FOIA Data Base - The Law Office of Jeffrey Downey

Serving clients in Washington D.C., Virginia and Maryland
If you have been injured in a nursing home or assisted living facility, call the law office of Jeffrey J. Downey for a free consultation.
Visit http:/www.jeffdowney.com

Phone: 703-564-7318; email: jdowney@jeffdowney.com

Bethesda Health and Rehabilitation
5721 Grosvenor Lane
Bethesda, MD 20814

Facility Characteristics:

- Skills Nursing Facility with 200 beds
- Managing Employees are Henry Akinseye, Ronald Cheli, and Jeffrey Solarz
- Website at https://www.savaseniorcare.com/bethesda-health-and-rehabilitation-center
- The For-profit corporation is owned by SSC Bethesda Operating Company LLC
- As of 2018 Bethesda Health and Rehabilitation Center was evaluated as a one-star facility (much below average) on Medicare.gov

Researching Nursing Homes

A note by attorney Jeffrey J. Downey:
Thank you for visiting my website. Anyone who is considering the admission of a loved one into a nursing home should undertake a review of surveys or other data that will provide a snapshot of some of the issues or problems that the facility is experiencing. Keep in mind that this information can be limited and may not reflect the actual condition of the facility when your loved one is admitted. You should consider personal visits of any facility you are evaluating.

The Maryland Department of Health inspects nursing homes including the Bethesda Health and Rehabilitation Center in Bethesda, MD. Periodically they do inspections as complaint surveys which should be public record. You can write to the Office of Health Care Quality, Spring Grove Center, Bland Bryant Building, 55 Wade Avenue, Catonsville, MD 21228 or email maryland.molst@maryland.gov

Having already researched Bethesda Health and Rehabilitation Center and obtained FOIA responses, I am posting these statements of deficiencies here, in a searchable format. Keep in mind that these surveys have been altered during the conversion process and you should update your search results.

I am interested in any additional information you may have on this facility. Please call me with any question about this or any other facility you may be interested in searching or prosecuting civilly for patient neglect or abuse.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A. BUILDING _____ B. WING _____	03/02/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BETHESDA HEALTH AND REHABILITATION	5721 GROSVENOR 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.

