual survey. The findings include: 1) Minimum Data Set (MDS) is a core set of screening, clinical, and functional status data elements, including common definitions and coding categories, which form the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare or Medicaid. The data elements (also referred to as items) in the MDS standardize communication about resident problems and conditions within nursing homes, between nursing homes, and between nursing homes and outside agencies. MDS assessments need to be accurate to ensure each resident receives the care they need. According to CMS guidelines, an MDS annual assessment must be completed within 14 days of the Assessment Reference Date (ARD). On 1/9/25 at 3:00 PM, a review of the MDS assessments revealed that the following annual assessments were not completed and were more than 30 days overdue of the ARD: 1. Resident #4 was admitted on [DATE]. An annual assessment was initiated with an ARD of 11/25/2024, however, the assessment was still in progress. 2. Resident #6 was admitted on [DATE]. An annual assessment was initiated with an ARD of 11/4/2024, however, the assessment was still in progress. 3. Resident #11 was admitted on [DATE]. An annual assessment was initiated with an ARD of 11/30/2024, however, the assessment was still in progress. 4. Resident #71 was admitted on [DATE]. An annual assessment was initiated with an ARD of 11/8/2024, however, the assessment was still in progress. 5. Resident #94 was admitted on [DATE]. An annual assessment was initiated with an ARD of 11/28/2024, however, the assessment was still in progress. On 1/10/25 at 10:19 AM, during an interview with the Lead MDS Coordinator, she stated that the timeline for completing an MDS assessment was within 14 days of the ARD. She confirmed that the facility was aware of the late assessments, and she revealed that lately, she was not able to complete the assessments due to the increased number of facility admissions and the number of nurses who completed the MDS assessments were trimmed down from 3 to 2. She added that currently, it was just her and the Licensed Practical Nurse (LPN #14), who did the MDS assessments. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/10/25 at 11: 08 AM, the Nursing Home Administrator (NHA) and the Director of Nursing (DON) were notified of the concern. 50504 2) Resident #405 was admitted to the facility on [DATE]. On 01/15/2025 at 11:31 AM the surveyor conducted a record review of the MDS assessment for Resident #405. The record review revealed that an initial comprehensive assessment was not completed for the resident for over 14 days. The MDS record stated 12/27/2024 Admission - None PPS 3.0 - In Progress On 01/10/2025 at 10:19AM in an interview with the surveyor, Staff #4 stated that the MDS assessment was not completed within 14 days because of changes in the facility including staffing issues. On 01/10/25 at 11: 08 AM the surveyor notified the Nursing Home Administrator and the Director of Nursing of the findings.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident's assessment is updated at least once every 3 months. 50502 Based on record review and interview, it was determined that the facility failed to complete the Quarterly MDS (Minimum Data Set) assessments within the required timeframe. This was evident for 18 (Residents #9, #11, #22, #30, #32, #46, #62, #64, #65, #76, #78, #81, #87, #96, #99, #101, #102 and #109) of 33 residents reviewed for resident assessments during the annual survey. The findings include: Minimum Data Set (MDS) is a core set of screening, clinical, and functional status data elements, including common definitions and coding categories, which form the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare or Medicaid. The data elements (also referred to as items) in the MDS standardize communication about resident problems and conditions within nursing homes, between nursing homes, and between nursing homes and outside agencies. MDS assessments need to be accurate to ensure each resident receives the care they need. According to CMS guidelines, an MDS Quarterly assessment must be completed within 14 days of the Assessment Reference Date (ARD). On 1/9/25 at 3:00 PM, a review of the MDS assessments in the facility revealed that the following Quarterly assessments were not completed within 14 days of the ARD: 1. Resident #9- ARD 11/30/2024, in progress 2. Resident #11- ARD 12/5/2024, in progress 3. Resident #22- ARD 10/27/2024, in progress 4. Resident #30- ARD 11/15/2024, in progress 5. Resident #32- ARD 10/23/2024, in progress 6. Resident #46- ARD 11/18/2024, in progress 7. Resident #62- ARD 11/12/2024, in progress 8. Resident #64- ARD 10/27/2024, in progress 9. Resident #65- ARD 11/28/2024, in progress 10. Resident #76- ARD 11/06/2024, in progress 11. Resident #78- ARD 10/23/2024, in progress 12. Resident #81- ARD 11/30/2024, in progress (continued on next page)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	13. Resident #87- ARD 10/23/2024, in progress 14. Resident #96- ARD 11/07/2024, in progress 15. Resident #99- ARD 11/14/2024, in progress 16. Resident #101- ARD 11/24/2024, in progress 17. Resident #102- ARD 12/04/2024, in progress 18. Resident #109- ARD 11/23/2024, in progress On 1/10/25 at 10:19 AM, during an interview with the Lead MDS Coordinator, she stated that the timeline for completing an MDS assessment was within 14 days of the ARD. She confirmed that the facility was aware of the late assessments, and she added that lately, she was not able to complete the assessments due to the increased number of facility admissions and the number of nurses who completed the MDS assessments were trimmed down from 3 to 2. She revealed that currently, it was just her and the Licensed Practical Nurse (LPN #14), who did the MDS assessments. On 1/10/25 at 11: 08 AM, the Nursing Home Administrator (NHA) and the Director of Nursing (DON) were notified of the concern.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. 50502 Based on record review and interview, it was determined that the facility failed to complete and transmit the Minimum Data Set (MDS) assessments. This was evident for 27 (Residents #4, #6, #9, #11, #22, #23, #30, #32 #46, #62, #64, #65, #71, #72, #76, #78, #81, #87, #91, #93, #94, #95, #96, #99, #101, #102 and #109) of 33 residents reviewed for resident assessments during the annual survey. The findings include: Minimum Data Set (MDS) is a core set of screening, clinical, and functional status data elements, including common definitions and coding categories, which form the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare or Medicaid. The data elements (also referred to as items) in the MDS standardize communication about resident problems and conditions within nursing homes, between nursing homes, and between nursing homes and outside agencies. MDS assessments need to be accurate to ensure each resident receives the care they need. Nursing homes are required to submit the Omnibus Budget Reconciliation Act (OBRA) required MDS records for all residents in Medicare- or Medicaid-certified beds regardless of the payer source to Centers for Medicare and Medicaid Services (CMS') Internet Quality Improvement and Evaluation System (iQIES). Skilled nursing facilities (SNFs) are required to transmit additional MDS assessments for all Medicare beneficiaries in a Part A stay reimbursable under the SNF Prospective Payment System (PPS). Assessment Transmission: Comprehensive assessments must be transmitted electronically within 14 days of the Care Plan Completion Date. All other MDS assessments must be submitted within 14 days of the MDS Completion Date. On 1/9/25 at 3:00 PM, a review of the MDS assessments revealed that the following MDS assessments were not completed and not transmitted in a timely manner: 1. Resident #4- ARD 11/25/2024 Annual 2. Resident #6- ARD 11/04/2024 Annual 3. Resident #9- ARD 11/30/2024 Quarterly 4. Resident #11- ARD 12/05/2024 Quarterly; 11/30/2024 Annual 5. Resident #22- ARD 10/27/2024 Quarterly 6. Resident #23- ARD 11/26/2024 Discharge Return Not Anticipated 7. Resident #30- ARD 11/15/2024 Quarterly 8. Resident #32- ARD 10/23/2024 Quarterly (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	9. Resident #46- ARD 11/18/2024 Quarterly 10. Resident #62- ARD 11/12/2024 Quarterly 11. Resident #64- ARD 10/27/2024 Quarterly 12. Resident #65- ARD 11/28/2024 Quarterly 13. Resident #71- ARD 11/08/2024 Annual 14. Resident #72- ARD 10/21/2024 Discharge Return Anticipated 15. Resident #76- ARD 11/06/2024 Quarterly 16. Resident #78- ARD 10/23/2024 Quarterly 17. Resident #81- ARD 11/30/2024 Quarterly 18. Resident #87- ARD 10/23/2024 Quarterly 19. Resident #91- ARD 11/01/2024 Discharge Return Not Anticipated 20. Resident #93- ARD 11/26/2024 Discharge Return Not Anticipated 21. Resident #94- ARD 11/24/23 Annual 22. Resident #95- ARD 11/8/2024 Discharge Return Not Anticipated 23. Resident #96- ARD 11/07/2024 Quarterly 24. Resident #99- ARD 11/14/2024 Quarterly 25. Resident #101- ARD 11/24/2024 Quarterly 26. Resident #102- ARD 12/04/2024 Quarterly 27. Resident #109- ARD 11/23/2024 Quarterly; 11/26/2024 End of PPS Part A Stay On 1/10/25 at 10:19 AM, during an interview with the Lead MDS Coordinator, she stated that the timeline for completing MDS assessment was within 14 days of the ARD. She revealed that the facility was aware of the late assessments, and added that lately, they were not able to complete the assessments due to the increased number of facility admissions and the number of nurses who completed the MDS assessments were trimmed down from 3 to 2. She added that they prioritize the Medicare assessments and then the Medicaid and Private ones. She stated that currently, it was just her and the Licensed Practical Nurse (LPN #14), who did the MDS assessments. On 1/10/25 at 11: 08 AM, the Nursing Home Administrator (NHA) and the Director of Nursing (DON) were notified of the concern.

