

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215353	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/19/2025
NAME OF PROVIDER OR SUPPLIER  Ingleside at King Farm		STREET ADDRESS, CITY, STATE, ZIP CODE  701 King Farm Boulevard Rockville, MD 20850	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>49148</p> <p>Based on the review of a facility reported incident and interviews with staff, it was determined that the facility failed to maintain an environment free of physical restraints. This was evident for 1 (MD00182052) out of 4 facility reported incidents reviewed during the annual and complaint survey.</p> <p>The facility implemented corrective measures following this incident and prior to the start of this Survey. The facilities plan and actions were verified during this survey, therefore this deficiency was found to be past noncompliance with a compliance date of 8/15/2022.</p> <p>The findings include:</p> <p>A physical restraint is any manual method, physical or mechanical device/equipment or material that limits a resident's freedom of movement and cannot be removed by the resident in the same manner as it was applied by staff.</p> <p>A gait belt or transfer belt is an assistive device put on a person who has mobility issues, by a care giver, prior to moving the person and can be used to help a person transfer from one surface to another, stand, or walk around.</p> <p>On 2/19/2025 at 9:30 AM, during a review of facility reported incident (FRI) MD00182052 investigative file, the Surveyor discovered that on 8/9/2022, a nurse identified the improper use of physical restraints by Resident #11's private duty aide (PDA) contracted by the family. The PDA was utilizing the resident's gait belt to restrain Resident #11 from getting up out of their wheelchair. The facility initiated an investigation.</p> <p>Further review of the investigative file revealed that the facility was able to substantiate the improper use of physical restraints for Resident #11. According to staff interviews, there were no other instances of physical restraint use. The facility requested that the PDA not return to the facility and education regarding restraints, abuse, and neglect for all agency PDA's.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/19/2025 at 9:45 AM, during an interview with the Administrator, the Surveyor confirmed that PDA's are to follow the facility's policies and procedures, including nursing care. Failure to do so will result in disciplinary action. The personnel files containing training records, background checks, health records, and facility agreements are maintained for each PDA within the facility and reviewed upon working with residents at the facility. The Administrator had no concerns with the PDA's currently working at the facility.</p> <p>On 2/19/2025 at 12:20 PM, the Surveyor performed a complete review of the facility's action plan, evidence gathered, credentialing for new and existing PDA's, requests for training for restraints, abuse, and neglect from agencies, policy for Private Duty Aides and Identifying Involuntary Seclusion and Unauthorized Restraint for staff, and disciplinary action for the PDA of Resident #11 pertaining to MD00182052. Based on the review of documentation, it was determined the facility had corrected the deficient practice prior to the start of the survey.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>49148</p> <p>Based on review of a facility reported incident (FRI) and interview with staff, it was determined that the facility failed to report an injury of unknown origin within 2 hours and submit the results of the investigation within 5 days as required to the Office of Health Care Quality. This was evident for 1 (MD00210330) out of 4 Facility Reported Incidents (FRI's) reviewed during the survey.</p> <p>The findings include:</p> <p>On 2/19/2025 at 9:15 AM, during a review of the investigative file for facility reported incident MD00210330, the Surveyor discovered that during activities of daily living (ADL) care on 9/28/2024 at 11:50AM Resident #11 was noted with a swollen left leg and bruise to the left shin. The Director of Nursing was made aware on 9/28/2024 at 12:05PM and started an investigation.</p> <p>BIMS stands for Brief Interview for Mental Status, a cognitive screening tool used to assess a person's mental status and is scored from 0-15, with lower the scores indicating a decline in cognitive performance.</p> <p>An additional review of the investigative file revealed that at the time of the incident, Resident #11 had a BIMS score of 2, indicating cognitive impairment and was unable to provide information regarding the injury. The facility was unable to determine how or when the incident occurred.</p> <p>On 2/19/2025 at 9:25 AM, further review of Resident #11's investigative file revealed that the facility submitted the initial report to the Office of Health Care Quality on 9/29/2024 at 11:50AM. The results of the investigation were submitted to the Office of Health Care Quality on 10/4/2024 at 3:30PM.</p> <p>On 2/19/2025 at 9:40 AM, during an interview conducted with the Nursing Home Administrator (NHA), the Surveyor confirmed that the facility reported incident should be reported to the Office of Health Care Quality within 2 hours and the results of the investigation should be submitted to the Office of Health Care Quality within 5 working days.</p>