(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** - Few	**Reasonably accommodate the needs and preferences of each resident.** Based on surveyor observations, review of the clinical record and interview with residents and facility staff, it was determined that the facility failed to ensure reasonable accommodation of residents' needs. This finding was identified in 3 of 38 residents selected for the survey. (#41, # 216, #29) The findings include: 1. Based on surveyor review of the clinical record and resident and staff interview, it was determined that the facility staff failed to accommodate the needs of a resident (#41) who could not operate a manual wheelchair, but had access to a power/motorized wheelchair for mobility. This finding was identified during the investigation of complaint #MD 046 and is valid. On 02-27-18 at 11:30 AM, surveyor interview with resident #41 revealed that she/he had been requesting facility staff assistance to obtain a battery for his/her power wheelchair (WC) in order to transport independently. At the time, the resident had only a manual wheelchair. On 02-28-18, surveyor review of the clinical record for resident #41 revealed that the resident was a quadriplegic (paralysis of all 4 extremities) and unable to independently move in a manual wheelchair. Further review of resident #41's clinical record revealed a care plan note, documented on 09-23-17, that stated will follow up with DON about the WC battery that missing in relation to his/her activity and mobility. In addition, a 11-09-17 care conference note stated ambulates motorized wheelchair, needs battery at this time . cognitively intact . can make his/her own decisions. Surveyor review of the occupational therapy notes revealed that resident #41 was seen by occupational therapy from 10-24-17 through 12-13-17 with a long term goal to safely operate a power wheelchair within the facility and outside on the pavement. Further record review revealed a care conference note documented on 12-12-17 On 12-11-17 this writer met with {resident #41}in reference to battery for Motorized Power wheelchair . This writer spoke with ADON{Assistant Director of Nursing}, Physician and DON in reference to getting the Gel Battery. {Resident} had eloped when his/her Power Wheelchair was working 2 years ago . He/She is requesting to go outdoor for fresh air. The team came up with a plan to provide him/her with a Manual Wheelchair this way we can keep an eye and he/she would not be able to move around fast as he/she did with his/her Power Motorized Wheelchair. He/She can use his/her Manual wheelchair to get around outdoors for fresh air. However, there was no further evidence in the clinical record that the facility addressed resident #41's request for a battery to operate the power/motorized wheel chair until 01-31-18. On 01-31-18, the attending physician documented in the progress notes that, after speaking with the facility's ombudsman regarding resident #41's power wheelchair, a psychiatric consult for competency would be ordered. Further review revealed that, if the resident was declared competent, the resident could operate his/her power wheelchair. The physician further noted that the social worker and the administrator were made aware of this plan. On 02-12-18, resident #41 was evaluated by the facility's psychiatrist and was deemed competent . On 02-28-18 at 1 PM, surveyor interview with SW (social worker) #5 revealed that the battery had not been ordered, and that he/she would have to check with the Director of Social Work . On 02-28-18 at 4:30 PM, follow up interview with SW #5 revealed that, following surveyor intervention, the facility ordered a replacement battery for resident #41's power wheelchair. 2. On 02-26-18, surveyor review of the clinical record revealed that resident #216 had contractures of left upper extremity, and right upper extremity weakness secondary to a stroke. Further review revealed that the resident was dependent for all needs including turning and positioning. Contractures are a condition of shortening and hardening of muscles, tendons, or other tissue, leading to deformity and rigidity of joints. Surveyor observations on 02-26-18 at 3PM, 02-27-18 at 5:20PM and 03-01-18 at 11AM revealed resident #216 lying in bed, alert to tactile stimuli only, with their call light push button system located either behind the resident's bed or attached to the bedrail, inaccessible to the resident. Further observation revealed that the resident was incapable of pushing the button type call light due to weakness and contracture. On 03-02-18 at 4PM, surveyor interview with the Shenandoah unit manager revealed that the facility does have other types of call light devices, including a flat style pad that can be placed and activated with the movement of the resident's head. Further interview revealed that, after surveyor intervention on 03-02-18, an appropriate call light device was provided for resident #216. On 03-02-18 at 6PM, surveyor interview with the Director of Nursing (DON) revealed no additional information. 3. On 02-27-18, surveyor review of the clinical record revealed that resident #29 had contractures of the left upper extremity and right upper extremity with little mobility secondary to a stroke. Further review revealed that the resident was dependent for all his/her needs, including turning and positioning. Surveyor observations on 02-27-18 at 10AM and 02-28-18 at 10:17AM revealed resident #29 lying in bed, alert to tactile stimuli only, with a call light push button device attached to the bedrail, and inaccessible to the resident. Further observation revealed the resident was incapable of pushing the button type call light due to weakness and contractures of the upper extremities. On 03-02-18 at 4PM, surveyor interview with the Shenandoah unit manager revealed that the facility does have other types of call light devices, including flat style pad device that can be placed and activated with the movement of the resident's head. Following surveyor intervention, on 03-02-18, an appropriate call light device was provided for resident #29. On 03-02-18 at 6PM, surveyor interview with the Director of Nursing revealed no additional information.
F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** Based on surveyor review of the clinical record, interview with facility staff and resident, it was determined that the facility staff failed to protect resident #118's right to be free from any type of abuse. This finding was evident for 1 of 38 residents selected for the survey. The findings include: This finding was identified during the investigation of facility reported incident #MD 564. The facility reported incident was not validated but findings were related to the investigation of the incident. On 02-28-18 at 11:10 AM, surveyor review of resident #118's clinical record revealed that, on 01-08-18 at about 08:30 AM, resident #118's spouse reported to the facility's physical therapy department manager that resident #118 alleged that a facility staff member had touched his/her genitalia inappropriately while assisting him/her in the bathroom.