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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** 50502 Based on record review and interview, it was determined that the facility failed to accurately code the resident's discharge status on the Minimum Data Set (MDS) assessment. This was evident for 1 (Resident #152) of 4 residents reviewed for hospitalization s during the survey. The findings include: Minimum Data Set (MDS) is a core set of screening, clinical, and functional status data elements, including common definitions and coding categories, which form the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare or Medicaid. The data elements (also referred to as items) in the MDS standardize communication about resident problems and conditions within nursing homes, between nursing homes, and between nursing homes and outside agencies. MDS assessments need to be accurate to ensure each resident receives the care they need. On 1/10/25 at 12:18 PM, a record review of Resident #152 revealed a discharge date of [DATE]. The discharge summary dated 10/08/2024 indicated that Resident #152 was discharged to another nursing home. On 1/13/25 at 8:20 AM, a review of section A of the MDS Discharge Return Not Anticipated assessment with an Assessment Reference Date (ARD) of 10/8/2024 indicated, Discharge Status- Short- term general hospital (acute hospital). On 1/13/25 at 10:02 AM, in an interview with the Social Worker Director, she confirmed that Resident #152 was discharged to another nursing home. On 1/13/25 at 10:08 AM, Licensed Practical Nurse (LPN #14) confirmed that Resident #152 went to another facility and not to the hospital. The Lead MDS Coordinator also confirmed that the MDS assessment should reflect discharged to another facility, she stated that she will modify the assessment to reflect the accurate discharge status on the MDS. On 1/13/25 at 10:14 AM, the Nursing Home Administrator (NHA) was made aware of the MDS inaccuracy.

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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 and implement a comprehensive care plan for constipation, the use of intravenous (IV) fluids for hydration and Activities of Daily Living (ADLs) for dependent resident. This was evident for 3 (Resident #12, #355 and #356) out of 13 residents reviewed for care planning during the recertification survey. The findings include: 1) 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. On 1/08/25 at 8:19 AM, Resident #355 stated that he/she was constipated from 12/29/2024 and nothing had been done until 1/2/2025. He/she added that the facility staff gave him/her a medication that resulted in diarrhea and vomiting. On 1/14/25 at 3:08 PM, a review of Resident #355's medical record revealed the following medications for bowel regimen: - Colace Oral Capsule 100 MG (Docusate Sodium) Give 2 capsules by mouth at bedtime for constipation-start date: 01/03/2025 - Fleet Saline Enema Rectal Enema 7-19 GM/197ML (Sodium Phosphates) Insert 1 application rectally every 24 hours as needed for constipation-start date: 01/03/2025 - Milk of Magnesia Oral Suspension 400 MG/5ML (Magnesium Hydroxide) Give 30 ml by mouth every 24 hours as needed for constipation- start date: 01/03/2025 - MiraLax Oral Packet 17 GM (Polyethylene Glycol 3350) Give 1 packet by mouth one time a day for constipation- start date: 01/03/2025 - Senna Oral Capsule 8.6 MG (Sennosides) Give 2 capsules by mouth one time a day for constipation- start date: 01/02/2025 Further review of the medical record indicated that Resident #355 was not on any bowel regimen for the month of December 2024. In January 2025, Resident #355 received the following medications to address constipation: - Colace- 1/4, 1/5, 1/6, 1/7, 1/8 - Miralax- 1/4, 1/5, 1/6, 1/7, 1/8 - Senna- 1/3, 1/4, 1/5, 1/6, 1/7, 1/8 - Dulcolax- 1 time on 1/3 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The physician's progress notes dated 1/2/2025 indicated that Resident #355 was seen & examined for the evaluation and management of constipation and was started on bowel regimen. The surveyor conducted a review of Resident's care plan, however, there was no evidence that a care plan to address constipation was developed. 2) On 1/08/25 at 8:11 AM, in an interview with Resident #356, he/she stated that he/she had non-stop diarrhea on 1/7/2025. On 1/13/25 at 3:05 PM, a review of Resident #356's medical record revealed a diagnosis of irritable bowel syndrome (IBS), a chronic digestive condition that causes abdominal pain and changes in bowel movements. On 1/14/25 at 5:26 PM, a review of Resident #356's medical record revealed the following medications for bowel regimen: - Cholestyramine Oral Packet 4 GM (Cholestyramine) Give 1 packet by mouth three times a day for IBS - Digestive Advantage Oral Capsule (Probiotic Product) Give 1 capsule by mouth two times a day for supplement - Florastor Oral Capsule 250 MG (Saccharomyces boulardii) Give 1 capsule by mouth one time a day for probiotic for 14 Days The Nurse Practitioner's (NP) progress notes dated 1/8/2025 indicated that Resident #356 was seen for nausea, vomiting and diarrhea for a few days. The NP ordered the following: - Peripheral IV for hydration. Normal Saline 0.9% IV Solution, use 2 liters intravenously for 2 Days - Stool exam to confirm infection - Vancomycin 250mg po three times a day for 14 days - Florastor Oral Capsule 250 MG Give 1 capsule by mouth one time a day for probiotic for 14 Days On 1/15/25 at 9:04 AM, in an interview with the Unit Manager (UM #13) and the Assistant Director of Nursing (ADON), they discussed the process of care planning for Change of Condition (COC). They stated that the nursing managers met every morning and discussed COCs. They added that ADON and UM #13 created and updated the care plans as needed. The ADON and UM #13 confirmed that Resident #355 had no care plan for constipation and Resident #356 had no care plan for IV for hydration. On 1/16/25 at 12:30 PM, the Nursing Home Administrator (NHA) and the Director of Nursing (DON) were made aware of the concern. 50504 3) Activities of daily living 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. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #12 was admitted to the facility on [DATE] with diagnoses including Schizophrenia, Muscle Weakness Difficulty Walking and Intellectual Disabilities. He/she was readmitted on [DATE] with a primary diagnosis of New Onset Seizure. On 01/08/25 at 10:30 AM Resident #12 informed the surveyor that he/she does not get the help he/she needs. On 01/09/25 at 06:10 PM the surveyor reviewed Resident #12's functional abilities assessment dated [DATE] and comprehensive assessment record dated 09/07/2024. The records revealed that the resident was dependent on staff for toileting hygiene, shower/bathe, personal hygiene, and lower body dressing. In addition, the resident's progress note dated 10/16/2024 revealed that the resident requires one person assist with bed mobility and extensive assistance for transfers. Further review of the Resident #12's clinical record failed to reveal a care plan was initiated and implemented to address the resident's dependence on staff for Activities of Daily Living (ADLs) to include personal hygiene, shower/bathe, dressing and toileting hygiene. On 01/13/25 at 10:31AM the surveyor interviewed LPN Staff # 11 on the process of initiating care plans. LPN Staff #1 stated that upon admission and change in condition a clinical assessment is done by the Charge Nurse and the findings documented in the resident's clinical record. The Charge Nurse then informs the Unit Manager/ Supervisor who initiates and updates the care plans based on the resident's needs. The staff member stated that she was aware of Resident #12's dependence on staff but could not recall whether there was an ADL care plan in place. On 01/14/25 at 07:29 AM, the Director of Nursing was made aware of the findings and stated that he would look into the matter.

