STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215320	A. Building B. Wing	11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tuckerman Rehabilitation and Healthcare Center	5550 Tuckerman Lane North Bethesda, MD 20852

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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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. Based on record review and interview, it was determined that the facility failed to honor the wishes of the resident representative and allow the resident to stay at the facility while receiving hospice services. This was evident for 1 (#3) of 2 residents reviewed for discharge. The findings include:An interview with Resident #3's representative (RR) on 10/30/25 at 1:39 PM revealed that they were informed by the Social Services Director (SSD) the facility wanted to discharge the resident because they were unable to provide hospice services at the facility. The RR reported that s/he told facility staff they wanted the resident to stay at the facility and receive hospice care instead of taking the resident home. The RR reported that it was after they appealed the discharge two times, attempted to find another nursing home but were denied because of the wound care, and feeling pressured by facility staff to take the resident home; they finally took the resident home. A medical record review on 10/28/25 at 9:44 AM revealed a progress note dated 6/18/25 written by the SSD, that documented she tried to issue a Notice of Medicare Non-Coverage (NOMNC) with a discharge date of 6/19/25, but the resident's family did not sign the NOMNC. Further noting, SSD explained again that resident can not be on Hospice at [facility name].On 10/31/25 at 10:30 AM a review of the grievance filed by the RR on 6/9/25 revealed that s/he made the Director of Nursing (DON) aware that they did not want the resident discharged . The family voiced concerns about taking the resident home because the spouse had dementia. The resolution was to have the family appeal the NOMNC, however this was misleading because Medicare will cover hospice care in a facility, but the family may be required to pay for room and board. On 11/5/25 at 10:30 AM a review of the facility's contract with a hospice provider revealed that the facility had an agreement with them to come to the facility and provide hospice for their residents. An interview with the SSD on 10/29/2025 11:46 AM confirmed that she had informed the family that the resident could not stay at the facility for hospice care. She was informed during an interdisciplinary team meeting that Resident #3 wasn't participating in rehab and needed to be discharged with hospice care. She reported that the facility provided short-term rehab services, and they discharged resident once they needed hospice care and/or long-term care. The Director of Nursing (DON) was interviewed on 10/29/25 at 12:52 PM and reported that Resident #3 was rapidly declining and failed to participate in rehab and needed hospice care. She reported that they discharge residents when they needed hospice care and/or long-term care. She further reported that the facility was able to provide care for a resident in need of hospice services, but they preferred to discharge them. On 10/29/25 at 12:11 PM an interview with the Nursing Home Administrator (NHA) confirmed that Resident #3 was discharged because of his/her need for hospice care. He stated that they will provide it for a few days until they can discharge the resident to an inpatient hospice or hospice at home. He confirmed that the facility was a dually certified facility, meaning they accepted residents for rehabilitation and long-term care. Cross reference F627

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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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review and interview, it was determined that facility staff failed to ensure that residents were free of chemical restraints and that PRN (as needed medications) psychotropics were limited to 14 days. This was evident for 1 (#4) of 2 residents reviewed for discharge. The findings include:A review of the transferring facility's medication list for Resident #4 on 11/4/25 at 11:00 AM revealed the resident was on quetiapine (an antipsychotic medication) for sundowning since 3/12/25 and lorazepam as needed every 8 hours for anxiety since 5/16/25. A medical record review on 10/30/25 at 11:40 AM for Resident #4 revealed a an informed consent form for use of psychotropic (mind altering drugs to include antipsychotics and antianxiety medications) medications that documented the resident was on quetiapine and lorazepam because all nonpharmacological approaches had been attempted with no alleviation of the symptoms, however this form was signed on the day the resident was admitted to the facility. A review of the physician's orders revealed an order for lorazepam 0.5 mg tablet to be given by mouth every 8 hours as needed for anxiety that was dated 6/30/25 with a revision date of 10/7/25. On 6/30/25 the resident was ordered quetiapine 25 mg 2 times a day by mouth for Alzheimer's/behaviors. There was an order on 7/15/25 to increase the amount of the quetiapine to 50 mg every morning and at bedtime for psycho-affective disorder (this is not a diagnosis). Further review of the orders failed to reveal an order to monitor the behaviors for which the resident was ordered these medications. In addition, there was no evidence that a gradual dose reduction of the medications was attempted. A continued medical record review on 11/4/25 at 10:18 AM revealed the resident was seen by a contracted psychiatric Nurse Practitioner (NP) on 