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A. BUILDING _____ B. WING _____	03/02/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BETHESDA HEALTH AND REHABILITATION	5721 GROSVENOR 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) Further record review revealed that the therapy department manager reported this allegation to the Director of Nursing immediately. On 01-08-18 an interview was conducted with resident #118 in which he/she identified physical therapist assistant (PTA) #2 as the alleged perpetrator. As a result of this accusation, the facility immediately suspended PTA #2 pending the outcome of the investigation Additional record review revealed that, on 01-09-18, interview of the resident by occupational therapist (OT) #4 indicated that resident #118 had informed him/her that it was not PTA #2 who touched his/her genitalia. Facility OT #4 stated that resident #118 identified GNA (geriatric nursing assistant) #3 as the alleged perpetrator. However, the facility failed to immediately follow through on OT #4's statement of the reported sexual event by resident #118. The alleged perpetrator, GNA #3, was kept on the schedule and continued to work with the complainant and other vulnerable residents. This was evidenced by surveyor review of the facility's employee scheduled assignment from 01-09-18 through 02-25-18. On 03-01-18 at 1:10 PM, surveyor interview with resident #118 revealed that GNA #3 was assigned to him/her during the investigation and later removed, but was still seen on the unit caring for other residents. This facility action potentially placed the resident under undue distress and risk. On 03-01-18 at 2:32 PM, surveyor interview with the Director of Nursing revealed no further information.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** Based on surveyor review of the clinical record, interview with facility staff and resident, it was determined that the facility staff failed to prevent further potential abuse or mistreatment while the investigation of an alleged sexual abuse was in progress. This finding was evident in 1 of 38 residents selected for the survey. (#118). The findings include: This finding was identified during the investigation of facility reported incident #MD 564. The facility reported incident was not validated but findings were related to the investigation of the incident. On 02-28-18 at 11:10 AM, surveyor review of resident #118's clinical record revealed that, on 01-08-18 at about 08:30 AM, resident #118's spouse reported to the facility's physical therapy department manager that resident #118 had alleged that a facility staff member had touched his/her genitalia inappropriately while assisting him/her in the bathroom. Further record review revealed that the therapy department manager reported this allegation to the Director of Nursing immediately. On 01-08-18, an interview was conducted with resident #118 in which he/she identified physical therapist assistant (PTA) #2 as the alleged perpetrator. Due to this accusation, the facility immediately suspended PTA #2 pending the outcome of the investigation. Additional record review revealed that, on 01-09-18, interview of the resident by occupational therapist (OT) #4 indicated that resident #118 had informed him/her that it was not PTA #2 who touched his/her genitalia. OT #4 stated that the resident #118 identified GNA (geriatric nursing assistant) #3 as the alleged perpetrator. However, the facility failed to suspend or remove this alleged perpetrator from the unit while the investigation of this allegation of sexual abuse was in progress. Surveyor review of disciplinary action in the employee file of GNA #3 revealed that he/she was suspended on 02-26-18, which was 26 days after the alleged abuse allegation against him/her was reported. On 02-28-18 at 2:10 PM, surveyor interview with the Director of Nursing revealed no further information.
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** Based on surveyor observation, record review, and resident and staff interview, it was determined that the facility failed to provide food that accommodated residents intolerance, preferences, and offer options to residents who choose not eat the food that was initially served. This finding was evident for 3 of 38 residents reviewed during the survey.(#61, #71, #4) The findings include: 1. On 02-27-18 at 9:30 AM, surveyor interview with resident #61 revealed that the facility continued to serve chicken and turkey to the resident despite the resident's preference not to have these meats. Further interview revealed that, when the resident dines in his/her room, he/she is served whatever the main entree is, with no alternatives provided, unless he/she eats in the dining room. On 03-01-18 at 2:30 PM, surveyor interview with the Chesapeake unit manager provided no additional information. On 03-01-18 at 3:00 PM, surveyor interview with the Director of Nursing provided no additional information. 2 On 02-26-18 at 08:40 AM, surveyor interview with resident #71 revealed that he/she was not offered an opportunity to choose what to eat from the menu of the day. Resident #71 stated that they are forced to eat whatever is served. Further interview revealed that, although there is an alternative, the resident will not be able to get the alternative unless he/she eats in the dining room. Resident #71 prefers to dine in their own room. On 02-26-18 at 12:35 PM, surveyor observation revealed the resident intake was only about 5-10% of the lunch served. When the surveyor inquired why he/she did not eat much of the served lunch, the resident revealed I didn't like what was given to me. They have been serving me beef liver and onions at least 3 times weekly for lunch for at least 3 weeks. Surveyor review of resident #71's meal ticket revealed that the resident was served beef liver and onions, whole kernel corn, mashed potatoes and a dinner roll/bread, as a main entree. However, Review of the POS [REDACTED]. Further interview with resident #71 revealed that he/she was unaware that chicken was being served. He/she would have preferred the chicken to the beef liver and onions which was served, although this request was not made by the resident. On 02-26-18 at 1:10 PM, surveyor interview with the facility's food service manager revealed that resident #71 was served the wrong lunch meal. Further interview revealed that the beef liver and onions were supposed to be for another resident who had made the request a couple of weeks ago. Following surveyor intervention, on 02-26-18, a new nutritional assessment was completed on resident #71 and all food preferences were taken into consideration. On 02-26-18 at 2:30 PM, interview with the Director of Nursing (DON) revealed no new information. 3. Based on surveyor review of the clinical record, observation of staff practices and interviews with the facility staff, it was determined that the facility staff failed to deliver food to resident #4 that met his/her individual tolerance. This finding was identified during the investigation of complaint MD 041. On 03-02-18, record review revealed that resident #4 had Celiac Disease and had an order for [REDACTED]. On 03-02-18 at 7:45AM, surveyor observation of the kitchen staff during breakfast preparation, revealed gluten free toast being plated for resident #4 in accordance with a diet menu marked as gluten free due to the resident's Celiac Disease. However, the toast was prepared in the same toaster appliance as all other toasted items containing gluten, thereby, contaminating resident #4's gluten free products with gluten. On 03-02-18 at 7:45 AM, interview with the food service manager revealed that not all kitchen staff were aware of necessary measures to provide a gluten free diet to a resident with Celiac Disease. Foods must be prepared separately and remain free of cross contamination. When preparing gluten-free foods, it is important to avoid cross-contamination. Cross-contamination occurs when foods or ingredients come into contact with gluten containing foods, generally through shared utensils or a shared cooking/storage environment. In order for food to be safe for someone with celiac disease, it must not come into contact with food containing gluten. On 03-02-18 at 10:00 AM, an interview with the Director of Nursing revealed no additional information. On 03-02-18 at 5:45 PM, an interview with the facility's Registered Dietician revealed that a gluten free diet for a resident with Celiac Disease should be prepared separately on dedicated surfaces, with dedicated utensils, to avoid cross contamination.