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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** 45733 Based on observation, interview and medical record review it was determined that the facility failed to provide an invitation to residents for care plan meetings, failed to provide residents with care plan meetings and failed to revise resident care plans. This was found to be evident in 5 (Resident #1, #58, #62, #158 and #164) out of 10 Residents reviewed for care plan timing and revision. The findings include: Care Plan meetings are meetings with a team of care providers (attending physician, a registered nurse, nursing assistant dietary services, resident, and the resident ' s representative if applicable) to ensure the plan is continually adjusted to meet the changing needs or concerns of residents. Care Plan meetings are to be held quarterly. BIMS uses a scoring system that is a number between 0 and 15 that indicates a resident's cognitive health in a long-term care facility. The BIMS score is used to help identify early signs of cognitive decline and the need for further evaluation. Scores: 13-15: Intact cognition, 8-12: Moderate cognitive impairment & 0-7: Severe cognitive impairment. 1) In interview on 01/07/25 at 04:40 PM, Resident #1 stated I don't know what care plan was for? Record review, 01/13/25 at 02:48 PM, revealed that Resident #1 was admitted to the facility on [DATE] with diagnoses of encephalopathy and cognitive function decline. A cognitive evaluation on 10/21/24 by Social Worker #2 with the BIMS score showed 10, indicating moderate cognitive impairment . Further record review found no social worker's care plan conference invitation nor conference notes. During an interview, on 01/16/25 at 09:49 AM, Social Worker Staff #2 stated that she worked in the facility for over [AGE] years. She reported that upon admission Resident #1 had a case worker from the Adult Protection Service following the Resident's care. Staff #2 was able to contact the case worker by phone for financial concerns but not for care-plan meetings. Staff #2 could not explain why she never sent out a care-plan meeting invites to this Resident and the case worker. Interview, on 01/16/25 at 09:59 AM, the Administrator was made aware of the above findings and agreed that there was a deficient practice. 49815 2) On 1/8/2025 at 11:08 AM the surveyor interviewed Resident #62 who stated that he/she does not recall attending care plan meetings recently. The surveyor conducted a review of Resident #62's medical record on 1/14/2025 at 9:30 AM. The review of the medical record revealed that there was one care plan meeting note in the progress notes of Resident #62's medical record for the past year. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the Nursing Home Administrator (NHA) at 8:30 AM on 1/15/2025 the surveyor conveyed to the NHA that there was only one care plan meeting note in Resident #62's medical record. The NHA provided the surveyor with the plan of care progress note and an attendance sheet dated 8/8/2024 which indicated that the care plan was discussed with Resident, responsible party and the interdisciplinary team. The surveyor asked the NHA for additional care plan meeting documentation for Resident #62 over the past year and the NHA stated to the surveyor that there was not any additional documentation of care meetings for the past year for Resident #62. 3) During an interview on 1/9/2025 at 8:15 AM Resident #58 stated to the surveyor that he/she has never been invited to a care plan meeting and that this was the first time that he/she heard about a care plan meeting. The surveyor reviewed Resident #58's medical record on 1/13/2025 at 9:15 AM. There was no documentation that a care plan invitation was provided, or a care plan meeting was held for Resident #58 for August 2024. The surveyor interviewed the Nursing Home Administrator (NHA) at 1:30 PM on 1/13/2025 and the NHA provided the surveyor with copies of progress notes detailing care plan meetings that were held 5/20/2024 and 10/29/2024 for Resident #58. The NHA was unable to provide a progress note for the care plan meeting or that a care plan meeting was held or that an invitation was provided for the month of August 2024 for Resident #58. The progress notes for May 2024 and October 2024 indicated the following: discussed plan of care with patient & daughter. In a follow-up interview with the NHA at 11:30 AM on 1/13/2025 he stated that these were the only 2 care plan meetings that were held for Resident #58 during the past year which were documented in the progress notes and that there was no documentation for invitations to care plan meetings for additional care plan meetings that were held during the past year. An Arteriovenous (AV) Fistula is a surgical connection made between an artery and a vein typically located in the arm in preparation for dialysis by a vascular specialist. AV Fistulas are the preferred vascular access for long-term dialysis. With an AV Fistula, blood flows from the artery directly into the vein, increasing the blood pressure and the amount of blood flow through the vein. The increased flow and pressure cause the veins to enlarge. The enlarged veins will be capable of delivering the amount of blood flow necessary to provide adequate treatment for hemodialysis. A permacath or permanent catheter for dialysis is a flexible tube that is used to treat kidney disease with dialysis. It is inserted into a blood vessel in the neck or upper chest and threaded to the right side of the heart. The catheter has two tubes inside, one for blood to the dialysis machine and one for the blood return. The cuff under the skin keeps the catheter in place. Permacaths are used for short term dialysis or until an AV Fistula can be created. On 1/9/2025 at 8:15 AM the surveyor observed Resident #58 in the Resident room with an AV fistula to the right upper arm. The surveyor reviewed the medical record of Resident #58 on 1/13/2025 at 9:15 AM. The review of the medical record revealed that Resident #58 had a current care plan for a permacath for dialysis. Further review of the current physician orders revealed that Resident #58 had current orders for an AV Fistula for dialysis. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The surveyor interviewed the Director of Nursing (DON) on 1/15/2025 at 10:45 AM and reviewed Resident #58's current care plan and physician orders for dialysis. The surveyor conveyed to the DON that the care plan indicated that the Resident had a permacath but the physician orders indicated that the Resident had an AV Fistula. The Director of Nursing acknowledged that the Resident #58 had an AV Fistula for dialysis and no longer had a permacath for dialysis. On 1/16/2025 at 8:30 AM the DON provided the surveyor with a revised care plan for dialysis which indicated that Resident #58 had an AV Fistula. 51491 4) During a review of Resident Medical Records on 1/08/25 at 03:54 PM it was discovered that Resident #158 had been a resident in the facility since May 2022. Resident #158 had several medical conditions and was dependent on staff for care, including eating, transferring, and mobility. It was found that the Resident had not had quarterly Care Plan Meetings on regular basis. The only documented Care Plan Meeting was held on 7/15/2024. During an interview with Social Service Designee #2 on 1/15/25 at 10:54 AM, she confirmed that they are behind on Care Plan Meetings and that Social Worker Designee #29 handles Residents #158 and #164. During an interview with Social Worker Designee #29 on 1/15/25 at 11:13 AM, she confirmed that Care Plan Meetings are not up to date. She reported that the Care Plan Meetings are documented in the Resident's Medical Records, and she maintains the attendance sheets for Care Plan meetings. During an interview with the Nursing Home Administrator (NHA) on 1/15/25 at 12:30 PM, the NHA provided a signoff sheet for a Care Plan meeting for Resident #158 dated 7/15/24. The signoff sheet included the Dietician, Social worker Designee, Unit Manager, and Activities. He confirmed there were no additional attendance sheets or documentation of Care Plan Meetings. The NHA advised he was aware of the late status of Care Plan meetings. The Attendance sheet provided for the Care Plan Meeting for 07/15/24 included the son, dietician, unit manager activities and Social Services, no other documented Care Plan Meetings for Resident #158 were provided. 5) During a Review of Resident Medical Records on 1/15/25 at 07:45, it was discovered that Resident #164 had been a resident in the facility from December 2022 until January 2024. The Resident had several medical conditions and was dependent on staff for care. It was found that the Resident had not been given the required quarterly Care Plan Meetings. The Resident had a documented Care Plan Meeting for 3/2/23, no additional meetings were found. During an interview with Social Service Designee #2 on 1/15/25 at 10:54 AM, she confirmed that they were behind on Care Plan Meetings and that Social Worker Designee #29 handles the Residents #158 and #164. During an interview with Social Worker Designee #29 on 1/15/25 at 11:13 AM, she confirmed that Care Plan Meetings were not up to date. She reported that the Care Plan Meetings were documented in the Resident's Medical Records and she maintained the Attendance sheets for 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	During an interview with the Nursing Home Administrator (NHA) on 1/15/25 at 12:30 PM, the NHA had no Attendance Sheets for care plan meetings for Resident #164. He confirmed there were no additional attendance sheets or documentation of Care Plan Meetings. He was made aware of the late status of Care Plan meetings.