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<p>F 0790</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide routine and 24-hour emergency dental care for each resident.</p> <p>50573</p> <p>Based on record review and staff interview, it was determined that facility staff failed to ensure a resident received routine dental care. This was evident for 1 of 1 resident (Resident #15) reviewed for dental services during the survey.</p> <p>The findings include:</p> <p>On 02/14/25 at 09:05 AM, review of Resident #15's medical record revealed a progress note dated 11/9/2021 at 11:15 PM which indicated that an order was created for the resident to receive a dental evaluation for a broken tooth.</p> <p>On 02/14/25 at 09:05 AM, further review of Resident #15's medical record failed to reveal documentation that indicated Resident #15 received dental services prior to the broken tooth.</p> <p>On 02/19/25 at 12:44 PM, an interview with the NHA revealed that the facility would not provide residents with routine dental services. She further indicated that residents are informed to arrange their own routine dental services or could have dental appointments arranged by the facility which would only be when a concern is identified.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>50573</p> <p>Based on record review and staff interview, it was determined that facility staff failed to ensure a resident's medical record included all documentation related to dental treatment, and beneficiary notification documentation was correctly completed. This was evident for 1 (Resident #15) of 1 resident reviewed for dental services, and 2 (Resident #189 and #190) of 3 residents reviewed for beneficiary notification during the survey.</p> <p>The findings include:</p> <p>1) On 02/14/25 at 09:05 AM, review of Resident #15's medical record revealed a progress note dated 11/9/2021 at 11:15 PM which indicated that an order was created for the resident to receive a dental evaluation for a broken tooth.</p> <p>On 02/18/25 at 10:44 AM, review of a document provided by NHA titled, Dental Notes with a letterhead of SENIOR smile dated 12/09/21 revealed visit notes from the dental provider. The dental notes indicated that the visit occurred on 11/29/21 and the treatment plan was to be determined (TBD) with the Power of Attorney (POA).</p> <p>On 02/18/25 at 11:57 AM, the surveyor requested documentation of what the treatment plan was for Resident #15 once the POA was contacted.</p> <p>On 02/19/25 at 07:58 AM, an interview with the NHA revealed that she was unable to provide documentation of what the treatment plan was from the 11/29/21 dental visit.</p> <p>2a) On 02/18/25 at 09:30 AM, the surveyor randomly selected Resident #189 as a resident for beneficiary notification facility task. The resident was on a list provided by the facility of residents discharged from the facility within the last six months who received Medicare Part A Services.</p> <p>On 02/18/25 at 11:29 AM, review of Resident #189's beneficiary notification documentation indicated that the resident's last covered day of service was 11/3/24, it was voluntary (requested) discharge, and a Notice of Medicare Non-Coverage (NOMNC) was not provided to the resident.</p> <p>On 02/18/25 at 11:29 AM, further review of beneficiary documentation for Resident #189 revealed a progress note by Director of Social Services (Staff #6) dated 11/04/24 at 4:13 PM, which revealed that the Doctor (Staff #20) was discharging the resident today and that she was unable to provide the resident with a NOMNC or discharge letter due to not being given notice of discharge.</p> <p>On 02/19/25 at 8:23 AM, an interview with the NHA regarding the progress note dated 11/04/24 revealed that the resident requested to be discharged . The surveyor requested documentation that indicated the resident or resident representative requested to be discharged .</p> <p>On 02/19/25 at 11:10 AM, the NHA indicated she agreed that the wording from documentation provided did not indicate the resident requested to be discharged and was unable to provide further documentation regarding the concern.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2b) On 02/18/25 at 09:30 AM, the surveyor randomly selected Resident #190 as a resident for beneficiary notification facility task. The resident was on a list provided by the facility of residents discharged from the facility within the last six months who received Medicare Part A Services.</p> <p>On 02/18/25 at 11:29 AM, review of Resident #190's beneficiary notification documentation indicated that the resident's last covered day of service was 10/21/24 and it was a facility/provider initiated discharge when benefit days were not exhausted.</p> <p>On 02/18/25 at 11:29 AM, further review of Resident #190's beneficiary notification documentation revealed that the resident received a Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNFABN) which failed to be completed based on document instructions.</p> <p>On 02/18/25 at 11:30 AM, the surveyor noted that the facility failed to ensure that the resident selected at least one of three options regarding Medicare and payment, which is what the instructions on the document indicate.</p> <p>On 02/18/25 at 12:22 PM, the surveyor reviewed the concern with the Director of Social Services (Staff #6). She agreed that one of the three options on the SNFABN document should have been marked.</p>		