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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215353	A. Building B. Wing	02/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ingleside at King Farm	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.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 42782 Based on observations and interviews, it was determined that the facility staff failed to maintain a homelike environment as evidenced of marring on the wall behinds residents' beds. This deficient practice was evidenced in 3 (Resident #4, #11, #28) of 6 resident rooms entered during the medication administration assessment conducted during the survey. The findings include: On 02/14/25 at 8:44 AM, during Resident #11 medication administration observation with Registered Nurse (RN) #7, the surveyor observed damaged drywall behind the resident's bed. RN #7 confirmed the surveyor's observation. At 9:12 AM, during a continuation of the medication administration observation of Resident #28 medications, the surveyor observed marring on the wall behind the bed. RN #7 confirmed the surveyor's observation. At 9:31 AM, during Resident #4 medication administration observation with Licensed Practical Nurse (LPN) #8 the surveyor observed damaged drywall behind the resident's bed. LPN #8 confirmed the surveyor's observation and verbalized the resident's bed may have caused the damage although the bed has a stopper. During an interview with LPN #8 on 02/14/25 at 1:44 PM, the surveyor asked how the staff reports maintenance issues. LPN #8 verbalized the staff used a computer-generated app named Worxhub Links to complete a maintenance request. The surveyor asked did they report the drywall damage to maintenance. LPN #8 verbalized he/she did not notice the drywall was damaged until the surveyor bought it to their attention. On 02/14/25 at 1:48 PM, during an interview with RN #7 the surveyor asked did he/she reported the damaged drywall in Resident # 11 and Resident #28 prior to that day. RN #7 verbalized they were on vacation for two weeks prior to working on 02/14/25.

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 49148 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. The findings include: 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. 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. 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. 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. 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.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 49148 Based on record review and interview with staff, it was determined that the facility failed to ensure a resident centered care plan had been revised to meet the needs of the resident in response to current interventions. This was evident for 1 (Resident #4) out of 2 residents investigated for communication/sensory during the survey. The findings include: A care plan is used to summarize a person's health conditions, specific care needs, and current treatments. It outlines what needs to be done to plan, assess, and manage care needs. This helps to evaluate the effectiveness of the resident's care. On 2/18/2025 at 11:45 AM during a review of Resident #4's electronic medical record, the Surveyor discovered that the resident had diagnoses including but not limited to dementia, anxiety, hearing deficit, and major depressive disorder. An additional review revealed physician orders to assist resident putting on bilateral hearing aids (on in AM and off at bedtime), place hearing (aids) on charger every bedtime after removing them, and patient needs to see a person face and mouth to communicate effectively per audiology (every shift). On 2/18/2025 at 11:55 AM, the Surveyor reviewed an Orders Administration note dated 1/8/2025 at 2:59 PM which stated that the resident refused to put on the bilateral hearing aids and the resident stated the noise is too much and feels uncomfortable while in the dining room. Resident #4 was noted to refuse to wear hearing aids 20/31 days in December 2024, 15/31 days in January 2025, and 11/18 days in February 2025. Further review revealed a Health Status note dated 1/16/2025 at 2:27 PM which stated Resident #4 was seen by in house audiology. According to the Audiologist, the resident's hearing aids were adjusted to a comfortable volume and the resident relies on both hearing aids and visual cues to communicate. Staff should look straight to the resident so the resident can read lips to communicate effectively. A continued review of Resident #4's electronic medical record revealed a care plan initiated on 10/11/2023 with a revision on 1/12/2024 which stated, Resident #4 has a communication problem related to dementia and hearing deficit. Further review failed to reveal a revision that notated the resident's refusal to wear hearing aids or the updated recommendations to effectively communicate with the resident from the audiology visit on 1/16/2025. On 2/18/2025 at 12:05 PM, during an interview conducted with the Assistant Director of Nursing (ADON), the Surveyor was informed that Resident #4 uses hearing aids sometimes and then other times refused to wear them. The Surveyor expressed the concern that Resident had a hearing deficit and communication problem stated in the care plan, however there was no mention of hearing aid use, refusals to wear hearing aids, or updated recommendations for effective communication.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 50573 Based on record review and staff interview, it was determined that the facility failed to ensure services provided maintained professional standards of practice regarding resident weights. This was evident for 2 (Resident #7 and #21) of 4 residents reviewed for nutrition. The findings include: 1) On 02/13/25 at 01:10 PM, record review revealed Resident #7 weighed 108.2 lbs on 01/04/2025. Further review of the resident's record revealed on 02/03/2025, the resident weighed 97.2 pounds which was a 10. 