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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. 48393 Based on observation, clinical record review and staff interviews, it was determined that the facility staff failed to provide an ongoing activities program to meet the needs and preferences of residents. This was evident for 1 (#94) of 4 residents reviewed for activities during the survey. The findings include: Minimum Data Set (MDS) is a standardized, primary screening and assessment tool of health status which forms the foundation of the comprehensive assessment for all residents of long-term care facilities certified to participate in Medicare or Medicaid. The MDS contains items that measure physical, psychological and psycho-social functioning. The items in the MDS give a multidimensional view of the patient's functional capacities. On 01/09/2025 at 09:41 AM, an observation was made of Resident #94 sitting in a wheelchair in the hallway across from the nurses' station. On 01/10/2025 at 11:14 AM Resident #94 was observed again sitting in a wheelchair in the hallway across from the nurses' station. The resident was not observed participating in any activities. On 01/10/2025 at 12:13 PM, an interview conducted with the Assistant Director of Nursing (ADON) revealed that Resident #94 is sometimes taken to group activities but mostly sits by the nurses' station. On 01/14/25 at 08:28 AM, a review of Resident #94's electronic clinical record revealed that an annual MDS assessment was completed on 11/24/2023. Resident #94's documented responses in Section F0500 (Activity Preferences) showed how important is it to have books, newspapers and magazines to read? The response was very important. How important is it to you to listen to music you like? The response was very important. How important is it to you to keep up with the news? The response was very important. How important is it to do things with groups of people? The response was very important. How important is it to you to do your favorite activities? The response was very important. How important is it to you to participate in religious services or practices? The response was very important. On 01/15/2025 at 09:03 AM, a review Resident #94's activity care plan dated 11/28/2023 revealed that he/she is dependent on staff for meeting emotional, intellectual, physical and social needs r/t Altered mental status and visual impairment. Resident #94 had a goal that stated he/she should attend/participate in activities of choice 3-5 times weekly by next review date. Additionally, interventions included in the care plan stated to provide a program of activities that is of interest and empowers him/her by encouraging/allowing choice, self-expression and responsibility and ensure that the activities the resident is attending are: Compatible with physical and mental capabilities; Compatible with known interests and preferences; Adapted as needed (such as large print, holders if resident lacks hand strength, task segmentation), Compatible with individual needs and abilities; and age appropriate. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/14/2025 at 1:19 PM, the surveyor reviewed a facility provided documentation survey report of Resident #94's participation in tasks for November 2024. The report documented two days of activity, 11/18 and 11/19, and included documented tasks such as exercise/sports, games and trivia. The remainder of the report was blank. Resident #94's activity participation reports for December 2024 and January 2025 were requested. However, no documentation of activities was provided for December 2024 and January 2025. On 01/15/2025 at 09:06 AM, an interview conducted with the Activities Director (AD) revealed that resident likes and dislikes are made known during the admission process and confirmed that she was familiar with Resident #94's health conditions and activity preferences. The AD stated that the facility offers sensory stimulation activities to residents with visual impairment. The AD further stated that Resident #94 is sometimes taken to group activities but he/she yells out so he/she doesn't stay long. On 1/15/2025 at 9:44 AM, a follow up interview with the AD revealed that she documents resident #94's activity participation in the electronic clinical record and keeps a list of the residents that attend activities on paper in a separate notebook. The AD reviewed her participation notes together with the surveyor and stated, I don't have much in here for Resident #94. Further review of Resident #94's clinical record revealed no documentation to support that Resident #94 is engaged in an ongoing and individualized activities program. Multiple observations conducted throughout the survey revealed Resident #94 sitting in the hallway across from the nurse's station in the hallway. Resident #94 was not observed participating in structured, individual activities throughout the survey.

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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** 50504 Based on record reviews and interviews, it was determined that the facility failed to follow up on recommendations for specialty consultations for residents. This was evident for 1 (Resident #12) of 1 resident reviewed for consultations. The findings include: On 01/10/25 at 7:10 PM a review of Resident #12's clinical record revealed that the resident was admitted to the facility on [DATE]. On 10/12/24 the resident was transferred to the hospital for unresponsiveness. On 10/16/24 Resident#12 was readmitted to facility with a primary diagnoses of New Onset Seizure. The resident's discharge summary dated 10/16/24 requested an appointment be made with a Neurologist within 4 weeks of discharge. Further review of the resident's clinical record revealed the Physicians and Nurse Practitioners progress notes stated as follows: - 10/16/24 at 17:04 Physician (Re-admission): Per discussion with neurology, the patient will need to be seen in the near future for follow-up (appointment has to be made by family/staff) - 10/25/24 at 11:06 Physician Progress Note (History & Physical) - Assessment/Pan - Seizure continue Keppra. F/U (follow-up) with Neurology - 12/13/2024 at 12:38 Nurse Practitioner Progress Note- Seizure continue Keppra. F/U (follow-up) with Neurology There was no documentation in Resident #12's clinical record to show whether the resident had a follow-up appointment with Neurology or why the resident was not seen by a Neurologist. On 01/13/25 at 11:28 AM in an interview with Staff #1 the surveyor inquired about the process for making consultation appointments. Staff #1 stated that the Nurse Manager, Nurse Supervisor or Charge Nurse would make appointments based on the physician's order and hospital recommendations. Staff #1 was unable to confirm whether a Neurology appointment was scheduled for Resident #12. On 01/13/25 at 2:53 PM the surveyor conducted an interview with the Medical Director who acknowledged the Physicians and Nurse Practitioners' progress notes regarding Resident #12's neurology consultation and stated that the nurses usually review the clinical record and make appointments. He also stated that since the progress notes indicated follow-up appointments and Resident #12 was not seen by a Neurologist, he should have written a note addressing the issue. Further, the resident was stable with medications and after 2 months a consultation was not indicated. On 01/14/25 at 07:15 AM in an interview, the Director of Nursing was informed of the lack of follow up on Resident #12's Neurology recommendation. The DON stated that he would speak with the Medical Director.

