STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215287	A. Building B. Wing	03/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maplewood Park Place	9707 Old Georgetown Road 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.

(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51789 Based on record review, observation, and staff interviews, it was determined that facility staff failed to develop and implement a comprehensive person-centered care plan for the resident. This was evident for 1(Resident # 5) of 10 residents reviewed for care plans during an annual survey. The findings include: The MDS (Minimum Data Set) is a complete assessment of the resident, which provides the facility information necessary to develop a care plan, provides the appropriate care and services to the resident, and modifies the care plan based on the resident's status. The CAA (Care Area Assessment) process provides a framework for guiding the review of triggered areas and clarification of a resident's functional status and related causes of impairments. It also provides a basis for additional assessment of potential issues, including related risk factors. The assessment of the causes and contributing factors gives the interdisciplinary team (IDT) additional information to help them develop a comprehensive plan of care. When implemented properly, the CAA process should help staff. Each resident will have a person-centered comprehensive care plan developed and implemented to meet his or her preferences and goals. It will address the resident's medical, physical, mental, and psychosocial needs. On 3/6/2025 at 11:12 AM, an initial medical record review was conducted. It was noted that Resident # 5 had a fall on 2/5/2025 with no injury. On 3/7/2025 at 7:19 AM, an electronic medical record review was done. Resident # 5 was admitted to the facility on [DATE] after a fall incident with injury. He/she was hospitalized on [DATE] due to a displaced left hip fracture and underwent surgery. Additional diagnoses were Cognitive Impairment, Osteoporosis, Urinary Tract Infection, and Atrial Fibrillation with respiratory failure. Upon further review, the Minimum Data Set (MDS) comprehensive assessment dated [DATE] revealed in Section GG that he/she was required to have moderate to extensive assistance for activities of daily living such as bed mobility, transfers, toileting, dressing, and bathing. Section J of the assessment confirmed a history of a fall with fracture within the last 6 months before admission. The Care Area Assessment (CAA) was triggered for falls. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The care plan for Resident # 5, who was at risk of falls, was reviewed and initiated on 5/23/2024. The interventions stated: 1. Anticipate and meet the residents' needs daily. 2. Call light within reach and remind and encourage the residents to use it to request assistance if it is needed. 3. Educate the Resident about safety and use of any devices or to request assistance as needed. Further review of the care plan revealed a care plan for an actual fall that was initiated on 8/29/2024. It was stated that Resident # 5 had an actual fall on 6/21/2024 and 2/5/2025, both with no injuries. The interventions were: Assess/report and monitor resident x72 hours /document any changes or injuries. Report to the physician any signs and symptoms of pain, bruises, change in mental status, and any new onset: confusion, sleepiness, inability to maintain posture, agitation. Physical Therapy consult for strength and mobility post fall and as needed. On 3/7/2025 at 11:57 AM, Resident # 5 was observed to have bilateral fall mats with the bed in the lowest position. No documentation was found in the resident's medical record for the fall mat and bed in the lowest position. On 03/07/25 at 12:14 PM, an interview with the Director of Nursing (DON) conducted. The surveyor shared the findings that Resident # 5 had the bilateral fall mats with the bed in the lowest position; however, it was not found in the medical record. The DON confirmed that the fall mats and the bed in the lowest position were already in place before the resident's most recent fall that happened on 2/5/2025. The DON reviewed the electronic medical record with the surveyor, and she confirmed the findings.