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A. BUILDING _____ B. WING _____	11/21/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BETHESDA HEALTH AND REHABILITATION	5721 GROSVENOR 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0225 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**1) Hire only people with no legal history of abusing, neglecting or mistreating residents; or 2) report and investigate any acts or reports of abuse, neglect or mistreatment of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor review of a facility reported incident, record review, and staff interviews, it was determined that the facility failed to thoroughly investigate an injury of unknown origin. This finding was evident in 1 of 18 residents reviewed during a complaint survey. This finding is related to a facility reported incident received while on site and is valid. The findings include: a. On 11-21-17, surveyor review of the clinical record for resident #11 revealed an emergency room report, dated 08-12-17, that stated the resident was transferred to the emergency room to be evaluated due to an abrasion of the right eyebrow. In addition, the head CT scan report for 08-12-17 stated abrasion to right eyebrow. Possible fall. Further review of the clinical record revealed a progress note dated 08-13-17 that stated resident #11 returned to the facility at 3 AM from the emergency room . Right eye brow remained slightly swollen, but the resident denied pain. On 08-14-17, a change of condition reflected that resident #11 had an abrasion to right eyebrow, slight swelling right wrist and documented that rehab staff reported that the resident ststed he/she fell out of bed. Review of the facility incident/accident investigation follow up, dated 08-14-17, revealed that no evidence of fall could be confirmed or corroborated at this time. Based on interview with the Director of Nursing, resident #11 would not have been able to get up on his/her own. There was no evidence that the facility attempted to further investigate the cause of resident #11's injuries and implement a plan to prevent further injuries. On 11-21-17 at 3 PM, surveyor interview with the Director of Nursing provided no additional information. b. On 11-21-17, surveyor review of a facility reported incident received while on-site regarding a second injury of unknown origin for resident #11 revealed that the resident was transferred to the emergency roiagnom on [DATE], where a head CT scan showed right sided facial fractures below the right eye and temple area. The resident reported that he had fallen to rehab (therapy) staff at the facility. Further review of the facility investigation for resident #11's injuries revealed statements from nursing staff who had provided direct care to the resident and housekeeping staff who entered the room for the previous three days. These statements all reflected that staff were not aware of any fall for resident #11. Surveyor review of the physician progress notes [REDACTED].#11 is non ambulatory with significant right sided weakness and fully dependent for care. The nurse practitioner also documented Family takes patient outside during the day without supervision. In addition, surveyor review of the medical director note, dated 10-03-17, revealed unclear how patient had injury. There has been no report of falls prior at nursing home. If patient fell he/she would have required staff to pick him/her up . no report from staff of finding patient on floor. Review of the nurses notes revealed that, on 09-29-17, resident #11 went out for an appointment with a specialist regarding the facial fractures. However, there was no evidence of a report from the specialist or follow up by facility staff with the specialist. On 11-22-17, following surveyor intervention, facility staff obtained the specialist report regarding resident #11's facial fractures. The report stated that the story is a bit unclear if resident #11 had a fall and noted that the resident had a similar incident on 08-12-17. However, there was no further information regarding how resident #11 sustained the injury. There was no evidence in the investigation that facility staff expanded interviews of non-direct care staff, rehab staff or family of resident #11 when direct care staff did not witness any falls, nor was there evidence that the facility expanded the investigation to include other possible causes of the injury. On 11-21-17 at 3 PM, surveyor interview with the Director of Nursing provided no additional information.
F 0278 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Make sure each resident receives an accurate assessment by a qualified health professional.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor review of the clinical record and interview with the facility staff, it was determined that the facility staff failed to ensure accurate MDS (Minimum Data Set) documentation for residents. This finding was evident in 2 of 18 (#2, #3) residents identified during the complaint survey. The findings include: The Minimum Data Set (MDS) is a mandated process for clinical assessment of all residents in Medicare or Medicaid certified nursing homes. This process provides a comprehensive and accurate assessment of each resident's functional capacity and health status to assist nursing home staff in identifying health problems. MDS assessments are required for residents on admission to the nursing facility and then periodically, within specific guidelines and time frames. 1. On 11-20-17, surveyor review of the clinical record for resident #2 revealed 08-22-17 staff documentation that the resident is making several attempt to exit unit. In addition, the resident wears a Wanderguard secondary to exit seeking behavior. A Wanderguard is an alarm system used in wandering or elopement management. The system usually involves some type of antenna system connected to a controller and a door contact switch. Residents who are at risk wear a wrist or ankle transmitter, when, if the transmitter comes in contact close to the door that is protected by this type of system, the antenna singles out the transmitter on the resident. Further review revealed an 08-23-17 an elopement risk assessment for resident #2 with a total score of 12, which indicated that the resident was at risk. The assessment total score included a resident's placement perception status regarding the resident verbalizes desire or plan to leave the facility unauthorized/unsupervised. However, review of the MDS section E's (Behavior),with a 08-23-17 ARD (Assessment Reference Date), response to the question if resident #2 wandered during the 7 day look back period (08-16 to 08-23-17), staff documented that there was no wandering behavior exhibited during the look back period. On 11-20-17 at 3PM, surveyor interview with the [MEDICATION NAME] unit social worker revealed no additional information. On 11-21-17 at 3:30PM, interview with the facility administrator and the Director of Nursing revealed no additional