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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, medical record review and interviews it was determined that the facility failed to follow appropriate respiratory care and services. This was found to be evident in 1 (Resident #145) out of 1 Resident reviewed for respiratory care and services. The findings include: On tour of the Nursing Unit 1 on 1/8/2025 at 10:39 AM the surveyor observed an oxygen humidifier bottle and oxygen tubing attached to the oxygen concentrator in Resident #145's room without a date on the humidifier bottle and the tubing. In addition, the surveyor did not observe an oxygen usage sign on the Resident room door or on the doorframe of the Resident #145's room. The surveyor conducted a record review of Resident #145's medical record on 1/10/2025 at 8:15 AM. The medical record review revealed that Resident #145 had current physician orders for oxygen and an order to change the oxygen tubing and humidifier bottle every Monday on the night shift. Further review of the medical record revealed that Resident #145 had a care plan for oxygen therapy related to respiratory illness. In addition, the surveyor reviewed the facility's oxygen concentrator policy and procedure dated 7/20/2022. The policy guidelines were to place an oxygen sign on the Resident's door, to change the tubing/cannula weekly and as needed, and to change humidifier bottle when empty or every seventy-two hours. The surveyor interviewed the Director of Nursing (DON) on 1/16/25 at 10:30 AM and reviewed Resident #145's oxygen usage. The surveyor asked the DON what the expectation was for oxygen signage and changing of oxygen tubing and humidifier bottles when Residents use oxygen. The DON stated that there was to be a sign on the Resident room door that indicated oxygen was in use and that the oxygen tubing and humidifier bottles were to be changed weekly. The DON stated that this must have been overlooked for Resident #145.

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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** 50504 Based on record review and interview, it was determined that the facility failed to discontinue a medication in a timely manner as ordered by the attending physician. This was evident for 1 (Resident #73) of 2 residents reviewed for unnecessary medications. The findings include: Resident #73 was admitted to the facility on [DATE] with diagnoses including Cognitive Communication Deficit, Major Depressive Disorder and Psychosis. On 01/13/25 at 07:40 AM a review of Resident #73's clinical record revealed that the Licensed Pharmacist on 09/11/2024 made a recommendation to the physician to discontinue the medication, Oxycodone PRN (as needed) because it was not utilized by the resident. On 09/17/2024 the physician reviewed the recommendation and ordered Oxycodone PRN be discontinued. Further review of the clinical documentation revealed that the facility failed to follow up on the physician's order to discontinue the medication on 09/17/2024. On 11/12/2024 the Licensed Pharmacist again issued a recommendation for oxycodone PRN to be discontinued. The medication was subsequently discontinued on 11/15/2024, two months after the physician issued an initial order to discontinue the medication. On 01/10/25 at 08:33 AM in an interview, the Director of Nursing (DON) was asked about the process for pharmacy recommendations. The DON stated that when he receives the recommendations from the pharmacy, he distributes them to the nurses for follow up. Physicians and Nurse Practitioners are given the recommendations by the nurses for their decision and orders. The nurses then ensure that the orders are implemented. The surveyor reviewed the pharmacy recommendations for Resident #73 with the DON who confirmed the findings.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45733 Based on interview, observation and record review it, was determined that the facility staff failed to promptly provide or obtain/schedule for dental services. This was found to be evident for 1 (Resident #1) out of 3 residents reviewed for dental services during an annual survey. The findings include: During a floor rounding, on 01/07/25 at 01:09 PM, Resident #1 stated I had my teeth problem and a cap fell out and it hurts, I told the staff first when I was admitted . Record review, on 01/13/25 at 02:48 PM, revealed that Resident #1 was admitted on [DATE] to this facility with the diagnoses of severe protein-calorie malnutrition and encephalopathy. On 10/20/24 an initial dental assessment was done by the Social Worker Staff #2. Under The Minimum Data Set (MDS) section L0200, the assessment code was Yes to a broken or loose-fitting tooth (chipped, cracked, uncleanable or loose). The Minimum Data Set (MDS) is a standardized assessment tool that measures health status in nursing home residents. MDS assessments are completed every 3 months (or more often, depending on circumstances) on nearly all residents of nursing homes in the United States. These assessments are performed and recorded by nursing home staff and include information on a number of aging-relevant domains including functional and cognitive status, psychosocial functioning, geriatric syndromes, and life care wishes. As such, MDS is an extremely valuable resource for studying function and disability on a large scale in vulnerable older adults. MDS data is collected and made available as one of the many data products of the Centers for Medicare and Medicaid Services (CMS). However, on 12/23/24 the MDS assessment code under L0200, was changed by the Social Worker Staff #2 to No and to no to all other areas. Therefore, the broken tooth was never referred to the on-site dental service. Interview, on 01/13/25 at 3:16 PM, the Administrator was made aware that MDS initial dental assessment section was de-coded from Yes to No of a broken tooth and subsequently, Resident #1 had not seen a dentist for the tooth. He agreed that the facility staff failed to promptly provide or obtain a dental visit/appointment.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. 42783 Based on observation, interview and record review the facility failed to 1) ensure a diet met the need of the resident and 2) provide a resident with a lunch meal to accompany resident on scheduled days of dialysis to an outpatient dialysis center. This was found to be evident in 2 (Resident #58 and #169) out of 5 residents reviewed for food and nutrition services. The findings include: 1) A review of complaint MD00205719 submitted to the Office of Health Care Quality was conducted on 01/16/25 at 7:00 PM. The complaint reported a concern that the facility did not provide Resident #169 the low-fat low residue diet that the Resident's medical condition required. On 01/16/25 at 7:10 PM a review of Resident #169's hospital discharge summary dated 05/02/24 stated a low fiber low insoluble residue diet, avoid all coffee, and dairy. On 01/16/2025 at 7:46 PM review of Resident #169's Physician order showed the following diet orders: order dated 05/02/24 Regular diet Mechanical Soft texture, Regular/Thin consistency; order dated 05/10/24 Regular diet Regular texture, Regular/Thin consistency; and on 05/22/24 Dietary consult eval diet preference one time only for diet for 1 Day. During an interview conducted on 01/17/24 at 7:30 AM, the Registered Dietician (RD) #6 reviewed Resident #169's diet orders and confirmed that the resident was ordered a regular diet mechanical soft. During an interview conducted on 01/17/24 at 7:40AM, Supervisor Registered Nurse (RN) #24 stated that when a resident is admitted to the facility the admitting nurse will review the hospital discharge summary to identify the diet. The nurse will fill out a form called CHB (Carriage Hill Bethesda) Resident Diet Card and will check off the diet, if the diet is not listed then the diet such as low fiber diet is written in the other section. The Diet Card is then sent to the kitchen. The Supervisor also stated that a copy of the diet card was not kept therefore she was unable to verify the diet order that was sent to the kitchen for Resident #169. During an interview conducted on 01/17/24 at 8:33 AM, the Dietary Manager (DM) stated she no longer had Resident #169's CHB diet card sent from nursing on admission. On 01/17/24 at 8:34 AM, the DM, RD and Surveyor reviewed the meal ticket dated 5/23/24. The meal ticket showed that Resident #169 had a Regular/Thin Regular diet with likes: for low fiber, no raw vegetables, no milk and dislikes: no beef or pork but likes bacon. The DM stated that the Resident's family member was unhappy that the Resident had not received the low-fat low residual diet when admitted and requested that the resident have a low-fat diet. The DM further stated that the Resident's family member also advised the DM of the Resident's likes and dislikes. (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the continued interview, the DM showed this Surveyor handwritten notes in a composition notebook of likes and dislikes for the Resident. The DM was unable to provide the date of when the Resident's diet order was changed to a low-fat diet and the like and dislikes were added to the Resident meal preferences. The DM also provided a list of likes and dislikes that she received via email from the RD on 05/23/24. 