3 occasions during his/her stay. On 7/1/25, she noted that the resident was delusional. On 9/2/25, she documented she visited the resident due to increased agitation and aggression, and refusal of care. She documented to continue the quetiapine to modify behavior such that normal care is possible while the resident is in the nursing home. Further noted was the quetiapine was given for behavior modification. During a visit on 10/2/25 it was noted that nursing staff confirm increased cooperativeness and decreased behavioral disturbances. Resident was participating more in care routines with no recent episodes of aggression, wandering, or care refusal reported. The diagnoses listed were delusional disorders and vascular dementia, unspecified severity, with psychotic disturbances. However, a review of the behavior notes revealed the resident was not being monitored for the behaviors that the antipsychotic was being given. A review of the resident's medication administration record for July 2025 - October 2025 revealed that the resident was administered the lorazepam on 9 occasions by the same nurse, Registered Nurse (RN) #2. There was no documentation as to why the medication was given and the nonpharmacological interventions were attempted prior to giving the medication.An interview with the attending physician on 11/4/25 at 11:26 AM revealed Resident #4 had trouble adjusting to the nursing home which was why he had increased the quetiapine from 25 mg to 50 mg. He stated the indication for the medication was entered incorrectly because it was for acute psychosis. He reported that acute psychosis would not last for 3 months and he left it up to the psychiatric NP to adjust the medications. Reviewed the concerns that there was no gradual dose reduction attempted. He stated that the resident would have went back to screaming and refusing care and medications. An interview with RN #2 on 11/4/25 at 12:23 PM revealed that she should have documented the symptoms the resident was having and the nonpharmacological interventions she attempted before giving the resident the lorazepam. She stated that she gave the medication because the resident was not calm, trying to get out of bed and the chair, and s/he was a fall risk. She reported that when she gave the medication the resident would eat in dining room without screaming and yelling, she would allow staff to provide care without pulling and biting them, and s/he would stay in bed. When asked if this was chemically restraining the resident, she stated she had that concern, but thought it was better that the resident could participate in the community. On 11/4/25 at 12:46 PM the Director of Nursing (DON) reported that she expected staff to monitor residents with routine psychotropics for the behaviors they were given the medication to control. She stated that when it was an as needed medication then she expected the nurses to document the behaviors they were having to indicate why it was given. She stated the goal was to try nonpharmacological interventions and then administer the as needed medication. She agreed that Alzheimer's was not an appropriate diagnosis for the quetiapine. Reviewed that the resident had an as needed order for lorazepam with no stop date. She agreed that it should have had a stop date of 14 days. Reviewed the concerns. She reported that she would look at the resident's record for behavior monitoring and documentation for the lorazepam and get back to the surveyor

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F 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not require residents to give up Medicare or Medicaid benefits, or pay privately as a condition of admission; and must tell residents what care they do not provide. Based on record review and interview, it was determined that the facility failed to inform residents and/or resident representatives about limitations in the care services that they provided. This was evident for 1 (#3) of 2 residents reviewed for discharge.The findings include:Hospice care - focuses on the care, comfort, and quality of life of a person with a serious illness who is approaching the end of life. On 11/3/25 at 2:15 PM a review of the facility admission packet, that was signed by Resident #3, was conducted. In section 2, care and services, ancillary it read that hospice services were provided. In section 3, transfers and discharges it read that resident will not be discharged unless the following criteria which did not include the need for hospice care or long-term care. In addition, the section regarding Medicaid coverage read, the facility participated in the Medicaid program and had a provider agreement with the state. There was no indication that there were limited services provided by the facility. A medical record review 10/28/25 at 9:44 AM revealed the discharge summary from the hospital for Resident #3. The following diagnoses were listed for the resident; metastatic (the cancer has spread to other areas of the body) scalp melanoma to the brain and lung, bladder cancer, and thymic cancer. The resident had been in the hospital for treatment of an infection and needed rehabilitation (rehab). A progress note written on 5/12/25 (4 days after the resident's admission) by Nurse Practitioner (NP) #1 revealed the family reported a decline. The resident was not talking, needed total care from staff, and she wrote the resident appeared frail and weak. Further noted the resident was considered end-of-life care. A progress note dated 6/16/25, written by the Social Services Director revealed the facility was discharging the resident back to the community for hospice care. She noted the family declined to sign the form and she