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A. BUILDING _____ B. WING _____	11/21/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BETHESDA HEALTH AND REHABILITATION	5721 GROSVENOR 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0278 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	(continued... from page 1) information. 2. On 11-20-17, surveyor review of the MDS section E (Behavior), with a 07-29-17 and 10-11-17 ARD, response to the question if resident #3 wandered during the 7 day look back periods, staff documented that the behavior of this type occurred 1 to 3 days. However, record review on 11-20-17 revealed no documented evidence of wandering behavior during the above 7 days of the look back periods for resident #3. On 11-20-17 at 4PM, surveyor interview with the [MEDICATION NAME] unit manager and the [MEDICATION NAME] unit social worker revealed no additional information. On 11-21-17 at 3:30PM, interview with the facility administrator and the Director of Nursing revealed no additional information for resident #3.
F 0309 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide necessary care and services to maintain the highest well being of each resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor review of the closed clinical record and interview with the facility staff, it was determined that the facility failed to ensure thst pain medication was administered in a timely manner to resident #8. This finding was evident in 1 of 18 residents selected in the complaint survey. The findings include: This finding was identified during the investigation of a facility reported incident MD 263 and is valid. On 11-21-17, surveyor review of the closed clinical record revealed a change in condition on 08-09-17 which noted that resident #8 was observed with a greenish discoloration of the left hip and complaining of left lower extremity pain by staff during late morning AM care. Further review of the change in condition revealed that LPN (Licensed Practical Nurse) #1 documented that the attending nurse practitioner (NP) was notified at 12PM, while the resident's responsible party was notified at 3PM. The NP orders at that time ordered an X-ray of the left hip and for resident #8 to receive a Now dose of [MEDICATION NAME] 400 mg x 1 for the pain. Review of the 08-09-17 documentation by the attending NP revealed a treatment plan for resident #8's acute left hip pain with left hip ecchymosis (discoloration) to include: a left hip X-ray to rule out fracture, [MEDICATION NAME] 25 mg at 12PM x 14 days for pain, [MEDICATION NAME] ([MEDICATION NAME]) 400 mg twice daily x 3 days with first dose now for pain management. In addition, staff to continue to administeruuu Tylenol every 12 hours for pain and monitor for effectiveness. Further closed record review revealed the 08-09-17 X-ray results of an acute left intertrochanteric fracture (left [MEDICAL CONDITION]). Review of the August 2017 MAR (Medication Administration Record) revealed staff administered Tylenol 325 mg 2 tablets on 08-09-17 at 8AM and 8PM to resident #8. In addition, another dose of Tylenol 325 mg 2 tablets was administered at 12PM on 08-09-17 for pain. Review of the 08-09-17 order summary report for resident #8 revealed physician orders [REDACTED]. There was no documented evidence that the NP request for the first dose now of [MEDICATION NAME] 400 mg was put into the electronic order system by facility staff as requested. On 11-21-17 at 12:10PM, surveyor observation and interview with the Chesapeake unit manager revealed that an interim medication supply box (with multiple individual packaged doses of [MEDICATION NAME] 200 mg available for immediate administration) was located both on the Chesapeake and the Gateway nursing units within the facility. On 11-21-17 at 1PM, surveyor interview with the [MEDICATION NAME] unit manager revealed that the [MEDICATION NAME] first dose now was documented as a one time only into the electronic system. However, further interview revealed no additional information for the documented delay for the first dose of the [MEDICATION NAME]. On 11-21-17 at 4PM, surveyor interview with the facility's administrator and Director of Nursing revealed no further documented evidence and/or information provided.
F 0323 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** Based on surveyor review of clinical and administrative records, facility policy, and staff interviews, it was determined that the facility failed to maintain a safe environment for a resident with a history of known memory impairment and exit seeking behavior. This deficient practice placed the resident at risk for elopement and serious harm. When the resident did elope, the facility failed to notify the administrator as soon as the resident was noted as missing, and failed to notify law enforcement authorities and the resident's responsible party when an initial facility search was not successful. The related concerns were evident 1(#1) out of 5 residents reviewed. Review of the facility's plan of correction implemented after the facility gained knowledge of the incident resulted in the deficiency being cited as past non-compliance. This finding was identified during the investigation of facility reported incident #MD 076 and is valid. The findings included the following: On 11-20-17, surveyor review of the clinical record revealed that resident #1 was assessed as a high risk for elopement with exit seeking behaviors. Resident #1 resided on a locked unit (Rosemary Unit). Further review of the clinical record revealed physician's orders for resident #1 to wear a wander guard bracelet and for staff to check for placement and functioning every shift. A wander guard system is an alarm system used to alert staff if a resident who has been determined at risk for elopement is trying to leave the facility or wander into a restricted area. A transmitter is placed on the at risk resident (typically on a band around the wrist or the ankle) and when the resident approaches a door way or area equipped with a wander guard sensor an alarm sounds to notify staff. Surveyor review of the facility investigation of resident #1's elopement revealed that, on 09-27-17 at 5:45 PM, resident #1 was noted to be missing from the facility. Surveyor review of the statement written by the Geriatric Nursing Assistant, (GNA) who was assigned to care for resident #1 on 09-27-17 on the 3-11 shift, revealed that the GNA noted the resident to be missing at dinner time on 09-27-17 and reported that to the charge nurse for Rosemary Unit. Surveyor review of the statement written by the charge nurse for Rosemary Unit revealed that, on 09-27-17 at 5:45 PM, resident #1 was not in the dining room and the charge nurse asked the GNA to check the resident's room. The resident was not in the room so the charge nurse and GNA started a search and informed the evening supervisor. Surveyor review of the statement written by the evening supervisor revealed that the supervisor was informed by the charge nurse that resident #1 was missing at approximately 7 PM. At that time, the supervisor started a room to room search of the entire facility and surrounding perimeter. The 3-11 supervisor noted that the 3-11 staff on Rosemary Unit denied seeing the resident at any time on the 3-11 shift. The 3-11 supervisor notified the Director of Nursing at 7:15 PM and the police at 7:30 PM of the missing resident. The resident's family member was notified at 7:38 PM. Surveyor review of the facility policy for a missing resident instructs staff to notify the administrator and director of nursing and make a thorough search of the building and premises. If the resident is not located, staff should notify the resident's legal representative, the physician, the police and state agency if required. However, the Administrator, Director Of Nursing (DON), police, and legal representative were not notified until at least one and a half hours after the resident was noted to be missing. Surveyor review of the facility's credible allegation of compliance revealed that, on 09-27-17 at 11 PM, it was identified that Rosemary unit's stairwell door would occasionally, not completely shut when staff entered the stairwell. In addition, the fire exit doors in the stairwell did not have an internal locking or alarm system. The pass code to enter the stairwell was changed at that time. Surveyor review of the statement written by the Rosemary Unit manager revealed that on 09-28-17 at 6:55 AM the exit door to the stairwell between rooms 119 and 121 was not closing properly. The unit manager notified maintenance and nursing staff monitored the stairwell door untilthe door was repaired at 9 AM. Surveyor review of resident #1's statement written by the Rosemary Unit manager on 09-28-17 revealed resident #1 stated that the resident pushed on the door located between the rooms 19 and 121, then he/she pushed on the other exit door, walked through the woods. On 11-20-17 at 12:10 PM upon surveyor interview, the Rosemary unit manager stated that resident #1 got out of the stairwell