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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** 51789 Based on observation, record review, and interviews with facility staff, it was determined that the facility failed to ensure that the resident received treatment and care to promote the highest practicable well-being as evidenced by failure to follow the physician order, monitor and document the outcome for effectiveness. This was evident for 1 (Resident # 4) of 14 residents reviewed during this annual survey. The findings include: The MDS (Minimum Data Set) is a complete assessment of the resident, which provides the facility information necessary to develop a care plan, provide the appropriate care and services to the resident, and modify the care plan based on the resident's status. On 03/06/25 at 11:35 AM, Resident # 4 was observed to have a palm protector on bilateral hands. On 03/06/25 at 08:31 PM, an electronic medical record review was conducted. Resident # 4 had a physician order initiated on 3/5/2025 that was written as: Palm protector on bilateral hands for skin protection on day shift for 8 hours. Remove every 2 hours and monitor the skin. On further review, the Treatment Administration Record (TAR) revealed that staff were signing off for the treatment with the time of administration of 7:00 AM - 3:00 PM. No further documentation was found for the skin check monitoring. On 3/7/2025 at 1:54 PM, Staff # 3 Registered Nurse (RN) was interviewed. The surveyor asked why Resident # 4 had the palm protector for the bilateral hands. Staff # 3 responded that it was a trial recommendation from the Rehab Department because his/her bilateral hands were stiff and his/her fingers were pressing on the palm. We applied them for 8 hours, removed them, and checked the skin every 2 hours. The surveyor asked if any documentation or notes were written about the palm protector and skin checks, and she stated none. On 3/9/2025 at 10:04 AM, a record review revealed the MDS (Minimum Data Set) Annual assessment dated [DATE], Section GG0115 Functional Limitation in Range of Motion was coded for limitation in range of motion for both upper and lower extremities. Upon further review, a care plan for the limited range of motion was initiated on 3/6/2025. The interventions were: 1. Apply Palm Protector on bilateral hands for skin protection to both palms; 2. Observe me and report to the nurse any change in my range of motion; 3. Observe me for any complaint of pain or altered comfort during care and mobility. On 3/10/2025 at 10:01 AM, The Director of Nursing (DON) was interviewed. The surveyor asked what the purpose of the palm protector was. The DON responded to prevent skin breakdown. It was a nursing recommendation. Resident # 4 was on a rehabilitation caseload for wheelchair positioning only. A follow-up question was asked: How do you monitor the palm protector and skin check? The DON stated the staff monitored the palm protector when it was applied and when removed. The Physician order for the palm protector was discontinued on 3/10/2025 because there was no need to take it out every 2 hours. A new order was created on 3/10/2025 for the palm protector. The new order stated: Palm Protector on bilateral hands for skin protection every shift, remove for hygiene, and monitor skin. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor shared with the Director of Nursing the concern from the previous order for the palm protector and that there was no documentation for the skin monitoring. DON stated that was the reason why the order was revised.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 51789 Based on the medication administration observation, review of the facility's policy and procedure for medication administration, and interview with facility staff, it was determined that licensed facility staff failed to ensure a medication error rate of less than 5 percent during the medication pass observation. This finding was evident for 3 out of 46 opportunities, which resulted in a medication error rate of 6.52%. The findings include: On 03/07/25 at 09:31 AM, the surveyor observed Staff # 3, a Registered Nurse (RN), administer medications to Resident #8. He/She received Triamterene - Hydrochlorothiazide (antihypertensive) 37.5-25 mg 1 tablet by mouth. The physician's order stated: Maxide 25 Triamterene - Hydrochlorothiazide) 35.5-25 mg tablet; give 0.5 tablet by mouth once a day for hypertension. Hold for Systolic Blood Pressure of less than 110. The surveyor did not observe Staff # 3 taking the resident's Blood Pressure before administering the medication. Staff # 3 documented the BP reading after the medication was given. The surveyor asked who was taking the blood pressure reading, and Staff # 3 responded that the Geriatric Nursing Aide (GNA) was taking it. On 03/07/25 at 09:35 AM, Staff # 3 prepared the medications for Resident # 6. Staff # 3 administered Amlodipine (antihypertensive), 5 mg 1 tablet by mouth, and Losartan (antihypertensive), 100 mg 1 tablet by mouth. Both medications had the physician's instruction to Hold for Systolic Blood Pressure of less than 110. The blood pressure was not taken before the administration of the two medications. After all the medications were given, Staff # 3 went to the medication cart and documented the blood pressure reading of Resident # 8. The Surveyor asked who took his/her blood pressure. Staff # 3 stated that the Geriatric Nursing Aide (GNA) took it. On 3/7/2025 at 9:47 AM, Staff # 5, a Registered Nurse (RN), went to Resident # 5 to administer his/her medications. Staff # 5 gave him/her half tablet of Metoprolol (antihypertensive) 25 mg tablet. The physician's order was as follows: Metoprolol tartrate 25 mg tablet, give 0.5 tablet orally every 12 hours. Hold for Heart Rate less than 60. After all the medications were given, the surveyor did not observe Staff #5 checking the heart rate before the medication was given. Staff # 5 documented the information in the electronic medical record and included the heart rate reading. The surveyor asked who was taking the heart rate for Resident # 5, and he responded that it was the Geriatric Nursing Aide.