explained to them that the resident cannot be in hospice care at the facility. An interview with Resident #3's representative on 10/30/25 at 1:39 PM revealed that they were not told at the time of admission that the facility was limited to rehabilitation services and planned to discharge the resident if s/he needed long-term care and/or hospice care. The representative reported that the Social Services Director (SSD) informed her that she would need to either take Resident #3 home or place him/her in an inpatient hospice facility. The representative reported that they filed a grievance with the facility, however, the SSD continued to contact them about discharging the resident. The representative reported that they finally contacted a hospice group and brought Resident #3 home.On 10/29/25 at 11:46 AM an interview with the SSD revealed she had been employed at the facility for the past 2 years. She reported that the facility had a Utilization Review meeting conducted with the interdisciplinary team to discuss each resident. When a resident was not participating in therapy or plateaued then she issued a NOMNC (Notice of Medicare Non-Coverage) form to them. If they needed long-term care or hospice care, she was told to work with them to find new placement. She confirmed she told Resident #3's family that the resident could not stay at the facility while receiving hospice care. The Nursing Home Administrator (NHA) was interviewed on 10/29/25 at 12:11 PM. He confirmed that they accepted residents with Medicare that needed skilled services, especially short-term rehabilitation. When asked what happened when a resident needed long-term care or hospice care, he stated facility staff would assist them to find new placement. He confirmed that this was not in the admission packet provided to the residents. He stated that they were told verbally. Reviewed the concerns and he acknowledged them. On 11/4/25 at 11:26 AM an interview with the Resident's attending physician confirmed that residents who need long-term care and/or hospice care were transferred to another facility. He reported that Resident #3 had a poor prognosis when s/he was admitted and was not a good fit for the facility because they specialize in rehabilitation services.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, it was determined that the facility discharged a resident without an appropriate reason and failed to appropriately document the discharge of a resident. This was evident for 2 (#3 and #4) of 2 residents reviewed for an inappropriate discharge. The findings include:Hospice care - focuses on the care, comfort, and quality of life of a person with a serious illness who is approaching the end of life. It is a service covered under Medicare Part A, but if a resident is in a nursing facility, they may have to pay room and board. Notice of Medicare Non-Coverage (NOMNC) is issued to a resident when their Medicare Part A coverage is going to end. Medicare Part A designates a certain number of days it will cover a stay in a nursing home. Advanced Beneficiary Notice (ABN) is issued to a resident when services they are receiving will not be covered by Medicare any longer. Such as, therapy services. 1. A medical record review for Resident #3 on 10/28/25 at 9:44 AM revealed a discharge summary from the hospital. According to this document dated 5/8/25, the resident had metastatic skin cancer that spread to the brain and lungs, bladder cancer, thymic cancer and had been recently hospitalized on multiple occasions. The last hospitalization was for 8 days due to acute encephalopathy with generalized weakness and a history of seizures. The resident was admitted to the facility for physical and occupational therapy. A review of the resident's admission contract revealed in section 2, care and services, it read that the facility offered hospice care. There was no mention in the contract that the facility had limited their services to short-term rehabilitation.A review of the progress notes revealed a note dated 6/18/25 that was written by the Social Services Director (SSD). The note read that the resident was admitted for rehabilitation and medical management of encephalopathy. Resident received a NOMNC [Notice of Medicare Non-Coverage] and the doctor was made aware to discharge back to the community under Hospice services. A NOMNC and appeal options discussed with resident and family. Another note written by the SSD on 6/16/25 read that she attempted to issue a NOMNC with last covered date of 6/18/25 and a discharge date of 6/19/25, however, the family declined to sign it. SSD documented she explained to them that the resident cannot be in hospice care at the facility. Further review of the record failed to reveal documentation that the resident met one of the reasons, defined in this regulation, a facility could initiate a discharge. On 10/29/25 at 12:04 PM a review of the facility's assessment revealed the facility was able to provide hospice services. On 10/31/25 at 10:30 AM a review of the grievance filed by the RR on 6/9/25 revealed that s/he made the Director of Nursing (DON) aware that they did not want the resident discharged . The family voiced concerns about taking the resident home because the spouse had dementia. The resolution was to have the family appeal the NOMNC, however this was misleading because Medicare will cover hospice care in a facility, but the family may be required to pay for room and board. On 11/3/25, the NHA provided a contract the facility had with a hospice provider that stated they would provide hospice care for the residents at the facility. On 8/20/25 the Office of Health Care Quality received a complaint alleging Resident #3 was inappropriately