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A. BUILDING _____ B. WING _____	**11/21/2017**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BETHESDA HEALTH AND REHABILITATION	**5721 GROSVENOR 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) door down here. Maybe someone went through and it didn't close all the way or he/she followed someone through the door. He/she is always trying to go somewhere. On 11-20-17 at 12:15 PM, upon surveyor interview, the Administrator stated that the conclusion of the facility investigation was that resident #1 went through the stairwell door then the exit door. The door to the stairwell required staff to put in a code to open the door. The fire exit door to the outside located in the stairwell did not require a code to open and was not alarmed. Neither door was equipped with a wander guard system. The administrator and the maintenance director, who checked all the doors on the night of 09-27-17, did not notice anything unusual about the door from the stairwell or exit door and the conclusion was that the the resident may have followed a staff member through the stairwell door then went through the outside door that was not coded or alarmed. Immediate actions taken by the facility on 09-27-17 included: The facility identified issue: Resident #1 eloped from the facility due to the facility's failure to maintain a safe and secure environment, placing the resident at risk for serious harm or death. Resident #1 was noted to be missing at on 09-27-17 at 5:45 PM, a search of the building and surrounding premises was initiated and the administrator, the DON, the police, and resident's legal representative were notified. The resident was found on 09-28-17 at 11:15 AM with some scratches on the face and both arms. The primary care physician conducted an evaluation of the resident upon return to the facility. All residents with exit seeking behavior were identified to be affected by the incident. Unit managers, Assistant Director of Nursing, and Director of Nursing conducted a 100% audit on all residents with exit seeking behaviors, as well as those with wander guards. The audit included review/update of elopement risk assessments, care plans, and wander guard check orders. The date of compliance was 09-28-17. The Administrator and the Maintenance Director re-evaluated the wander guard system, as well as security for all interior and exterior doors and windows through out the facility. It was identified at the time of this review that camera #6 on the Rosemary Unit's south corridor was not functional. This camera was immediately replaced. The Maintenance Director/designee will conduct weekly checks on the functions of all cameras in the building and will place all results in the TELs Reporting System. (TELs is a computer program used to track maintenance records). The need was also identified for an additional 14 cameras to enhance the monitoring of the current system. These additional cameras were immediately ordered. It was also identified that the Rosemary Unit's stairwell door would occasionally not completely shut when the staff entered that stairwell. This problem was corrected by the maintenance staff on 09-27-17. On 09-28-17 at 6:55 AM, it was identified that the Rosemary Unit's stairwell door was not closing properly. The door was monitored by nursing staff until maintenance staff corrected the problem on 09-28-17 at 9:00 AM. The stairwells on Gateway, Chesapeake, and the Rosemary Units were changed to emergency egress only on 09-28-17, as the fire exits in those stairwells had no internal locking or alarm system. Local alarms were ordered on 09-28-17 and installed on 10-02-17. The Director of Nursing, Staff Development Coordinator, and Nurse Mangers conducted education with all staff on 09-28-17 on monitoring, reporting and safety measures regarding an incident of elopement, as well as ensuring that doors with keypad/ badge swipe entries are closed after entry. The education also included ensuring staff awareness of the necessity to provide security and supervision for residents. Beginning 09-29-17, no staff was permitted to work until the training was complete. This education was included in the facility's new hire orientation and newly hired licensed nursing staff were not permitted to assume their floor responsibilities until they completed this education. In the weekly at risk meetings, The Interdisciplinary Team (including the Director of Nursing, Administrator, Social Services Director, Activities Director, Therapy Program Manager, Dietary Manager, Unit Coordinator or Unit Manager, Resident Care Management Director, and Medical Director) reviewed those residents who exhibited exit seeking behaviors to ensure that the appropriate measures for their safety had been put in place. The facility's compliance date was 10-02-17.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A. BUILDING _____ B. WING _____	03/07/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BETHESDA HEALTH AND REHABILITATION	5721 GROSVENOR 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0156 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Give each resident a notice of rights, rules, services and charges. Tell each resident who can get Medicaid benefits about 1) which items and services Medicaid covers and which the resident must pay for.** Based on surveyor review of clinical records, interview of social services director and review of facility policy and procedure, it was determined that the facility staff failed to inform an individual or his/her responsible party 48 hours before Medicare coverage was terminated. This finding was evident in 3 of 49 residents selected in stage 2 review (#161, #116 and #127). The findings included: 1. On 03-02-17, review of a notice of Medicare non-coverage revealed resident #161's surrogate decision maker was notified by phone on 10-26-16, a day before Medicare coverage was terminated on 10-27-16. Further review of the facility policy and procedure related to Medicare Letters of Non-Coverage revealed the facility staff were instructed to deliver a notice of Medicare Non-Coverage to a resident or his/her responsible party at least 2 days prior to the last Medicare coverage day. Interview of the social services director on 03-02-17 at 5 PM and interview of the facility administrator on 03-06-17 at 5:30 PM revealed no additional information. 2. On 03-02-17, review of a notice of Medicare non-coverage revealed resident #116's family member was notified on 12-01-16, the same day when Medicare coverage was terminated on 12-01-16. Interview of the social services director on 03-02-17 at 5 PM and interview of the facility administrator on 03-06-17 at 5:30 PM revealed no additional information. 3. On 03-02-17, review of a notice of Medicare non-coverage revealed resident #127's family member was notified on 02-23-17, 2 days after Medicare coverage was terminated on 12-01-17. Interview of the social services director on 03-02-17 at 5 PM and interview of the facility administrator on 03-06-17 at 5:30 PM revealed no additional information.
F 0157 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor and a family member of the resident of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor review of the clinical record and interview of facility staff, it was determined that the facility staff failed to inform resident#237's court appointed guardian related to a diagnostic test. This finding was identified during an investigation of MD 829, which is unrelated to the complaint allegations. The findings include: On 03-02-17, review of the clinical record revealed resident #237 was admitted to the facility in January 2017 following a hospitalization . There were 2 court appointed guardians available to make health care decision for resident #237. On 01-23-17, a swallowing evaluation was ordered after resident #237 complained of difficulty in swallowing. At that time, one of the court appointed guardians was notified about this order. On 02-02-17, a modified [MEDICATION NAME] swallow study (MBSS) was arranged to be done at a local hospital on 02-08-17 at 7:30 AM. In addition, specific instructions were given to resident #237 to bring a picture identification, a medication list and the insurance card. However, there was no evidence that one of the resident's court appointed guardians was notified about the date, time and location of this MBSS. In the morning on 02-08-17, the MBSS was canceled because no escort was available for resident #237. Neither of the guardians was notified. A new appointment for the MBSS was made on 02-15-17 at 9AM. However, there was no evidence that either of the court appointed guardians was notified about the delay of the MBSS. On 03-06-17 at 11 AM, interview of the Potomac unit manager revealed no nursing staff, who worked on 02-08-17, was available to go with resident #237 to the MBSS. Therefore, the MBSS was scheduled on 02-15-17 instead. On 03-07-17 at 2 PM, interview of the director of nursing revealed no additional information was provided that resident #237's legal guardians were updated regarding the MBSS.
F 0225 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**1) Hire only people with no legal history of abusing, neglecting or mistreating residents; or 2) report and investigate any acts or reports of abuse, neglect or mistreatment of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor review of the clinical record and interview with facility staff, it was determined that the facility failed to complete a thorough investigation of an injury of unknown origin for resident #244 and to notify Office of Health Care Quality (OHCQ). This finding was evident in 1 of 49 residents selected in the stage 2 review. The findings include: On 03-03-17 surveyor review of the clinical record revealed resident #244 was admitted to the facility in February 2017. [DIAGNOSES REDACTED]. Further review revealed nursing documentation that the resident was confused and was observed wandering and ambulating independently into other residents' rooms at times. Further review of a change in condition for 02-09-17 revealed around 8:25AM a staff member entered resident #244's room and found the resident sitting on the side of the bed with blood on his/her face and on the floor in the room. Further staff assessment revealed a small laceration on the resident's forehead area with moderate amount of blood and discoloration to the upper nose bridge area. Staff documented, on the change in condition, appears resident had fallen while walking in room and went back to sit on the side of bed. In addition, further staff documentation that unable to ascertain how resident fell at this time as resident unable to tell. Resident was then transferred to the emergency room at 9AM on 02-09-17 and received sutures to the [MEDICAL CONDITION]. However, on 03-06-17 further record review revealed no evidence of the facility initiating an investigation of the injury of unknown origin to resident #244. Additionally, there was no documented evidence that the facility reported the 02-09-17 injury of unknown origin to the OHCQ. On 03-07-17 at 9AM surveyor interview with the attending physician revealed resident #244 did have a fall at home prior to