49815 2) The surveyor interviewed Resident #58 on 1/9/2025 at 8:15 AM. Resident #58 stated that he/she goes to an outpatient dialysis center every Monday, Wednesday and Friday and that he/she leaves the facility after breakfast and returns around 4:00 pm. Resident #58 further stated that he/she is not provided with a lunch from the facility to take to dialysis and that the dialysis center does not provide lunch. On 1/13/2025 at 12:55 PM the surveyor observed the food delivery cart in the hallway on nursing unit 2. Resident #58's meal tray was on the food delivery cart with the meal ticket torn in half on the meal tray. The surveyor interviewed Geriatric Nursing Assistant (GNA) #17 who was in the hallway near the food delivery cart. The surveyor asked GNA #17 about Resident #58's meal tray that was observed on the food delivery cart. GNA #17 stated that Resident #58 was out of the facility today at dialysis and that was why Resident #58's lunch tray was on the food delivery cart with the meal ticket torn in half. Review of Resident #58's medical record on 1/13/2025 at 7:30 AM revealed that Resident had a current physician order for Regular diet, double protein and a nutritional care plan to provide and serve diet as ordered. On 1/14/2025 at 11:30 AM the surveyor interviewed Resident #58, and he stated that he/she went to dialysis yesterday and that lunch was not provided. Resident #58 further stated that when he/she returned from dialysis at 4:00 PM, the lunch tray was on the table in his/her room. The surveyor interviewed Resident #58's assigned Registered Nurse (RN) #19 on 1/15/2025 at 8:33 AM and RN #19 stated that the facility does not provide a lunch for Resident to take with him/her on dialysis days which is Monday, Wednesday and Friday. The Nursing Home Administrator (NHA) and the Director of Nursing (DON) were notified by the surveyor on 1/15/2025 at 8:40 AM that Resident #58 does not receive a lunch meal to take with him/her on scheduled dialysis days and that the outpatient dialysis center does not provide a lunch meal for the Resident. The Director of Nursing stated that he would check on this. On follow-up interview with the Director of Nursing (DON) and the Nursing Home Administrator (NHA) at 10:30 AM on 1/15/2025 they stated that Resident #58's daughter use to provide a lunch meal for Resident #58 on scheduled dialysis days. The surveyor conveyed to the DON and the NHA that Resident #58 stated that he/she was not provided a lunch and does not eat lunch at the dialysis center. No additional information was provided by the NHA or DON at the time of the exit.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42783 Based on observations, interviews and record review it was determined that the facility failed to adhere to menus and food provided to residents in accordance with resident preferences. This was found to be evident for 3 (Resident #255, #357, and #455) out 21 Resident's reviewed for food and dining during the survey. The findings include: 1) During an observation conducted on 01/13/25 at 9:33 AM the Surveyors observed Resident #455's breakfast tray and meal ticket. The breakfast meal ticket stated juice, hot or cold cereal, scrambled egg, biscuit gravy, biscuit, coffee and milk 2%. The Resident's breakfast tray had scrambled egg, 1 piece of toasted bread cut diagonally into 2 pieces, one 4 oz orange juice and 1 bowl of hot cereal. The breakfast tray did not have a biscuit, biscuit gravy, coffee, or milk. During an interview conducted on 01/13/25 at 9:34 AM, Resident #455 stated that since admission the meal trays had not matched the meal tickets. The Resident stated that he/she was concerned that the facility did not have adequate food supplies because the kitchen provided 1 packet of syrup for the toasted bread in place of butter and jelly. The Surveyors observed the breakfast tray and confirmed only syrup was provided for the 1 slice of toasted bread. On 01/16/25 at 8:33 AM the Surveyors and Nursing Home Administrator (NHA) observed the Resident's breakfast meal ticket listed juice, hot or cold cereal, French toast, sausage, coffee, and milk 2%. The Resident's breakfast tray had 1 slice of toasted bread cut diagonally into 2 pieces in place of French Toast, syrup, no sausage patty, a cup of cold cereal, milk, and one 4 oz container of apple juice. During an interview conducted on 01/16/25 at 9:09 AM the NHA stated he went to the kitchen and ordered another tray that included sausage for Resident #455. The NHA confirmed the kitchen did not prepare French Toast for breakfast as indicated on the menu. 48393 2) On 01/08/2025 at 10:05 AM, an interview with Resident #255 was conducted. Resident #255 stated, I am gluten free and I keep getting food I can't eat on my meal tray. An observation of Resident #255's meal ticket and meal tray was conducted on 01/10/2025 at 09:25 AM. The printed meal ticket showed NCS (No concentrated sweets) diet, regular texture, regular/thin liquid consistency. Breakfast was listed as juice, hot or cold cereal, sausage patty, toast, coffee, milk 2%, margarine, dt jelly. Further observation revealed a breakfast plate that had 2 muffins (blueberry) and 1 sausage patty along with 2 sugar packets, 1 jelly packet, 1 orange juice, 1 coffee on the tray. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A follow up interview with Resident #255 was conducted on 01/10/2025 at 9:27 AM in which he/she stated, Im gluten free, I can't eat what's on the tray. I took one bite of the patty and it's hard. I'm not eating anything else. On 01/13/25 at 12:25 PM, review of Resident #255's clinical record revealed that the Resident #255 was admitted to the facility on [DATE]. Further record review revealed the following physician's order: Date 12/31/2024 NAS (No Added Salt)/NCS (No Concentrated Sweets) diet, Regular texture, Regular consistency On 01/14/2025 at 11:45 AM, an interview was conducted with Dietary Manager (DM) #3 regarding Resident #255's gluten preference. The DM #3 stated, I met with Resident #255 for the first time today and he/she told me about the gluten free preference. I updated his/her likes/dislikes on the meal ticket today. The DM #3 further stated that she typically see residents to get their preferences the day of admission or the next day, but she is understaffed and had not been able to meet with new admits for the past few weeks. 50502 3) On 1/8/25 at 8:31 AM, Resident #357 told the surveyor that he/she was on a special diet, he/she added that he/she was admitted on [DATE] at night and on 1/7/2024, the staff brought his/her breakfast tray with the wrong diet. According to Resident #357, the staff took the tray out from the room to replace the wrong meal, but the staff never came back. He/she stated that he/she never had breakfast and his/her first meal on that day was lunch. Resident #357 stated that he/she had been waiting for the dietitian or the dining room manager to visit and fix the issues. Resident #357 had the same experience this morning. He/she stated that his/her breakfast tray was again wrong, so the aide removed the tray and had not replaced it. The surveyor notified the Unit Manager (UM #13) about Resident #357's concerns. On 1/09/25 at 8:51 AM, Resident #357 revealed that he/she received an inaccurate breakfast tray again. He/she showed the tray to the surveyor and indicated that he/she had orange juice, and the staff had not replaced the wrong tray. He/she stated that he/she was supposed to receive jelly and a fresh fruit cup and complained that the white toast was not properly toasted. The breakfast ticket dated 1/9/2025 indicated the following: Regular diet/ thin consistency Juice 4oz Hot cereal Sausage patty Fried egg Bread/ jelly (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coffee Milk 2% Margarine Beverage preference: orange juice, fresh fruit cup, ensure The surveyor verified the tray that was sitting on the table which contained only the following: toast that was soggy and an empty plastic cup labeled orange juice. However, the surveyor did not observe the following on the resident's tray: hot cereal, sausage patty, fried egg, fruit cup, jelly, coffee and milk. UM #13 was made aware of the concern. On 1/13/25 at 8:59 AM, a record review of Resident 357's diet order revealed: - Regular diet Pureed texture, Regular/Thin consistency - 01/06/2025 and was discontinued on 1/7/2025 - Regular diet Regular texture, Regular/Thin consistency- started on 01/07/2025 On 1/13/25 at 9:34 AM, the Registered Dietitian (RD) stated that Resident #357 had very specific preferences which were recorded in the culinary system. She added that the staff would contact the Certified Dietary Manager (CDM) if there were any issues. She revealed that the CDM had copies of the preferences. The RD stated that the residents' preferences were not documented in the electronic charting system. The RD was made aware of Resident #357's concerns. On 1/13/25 at 10:19 AM, in an interview with the CDM, she explained the process on how the food preferences were determined. She stated that she met the residents and obtained their preferences, likes and dislikes and documented the details in the menu system and printed the tray tickets. The CDM was made aware of Resident #357's meal tray ticket discrepancies. On 1/13/25 at 11:07 AM, the Nursing Home Administrator (NHA) was made aware of the concern.