17% weight loss within about a month of time. On 02/14/25 at 07:28 AM, record review revealed a nutrition/dietary note dated 2/10/25 at 09:51 AM, which indicated the resident had triggered for significant weight loss and that it may have potentially been a scale error. On 02/14/25 at 12:11 PM, an interview with the Registered Dietician (Staff #23) revealed she was able to see which residents are triggered for weight loss and communicates to the nurses to determine if they are aware. She further indicated that she was part time and came into the facility on Mondays and Wednesdays, and did not attend the facility meetings where weight was addressed. On 02/14/25 at 12:16 PM, further interview with Staff #23 revealed that she thought the weight of 108.2 taken on 01/04/25 could have been from the resident retaining fluid, but that she was not confident of that. She indicated that she requested for staff to get a reweigh when she noticed it on 01/06/25, but that the staff had not reweighed the resident until 01/08/25. During the same interview on 02/14/25 at 12:16 PM, Staff #23 indicated that she did not report to her supervisor that Resident #7 had not been reweighed as she requested when she identified the finding. On 02/14/25 at 12:17 PM, during an interview with Staff #23, she indicated that when a resident is triggered for significant weight loss, it was expected that an order be placed for the resident to be weighed weekly for 4 weeks. On 02/14/25 at 12:20 PM, review of Resident #7's medical record failed to reveal documentation that the resident had an order to be weighed weekly for 4 weeks. 2) On 02/13/25 at 01:27 PM, review of Resident #21's medical record revealed on 01/02/2025, the resident weighed 146.0 lbs. On 02/01/2025, the resident weighed 135.8 pounds which was a 6.99% weight loss within about a month of time. On 02/13/25 at 1:29 PM, record review revealed a nutrition/dietary note dated 2/10/2025 at 10:08 AM, which revealed the resident was triggered for significant weight loss within a month. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/14/25 at 12:33 PM, interview with Registered Dietician (Staff #23) revealed that the staff had a difficult time reweighing Resident #21. Further interview revealed she was unable to find documentation that the resident refused a reweigh. She further indicated that there should have been documentation of an order for weekly reweighs for 4 weeks, which she was unable to provide. On 02/18/25 at 10:17 AM, an interview with the Registered Nurse (Staff #5) revealed that when residents are weighed monthly, if there was a significant difference upon weight, they would reweigh the resident at that time to confirm and rule out a scale error. Further interview revealed that if a resident refused to be weighed or reweighed, that documentation would reflect it.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42782 Based on record review and interviews, it was determined that the facility staff failed to ensure the staff completed a competency required to care for resident's effectively. This was evident for 1 (Resident #8) of 5 staff records reviewed for training during the Medicare/Medicaid survey. The findings include: On [DATE] at 12:20 PM, a review of Licensed Practical Nurse (LPN) #8's training revealed their last documented completed Dementia training expired on [DATE]. During the survey LPN #8 worked on the memory care unit. On [DATE] at 12:30 PM, during an interview with Director of Human Resources #15 he/she verbalized the RELIAS trainings are assigned yearly to the staff and a report was sent to supervisors to keep track of the staff who need to complete their training. Twelve months of trainings are assigned for everyone. Different tracks are assigned to the nurses and Geriatric Nursing Assistants (GNA). Director of Human Resources #15 provided documentation to verify LPN #8 completed a training titled, Caring for Those with Cognitive Impairment, on [DATE]. A review of the training revealed there was mention of Dementia, but no detailed training concerning Dementia including caring for a resident with Dementia. In addition, a diagnosis of cognitive impairment is not the same as having a diagnosis of Dementia.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42782 Based on record review and interviews, it was determined that the facility staff failed to update the staffing sheets on the units after the staffing schedule changed. This was evident for 2 of 2 units in the Long-Term Care Wing. The findings include: On 02/19.25 at 10:25 AM, the surveyor reviewed the Daily Nursing Schedule log. While on [NAME] Grove unit the surveyor accounted for each staff member documented on the staffing sheet. The surveyor walked to [NAME] Park unit and asked where Geriatric Nursing Assistant (GNA) #22 was. Registered Nurse #5 verbalized GNA #22 called out. The staffing sheet did not indicate the GNA was not working. On 02/19/25 at 11:07 AM, during an interview with Director of Nursing #2 he/she verbalized sometimes the staff call the scheduler directly when they are unable to work. The master schedule is computer generated, and the updates are transcribed to the daily staffing sheet. GNA's #18 & GNA #19 were called into work that day. GNA #19 started working around 9 AM. DON #2 was made aware the staffing sheets on [NAME] Park and [NAME] Grove units were not updated to reflect the staff who were working on the unit. On 02/19/25 at 1:14 PM, the surveyor asked GNA #19 what time did they start working on the unit. GNA #19 replied, around 8:45 AM. GNA #18 was assisting a resident but the surveyor confirmed they were working on the unit, but was not added to the staffing sheet that morning.