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A. BUILDING _____ B. WING _____	03/07/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BETHESDA HEALTH AND REHABILITATION	5721 GROSVENOR 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0225 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) admission to the facility and was considered a fall risk. Since the resident does wander around the unit and into other residents' rooms, an investigation should be conducted since the injury was unwitnessed. Interview with the Director of Nursing on 03-07-17 at 9:15AM revealed no additional information.
F 0272 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Conduct initial and periodic assessments of each resident's functional capacity.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor review of the clinical record and facility staff interview it was determined that facility staff failed to ensure comprehensive assessments of residents' needs. This finding was evident in 3 of 49 residents selected in the stage 2 review. (#127, #71 and #26) The findings include: 1. On 03-06-17 surveyor review of the clinical record for resident #127 revealed the admission comprehensive assessment identified that the resident had [DIAGNOSES REDACTED]. However, surveyor review of the physician history and physical, the hospital record's history and physical, and the final hospital discharge summary, revealed no evidence that resident #127 was diagnosed with [REDACTED]. On 03-06-17 at 3:30 PM surveyor interview of the Director of Nursing (DON) provided no additional information. 2. On 03-06-17, review of the clinical record (SBAR summary) dated 02-07-17 revealed scratches were noted on resident #71's right and left chests. The resident explained that he/she scratched their chest with their own nails. However, no initial or routine skin assessment was done to determine whether these scratches were resolved or not. Interview of the DON on 03-06-17 revealed the facility staff should conduct weekly skin assessments until it was resolved. However, there was none available after 02-07-17. 3. On 03-06-17, review of the admission note dated 01-14-17 revealed resident #26 was admitted to the facility following a hospitalization . An eschar (area of dead tissue on the skin) of 0.5 cm x 0.5 cm was noted on the resident's right lateral heel. A suspected deep tissue injury of 0.3 cm x 0.3 cm was noted on the resident's left lateral heel. Upon admission, a treatment to apply skip prep twice a day on both heels was ordered. Further review revealed the nursing staff continued to apply skin prep on the resident #26's heels as of 03-06-17. However, there was no routine skin assessment done to monitor these heel ulcers. On 03-06-17 at 5:20 PM, observation of resident #26 in the presence of staff #6 revealed no ulcer was noted on the resident's heels. Instead, an eschar was noted on resident #26's right lateral (side) foot, which was painful to touch. Another eschar was noted on the resident's left lateral foot. Resident #26 stated these ulcers were caused by the shoes. However, there was no initial or routine skin assessment done related to these ulcers, which were located on the resident's lateral feet. On 03-07-17 at 1 PM, interview of the DON revealed he/she would follow up. On 03-08-17 at 2:50 PM, telephone interview of staff #5 revealed he/she made an error on the admission notes. Staff #5 stated that ulcers were noted on resident #26's bilateral feet, not heel upon admission. However, telephone interview of the DON on 03-08-17 at 3 PM revealed no routine skin assessment was done to monitor the ulcers on the resident's heels or feet after admission.
F 0279 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop a complete care plan that meets all of a resident's needs, with timetables and actions that can be measured.** Based on surveyor review of the closed clinical record and interview with facility staff, it was determined that the facility failed to develop a comprehensive plan of care regarding urinary incontinence for resident #5. This finding was evident in 1 of 49 residents selected in the stage 2 review. The findings include: On 03-06-17 closed record review revealed that resident #5 was initially admitted to the facility in November 2016 after a hospitalization . Upon admission, the resident was admitted with a gastrostomy tube (tube is passed into the stomach through the abdominal wall to provide a means of feeding) secondary to an inability to tolerate oral feedings and a Foley catheter. A Foley catheter is a flexible tube that is often passed through the urethra and into the bladder. One lumen is open at both ends, and allows urine to drain out into a collection bag. Further review revealed on 11-18-16 the attending physician ordered staff to discontinue the Foley catheter for resident #5 . However, staff were unsuccessful in removing the catheter until 11-19-16 when the Foley was discontinued. On 03-06-17 review of the November 2016 GNA (Geriatric Nursing Assistant) documentation revealed resident #5 was incontinent of urine from 11-19-16 until the resident's discharge from the facility in February 2017. However, review of the comprehensive plans of care revealed no evidence of a plan of care addressing resident #5's urinary incontinence. In addition, there was no evidence of a plan of care addressing the resident's use of a Foley catheter from the time of the initial assessment at admission until 11-19-16. On 03-07-17 at 9:30AM surveyor interview with the Director of Nursing revealed no additional information.
F 0281 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Make sure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor review of the clinical record, surveyor observation of medication pass and interviews with the resident and facility staff, it was determined that the facility staff failed to ensure standards of nursing practice for residents. This finding was evident in 3 of 49 residents selected in the stage 2 review. (#19, #225 and # 237). The findings include: 1. On 03-06-17 surveyor review of the March 2017 MAR (Medication Administration Record) for resident #19 revealed a scheduled 4PM medication included [MEDICATION NAME]-chrondroitin 500-400 mg twice daily for pain and scheduled 4:30PM medications that included [MEDICATION NAME] 1000 mg (400 mg tablet and 600 mg tablet) before meals for pain and [MEDICATION NAME] 2 mg before meals for spasms. Further review revealed resident #19 had 1 scheduled medication at 6PM, 1 medication at 8PM, 1 medication at 9PM and 2 medications at 10PM On 03-06-17 at 5:10PM surveyor observation of medication pass revealed LPN (licensed practical nurse) #8 administered 1 scheduled medication to resident #139. After they completed medication pass, interview with LPN #8 revealed there were no other residents scheduled for medication administration after resident #139. Further interview at 5:15PM with LPN #8 revealed when asked about resident #19's scheduled 4PM and 4::30PM medications, LPN #8 revealed that resident #19 had no other scheduled medications until 6PM. Further review of the March 2017 MAR indicated [REDACTED]. However, there was no documented evidence the [MEDICATION NAME] 600 mg tablet was administered nor the [MEDICATION NAME] 2 mg at the same scheduled times. On 03-06-17 at 5:18PM surveyor interview with resident #19 revealed that LPN #8 had not administered any medications to the resident since the start of the shift at 3PM. Further interview revealed that LPN #8 usually does not administer medications to the resident until about 6PM and there are about 5 pills at that time. Interview with LPN #8 on 03-06-17 at 5:30PM, in the presence of the Chesapeake unit manager, revealed that resident #19's scheduled 4PM and 4:30PM medications were administered as documented, but that the 600 mg [MEDICATION NAME] and [MEDICATION NAME] had not and still had time to administer them at this time (meaning within the hour of being scheduled). Medications are considered on time when administered within one hour before or after the scheduled time. Further interview with LPN #8 revealed that resident #19 had told LPN #8 that he/she did not want the medications at the time the other dose of 400 mg [MEDICATION NAME] was administered. No additional information provided. However, there was no documented evidence of this exchange between LPN #8 and resident #19 in the clinical record which was inconsistent with the resident and staff initial interview or any evidence that LPN #8 notified the attending physician of a change in the medication administration times during surveyor review of the clinical record. As stated in the Nurse Practice Act (10.27.10.02-2 (g)) performing nursing interventions in a competent safe manner appropriate to the LPN's scope of practice including (i) administration of medication treatments. In addition, as stated in (10.27.10.02-3 (c)) Reporting to other members of the health care team in a timely, accurate and complete manner on data