discharged from the facility because it was medically unsafe. A telephone interview conducted on 10/30/25 at 1:39 PM with the complainant revealed that they felt the facility had inappropriately discharged the resident home because they felt that it would not be good for the resident's spouse who had dementia. The complainant confirmed that they were not made aware of limitations in the services provided at the facility at the time of admission or they would have chosen another facility. The complainant reported that once the SSD issued them the NOMNC, it felt that the SSD, the Business Office Manager, and the Director of Nursing (DON) were trying to get rid of the resident. The complainant reported that the family appealed to the NOMNC, tried to find another facility for the resident to go to but was unsuccessful because of the resident's sacral wound, and filed a grievance with the facility. The complainant reported that s/he spoke to the Nursing Home Administrator (NHA) who told them it was unacceptable to discharge a resident because they needed hospice care and that he would check into it. However, he came back and told them the facility did not have the means to care for the resident because s/he needed hospice care. The complainant reported that they took Resident #3 home because they were concerned about the care s/he would receive since the facility was trying to discharge him/her. An interview with the Social Services Director on 10/29/25 at 11:46 AM revealed that she attended utilization review meetings with the interdisciplinary team to discuss each resident's potential in rehabilitation. She reported that when it was determined the resident was no longer participating or plateaued in therapy; then she was told to issue a Notice of Medicare Non-Coverage (NOMNC) and discharge them. She stated the facility does

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record review and interview, it was determined that the facility failed to issue a 30-day notice to residents when they planned to discharge them. This was evident for 2 (#3 and #4) of 2 residents reviewed for an inappropriate discharge. The findings include:Notice of Medicare Non-Coverage (NOMNC) is issued to a resident when their Medicare Part A coverage is going to end. Medicare Part A designates a certain number of days it will cover a stay in a nursing home. 1. A medical record review for Resident #3 on 10/28/25 at 9:44 AM revealed the Social Services Director (SSD) wrote on 6/16/25 that she attempted to issue a Notice of Medicare Non-Coverage (NOMNC) with the last date of coverage as 6/18/25 and a discharge date of 6/19/25. She noted the family declined to sign it, and she explained to them that the resident cannot be in hospice care at the facility. (A NOMNC was not required for a resident who was choosing hospice care because these services were covered by Medicare, but the resident's room and board may not be covered). Further review of the medical record failed to reveal that the resident and resident representative were notified in writing the reason for the discharge at least 30 days prior to discharge. During an interview on 10/30/25 at 1:39 PM with Resident #3's representative (RR), s/he reported that the family did not want the resident to be discharged home with hospice services because they felt it would be hard on the spouse who had dementia. The RR reported they were not issued a 30 day notice to inform them of the discharge and the basis of the discharge. The RR confirmed they had been issued a NOMNC which was confusing because the resident had Medicare days left. An interview with the SSD on 10/29/25 at 11:46 AM revealed she was told during a utilization review meeting to issue the NOMNC because the resident was no longer progressing in rehabilitation services. She stated that the facility discharged their residents when they stopped participating in therapy and needed long term care or hospice services. She confirmed that the resident's family had not initiated the discharge home. She reported that she assisted the family to set up hospice care at home. The SSD confirmed that she had not sent a 30-day discharge notice to the resident and the resident representative. An interview with the Director of Nursing (DON) on 10/29/25 at 12:52 PM revealed the facility discharged the resident because s/he needed hospice services. During an interview with the Nursing Home Administrator on 10/29/25 at 1:31 PM he confirmed that the resident was discharged because of the need for hospice care and they do not provide that service at the facility. Reviewed the concerns with him. 2. A medical record review for Resident #4 on 10/30/25 at 11:40 AM revealed a progress note written by the Social Services Director (SSD) on 8/18/25 that a Notice of Medicare Non-Coverage (NOMNC) was issued to the family with services ending on 8/20/25. In another note on 8/18/25, SSD documented the attending physician was made aware of the discharge to the community, the resident was going home with continued rehab services, and the family was appealing the NOMNC. Further review of the medical record failed to reveal a 30 - day discharge notice was issued to the resident's representative. An interview with the Nursing Home Administrator (NHA) and the Director of Nursing (DON) on 10/31/2025 9:56 AM revealed the resident was discharged because they determined the resident would benefit from a memory care unit. During an interview with the Social Services Director (SSD) on 10/31/25 at 1:02 PM, she confirmed that she issued a NOMNC to Resident #4's family and not a 30 - day notice of discharge. Concerns were reviewed with the NHA and DON on 11/5/25 at 11:00 AM. Cross Reference: F627