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 42782 Based on observation and interview it was determined that the facility's pharmacy failed to administer a prescribed supplement with a dosage. This was evident for 1 (Resident #19) of 5 resident medication administration observations during survey. The findings include: On 02/14/25 at 9:41 AM, during medication administration observation of Resident #19 medications, while Licensed Practical Nurse #8 prepared the resident's medications, the surveyor noticed the blister package with Vitron C did not have a dose. Vitron C 65-125 MG (Iron -Vitamin C) 1 tab by mouth (PO) two times a day (BID) for anemia was on Resident #19 medication administration record (MAR). The surveyor asked LPN #8 did he/she know if that was the correct dose. LPN #8 verbalized calling the pharmacy in the past to verify the dose. On 02/18/25 at 9:01 AM, the surveyor spoke with Pharmacist #17 and asked does they pharmacy typically sends medications/supplements that do not have a dose. Pharmacist #17 replied, no. On 02/18/25 at 11:12 AM, during an interview with Pharmacist #12 they verbalized it was not feasible to list all the ingredients in a supplement. The does may be written on the MAR, but the medication only comes one way, and they are not necessarily required if it only comes one way. The surveyor asked how the nurse administering the supplement/medication would know there was only one dosage. Pharmacist #12 verbalized the pharmacy would be more than happy to add the strength of the supplement/medication.

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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. 50573 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. The findings include: 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. 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. 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.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49148 Based on observation and interview with facility staff, it was determined that the facility failed to store food in a manner that maintained professional standards of food service safety. This practice had the potential to affect all residents who eat the food prepared in the facility's kitchen. The findings include: On [DATE] at 8:05 AM, during a tour of the main kitchen, the Surveyor observed the produce refrigerator. The Surveyor observed an opened and unlabeled bag of carrots, bag of lettuce, and bag of spinach. During a continued tour of the kitchen, the Surveyor observed the meat/fish cooler. The Surveyor observed an uncovered large tub of apple cider and uncovered pan of greens on a short metal rolling cart. There was an uncovered large tub of chicken stock and an uncovered container of BBQ sauce on a shelving unit. There was an opened and unlabeled 4.4lb jug of kalamata olives, 1 liter carton of lemon juice, 32oz container of chopped garlic in water, two 32oz containers of basil pesto, 105oz jug of Frenches Dijon mustard, 1 gallon jug of Cattlemens BBQ sauce, 1 gallon jug of Kens Cocktail sauce, 1 gallon jug of sweet pickle relish, 32oz jug of horseradish, and 1 gallon jug of pepperoncini. There was an expired 30oz container of ginger garlic paste, 32oz jar of Sysco capers, a container of cherry sauce labeled left over [DATE]-[DATE], and a container of sundried tomatoes labeled [DATE]-[DATE]. An observation of the main freezer on [DATE] at 8:27 AM revealed an opened bag of spinach, an opened and unlabeled bag of chicken nuggets, and an uncovered pan of breaded meat sitting on a tall rolling metal shelf. During an observation of the refrigerator containing dairy products on [DATE] at 8:45AM, the Surveyor observed an opened and unlabeled block of white cheese wrapped in plastic wrap, a container of cottage cheese and a 5lb container of sour cream. During an observation of the dry goods storage area on [DATE] at 9:00AM, the Surveyor noted a opened an unlabeled bag of pasta and bag of craisins. On [DATE] at 9:04 AM, the Surveyor and the Certified Food Services Manager (CFSM) #4 confirmed the findings of opened and unlabeled foods, expired foods, and uncovered foods in the refrigerators, freezer, and the dry goods areas. CFSM #4 immediately discarded the food appropriately. On [DATE] at approximately 2:00 PM, the Surveyor reviewed the Food and Supply Storage policy which stated to cover, label and date unused portions and open packages and expired foods should be discarded by the use by, sell by, best by, or enjoy by date. CFSM #4 provided the Surveyor with a copy of an in-service conducted with kitchen personnel which reviewed Label and Dating in the Kitchen: Close and Label Open Items and Cover All Food.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 50573 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. The findings include: 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. 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). 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. 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. 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. 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. 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. 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 . 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. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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. 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. 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. 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.