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48393 Based on observations, clinical record reviews and interviews, it was determined that the facility failed to ensure that medical records maintained for residents reflect an accurate representation of the care and services provided across all disciplines and failed to ensure the accuracy of the Medical Orders for Life-Sustaining Treatment (MOLST) order form. This was evident for 8 (Resident #94, #158, #166, #255, #256, #455, #1 and #10) out of 74 residents sampled during the annual survey. The findings include: 1) On 01/14/2025 at 12:38 PM, the Director of Nursing (DON) stated that the activities staff keeps activity logs for residents under the plan of care (POC) Task section in Point Click Care (PCC), the electronic health record. On 01/14/25 at 1:19 PM, a review of the POC Task documentation provided by the facility administrator showed that Resident #94 participated in activities for two days, 11/18 and 11/19, in November 2024. December 2024 and January 2025 activity documentation was requested, however no further POC Task documentation of activities for Resident #94 was provided. On 01/15/2025 at 9:44 AM, an interview conducted with the Activities Director (AD) #21 confirmed that Resident #94's activity participation is documented in PCC under the POC Task section. The AD #21 stated that there was no documentation in PCC for Resident #94's December 2024 or January 2025 activity participation. The AD further stated that some participation notes are kept on paper in separate notebooks and that she would provide the notes for review. During a follow up interview with the AD #21 on 01/15/25 at 09:57AM, the AD #21 provided three notebooks to the surveyor for review and stated, These are the notes I keep of who attended activities. I don't have much in here for Resident #94. On 01/15/2025 at 10:04 AM, an interview conducted with the Activities Assistant #20 revealed that Resident #94 attends activities 1-2 times a week and that she keeps record of his/her attendance in a separate notebook in the office and in PCC. On 01/15/25 at 10:30 AM, Activities Assistant #20 reviewed the notebook pages together with the surveyor. There was no evidence to support that Resident #94 attends activities in the facility according to his/her care plan. At the time of exit conference, the facility did not provide any additional evidence to show that Resident #94's clinical record reflected an accurate representation of activities provided in the facility. 2) On 01/14/25 at 09:01 AM, a review of resident #255's clinical record revealed no data found for completed bathe/shower tasks in point click care (PCC), the electronic health record, for the last 14 days. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/14/2025 at 9:38 AM, the surveyor requested documents from the facility related to Resident #255's completed bathe/shower tasks. On 01/14/2025 at 11:44 AM, the Director of Nursing (DON) provided skin sheet documents which revealed that Resident #255 received a shower in the facility on 1/1/25, 1/4/25, 1/8/25, and 1/11/25. On 01/14/2025 at 1:07 PM, an interview conducted with the DON revealed that resident showers are documented on skin sheets and also in PCC. The DON stated that Resident #255's shower documentation from PCC would be provided for review. On 01/14/2025 at 1:35 PM, a subsequent review of Resident #255's shower documentation from PCC was conducted. The review revealed that Resident #255 received showers in the facility on 1/6/25, 1/9/25, and 1/11/25. On 01/14/2025 at 01:59 PM, a follow up interview with the DON confirmed that shower dates on Resident #255's skin sheet documentation from the binder did not match the dates on shower documentation entered in PCC. The DON stated that Resident #255's shower days recently changed due to a room change assignment. The DON further stated that his expectation for shower documentation is that nursing staff documents bathe/ shower tasks accurately on both skin sheets and in PCC for every resident. 3) On 01/14/25 at 09:01 AM, a review of Resident #256's clinical record in point click care (PCC) revealed no documented evidence to support his/her participation in an activities program. On 01/14/2025 at 9:38 AM, the surveyor requested documents from the facility related to Resident #256's activity participation in the facility for November 2024, December 2024 and January 2025. However, no further PCC documentation of activities for Resident #256 was provided. On 01/15/2025 at 9:44 AM, an interview conducted with the Activities Director (AD) #21 revealed that residents' activity participation is documented in PCC under the Task section. The AD #21 confirmed that there was no documentation in PCC for Resident #256's activity participation for requested months of November 2024, December 2024 or January 2025. The AD stated that some participation notes are kept on paper in separate notebooks and that she would provide the notebooks for review. During a follow up interview with the AD #21 on 01/15/2025 at 09:57AM, the AD #21 provided three notebooks to the surveyor for review and stated, These are the notes I keep of what residents attended activities but I don't have much in here for Resident #256. On 01/15/2025 at 10:04 AM, an interview conducted with the Activities Assistant #20 revealed that Resident #256 refuses to get out of bed for activities but that he/she receives the newspaper daily according to his likes and preferences. AD #20 further stated that she keeps record of his/her 1:1 room visits in a separate notebook and also documents in PCC. Multiple observations were conducted of Resident #256 reading the newspaper daily in his/her room throughout the annual survey. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/15/25 at 10:30 AM, Activities Assistant #20 reviewed the notebook pages together with the surveyor. There was no documented evidence of Resident #256's newspaper reading activities. There were also no documented incidences of Resident #256's refusals to attend activity offerings in the facility. At the time of exit conference, the facility did not provide any additional evidence to show that Resident #256's clinical record in PCC reflected an accurate representation of the resident's current activity participation status in the facility. 50502 4) Atorvastatin Calcium is a drug used to lower the amount of cholesterol in the blood and to prevent stroke, heart attack, and chest pain. On 1/16/2022 at 9:11 AM, a review of complaint MD00187193 dated 1/3/2023 indicated that Resident #166 did not receive his/her medication on January 1, 2023. On 1/16/2025 at 10:25 AM, a review of the physician orders revealed that Resident #166 was on ATORVASTATIN CALCIUM 40MG TABLET Give 1 tablet by mouth in the evening for cholesterol -Start Date: 12/28/2022 - Date discontinued: 01/30/2023. Further review of the Medication Administration Record (MAR) revealed that Resident #166 did not receive the Atorvastatin dose from December 28, 2022, to January 6, 2023. On 1/16/25 at 11:28 AM, during an interview with the Assistant Director of Nursing (ADON), she described the process on how the facility made sure that the residents received their medications. She said that they checked the MAR for blank spaces that indicated that the nurse did not sign and immediately called the attention of the assigned nurse. The ADON reviewed the MAR in front of the surveyor and confirmed that Resident #166 did not receive the Atorvastatin dose for 10 days. On 1/16/25 at 12:30 PM, the Nursing Home Administrator (NHA) and the Director of Nursing (DON) were made aware of the concern. 51491 5) During a Medical Record Review of Resident #455 on 1/09/25 at 03:48 PM it was discovered his/her care plan identified him/her as being at risk for skin breakdown due to generalized weakness, being mobility impaired, and having incontinence. The doctor ordered an air mattress for his/her bed for wound healing/prevention and to check the functioning and placement of the air mattress every shift. During an observation on 01/10/25 at 07:59 AM Resident #455 was seen lying in bed on a standard mattress, not an air mattress. During an observation on 01/13/25 at 09:10 AM Resident #455 was seen lying in bed on a standard mattress, not an air mattress. During a Medical Review of the Task Administration Record (TAR) on 1/13/25 at 10:35 AM, it was discovered that the order for monitoring of the Air Mattress was signed off as completed for 10 shifts, from night shift 1/09/25 to night shift 1/12/25. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/13/24 at 10:40 with the Director of Nursing (DON), he stated that the expectations are for the air mattress to be set up within 24 hours after ordered and agreed the resident should have had an air mattress. 6) A Medication Regimen Review is a review of all medications the resident is taking to identify any potential side effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. During a Medical Record review of Resident #158 on 1/08/25 at 04:02 PM it was discovered that the Resident was administered medications for bipolar disorder. The Pharmacy had completed a Medication Regimen Review (MRR) and had made recommendations for the doctor to modify medication orders. The MRR was not found in the Resident's Medical Records. During an interview with the Director of Nursing (DON) on 01/10/25 at 08:42 AM he stated the MRRs are not kept in the Resident's Chart, the recommendations are kept in a binder. During an observation on 1/10/25 at 10:23 the DON had provided 2 large, 3-ring binders marked, one binder for the first floor and one binder for the second floor. The binders were labeled Pharmacy Recommendations and inside the binder were the requested MRR's recommendations. The dates of the MRR records consist of records going as far back as 2021. During a Medical Regimen Review of the MRR in the binder on 1/10/25 at 10:44 AM it was discovered that the Pharmacy had made recommendations on 7/09/24 that stated Resident #158 has been on dual antipsychotic therapy without a Gradual Dose Reduction attempt in more than 2 years. For these reasons, please assess and evaluate if he/she is a safe candidate for a trial dose reduction on these agents. The Doctor responded disagreeing and the stated resident needed a Psych Consult. During an interview with the DON on 1/13/25 at 06:38 AM, the facility is not currently adding the MRRs to the Resident's charts. He reported that the Medical Records employee who was downloading them into the Resident's chart is no longer with the facility and the facility has been looking for a replacement to handle the duty. They are looking for someone to scan the MRRs into the Resident's chart. 45733 7) Maryland Medical Orders for Life-Sustaining Treatment (MOLST) order is a portable and enduring medical order form covering options for cardiopulmonary resuscitation and other life-sustaining treatments. The medical orders are based on a patient's wishes about medical treatments. An incapacitated person cannot sign a Medical Orders for Life-Sustaining Treatment (MOLST) form. Instead, a health care agent or surrogate can sign the form on their behalf. BIMS uses a scoring system from 0-15 to assess a nursing home resident's cognitive status. The BIMS score helps to identify early signs of cognitive decline and the need for further evaluation. Scores: 13-15: Intact cognition, 8-12: Moderate cognitive impairment and 0-7: Severe cognitive impairment. During a floor rounding, on 1/7/25 at 12:23 PM, Resident #1 stated, What is Medical Orders for Life-Sustaining Treatment? I like the color of the packaging. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215234	A. Building B. Wing	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carriage Hill Bethesda	5215 Cedar Lane Bethesda, MD 20814

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review, on 1/8/25 at 01:03 PM, revealed that Resident #1 was admitted to the facility, on 10/19/24, with diagnoses of encephalopathy, cognitive decline, confusion & paranoia. The resident's stay was authorized for skilled nursing care. Upon admission an initial Brief Interview for Mental Status (BIMS) was done and outcome was 9 which indicated moderate cognitive impairment. Further review of a Psychiatric Consult notes, dated 10/16/24 revealed that this resident was diagnosed with dementia, neurocognitive decline and delirium. However, on 10/21/24, the facility's physician staff #28 completed a MOLST order form marking the resident as a cognitive intact consent party. During the interview, on 01/09/25 at 02:24 PM, the Assistant Director of Nursing staff #1 and the Administrator were made aware of the above findings. Staff #1 agreed that Resident #1 was not reliable in making treatment decisions since the resident was admitted last year in October 2024. Both were informed that there was a concern in regards to the accuracy of the MOLST order. 8) Record review on 01/13/25 at 02:48 PM of Resident #10's admission record revealed that the resident was admitted to the facility on [DATE] with the diagnosis of altered mental status with encephalopathy and cognitive functions decline. Other documents supported that Resident #10's was cognitively impaired through an initial BIMS score of 9 on 9/25/23 as moderate cognitive impairment and a Physician Staff #30's progress notes on 1/10/24 revealed that the resident had dementia. Further review, a MOLST order form was issued on 4-26-23, certification for the basis of these orders: marked the patient of a discussion with and the informed consent. Interview, on 01/13/25 at 03:24 PM, the above findings were reviewed with the Administrator. He agreed that the facility staff failed to maintain accurate MOLST orders on file and that demonstrated it as a deficiency practice concern.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42783 Based on observations and interviews it was determined that the facility failed to ensure a safe environment. This was found to be evident during random observations conducted of the facility's environment during the recertification survey. This deficient practice has the potential to affect all Residents. The findings include: According to the Centers of Medicare and Medicaid Services the acceptable water temperature for nursing homes and facilities serving residents should be thermostatically controlled to a maximum of 120 degrees Fahrenheit at the fixture, ensuring hot water is at least 100 degrees Fahrenheit. During random observations conducted on 1/10/15 at 7:15 AM the surveyors obtained hot water temperatures with a calibrated handheld thermometer for the following Resident bathroom sinks: room [ROOM NUMBER] temperature was 125 degrees Fahrenheit , room [ROOM NUMBER] temperature was 123 degrees Fahrenheit, room [ROOM NUMBER] temperature was 121 degrees Fahrenheit, room [ROOM NUMBER] temperature was 123 degrees Fahrenheit, room [ROOM NUMBER] temperature was 123 degrees Fahrenheit, room [ROOM NUMBER] temperature was 122 degrees Fahrenheit, room [ROOM NUMBER] temperature was 121 degrees Fahrenheit and room [ROOM NUMBER] temperature was 123 degrees Fahrenheit. TELS (Total Energy Life Safety) is a building management platform and service system that helps with maintenance, repairs, and projects. During an interview conducted on 1/10/25 at 8:28 AM, the Maintenance Director (MD) stated that he conducts weekly water temperature monitoring and documents it in Tels. The Maintenance Director stated that he randomly checks rooms and that there had not been any recent concerns. The MD further stated that the facility had a mixing valve that regulated the water sent to the residential areas of facility. The mixing valve is set at 118 degrees Fahrenheit. Observation of the water system was conducted on 1/10/2025 at 10:25 AM, the Surveyors. MD and NHA observed the water supply and observed the mixing valve temp at 114 degrees Fahrenheit. During the continued observation the MD captured water temperatures with a thermometer that he stated was purchased 3 weeks ago. The surveyors, MD and NHA observed the following temperatures: room [ROOM NUMBER] temperature was 127.7 degrees Fahrenheit, room [ROOM NUMBER] temperature was 128.2 degrees Fahrenheit, room [ROOM NUMBER] temperature was 126 degrees Fahrenheit, room [ROOM NUMBER] temperature was 126.6 degrees Fahrenheit. During an interview conducted on 1/10/24 at 10:43 AM the MD stated that the temperatures varied because of the continued use of the water. When asked why the hot water temperatures were higher than the mixing valve temperature of 114 degrees Fahrenheit, the MD stated he could not explain why. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 01/10/24 at 11:29 AM, the NHA advised that he contacted an emergency contractor to assess the hot water system. The contractor was scheduled to come to the facility on [DATE]. The NHA also stated that the mixing valve temp had been lowered and an active audit of all resident rooms and showers temperature were to be captured. On 01/10/24 at 7:12 AM the NHA stated that the emergency contractor identified areas that required repair that included the mixing valve. The NHA stated the hot water temperatures continued to be monitored.