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A. BUILDING _____ B. WING _____	03/07/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BETHESDA HEALTH AND REHABILITATION	5721 GROSVENOR 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0281 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) collected from (i) the client and (iv) other health care providers and (g) documenting the evaluation data on appropriate records. On 03-07-17 at 9AM surveyor interview with the Director of Nursing revealed no additional information. 2. Based on surveyor review of a facility reported incident regarding verbal abuse of resident #225 revealed that the facility staff failed to ensure standards of nursing practice to report unethical behavior of a nursing employee to the Board of Nursing. On 03-07-17 review of the facility's investigation revealed that the incident of verbal abuse was substantiated that staff #9 had verbally abused resident #225. On 03-07-17 at 1:30 PM surveyor interview of the Director of Nursing revealed that staff #9 was not reported to the Board of Nursing after the facility substantiated the verbal abuse. As stated in the (NAME)land Nurse Practice Act (10.27.19.02 A(7)) a nurse is required to report unethical behavior to the Board of Nursing. 3. This finding was identified during an investigation of MD 829, which is unrelated to the complaint allegation. On 03-02-17, review of the clinical record revealed an abnormal potassium level laboratory report was faxed to the facility on [DATE] at 1:22 PM for resident # 237. Potomac unit manager reviewed the abnormality with the attending physician on the phone. A new order was given to administer a medication, [MEDICATION NAME], to lower resident #237's potassium level. Further review of the MAR indicated [REDACTED]. On 03-06-17, review of the facility interim medication list revealed [MEDICATION NAME] was available in the facility on 02-07-17. On 03-06-17 at 11 AM, interview of the director of nursing and Potomac unit manager revealed no additional information related to a 12 hour delay in administering [MEDICATION NAME] for resident #237 when the Potassium level was abnormally high. As a standard of nursing practice COMAR.27.09.02E (1) Implementation, the registered nurse shall implement the interventions identified in the plan of care.
F 0309 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide necessary care and services to maintain the highest well being of each resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor review of the clinical record and facility staff interviews, it was determined that the facility staff failed to follow physician's orders. This finding was evident in 3 of 49 residents in the stage 2 reviews. (#127, #248 and #237) The findings include: 1. On 03-06-17 surveyor review of the clinical record of resident #127 revealed a physician's order written on 01-05-17 for a urology consult for bladder mass. Further review of the clinical record revealed no evidence that the urology consult was obtained or scheduled for resident #127. On 03-06-17 at 3:30 PM surveyor interview of the Director of Nursing provided no additional information. 2. On 03-07-17 review of the clinical record for resident #248 revealed he/she was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The resident was scheduled to receive IV (intravenous) antibiotics for a period of six weeks via a peripherally inserted central catheter (PICC) line for the infection. A PICC line is a long, soft, flexible tube or catheter, that is inserted through a vein in the arm. The PICC catheter is designed to reach one of the larger veins located near the heart. It is usually used for administration of antibiotics and [MEDICAL CONDITION]. On 02-27-17 the physician ordered intravenous fluids (IV) for resident #248 for hydration. Normal saline 0.9% solution was ordered to be administered at 70 cc per hour intravenously every shift on Monday and Tuesday (twice weekly) via the PICC line. On 03-01-17 the PICC line became dislodged preventing further intravenous therapy. On 03-03-17 a new PICC line was re-inserted and the IV antibiotics were resumed, however the intravenous fluids for hydration were not resumed. On 03-07-17 at 9:20 AM, interview with the Gateway unit manager revealed that the normal saline 0.9% solution should have been administered on 03-06-17, (Monday) as initially ordered. However, following surveyor intervention, the IV fluids would be administered on 03-07-17 and 03-08-17. 3. This finding was identified during an investigation of MD 829, which is related to the complaint allegation. On 03-02-17, review of the clinical record revealed resident #237 was admitted to the facility on [DATE] following a hospitalization . a. Upon admission, a physician's order was written to arrange a consultation with a physiatrist (physical medicine specialist) for resident #237. However, there was no evidence that an arrangement was made. On 02-06-18, another physician's order was written to arrange a consultation with the physiatrist for resident #237. However, there was no evidence that an arrangement was made. On 03-06-17 at 5 PM, interview of the director of nursing revealed a consultant physiatrist visits the facility every Friday, but no additional information was provided to explain why the consultation was not done for resident #237 as ordered. b. On 01-25-17, a physician's order was written to administer a 14 day course of antibiotic, [MEDICATION NAME] 125 mg, three times a day due to an infection, [MEDICAL CONDITION], in the stool for resident #237. The last day of the antibiotic should have been on 02-08-17. Review of the Medication Administration Record [REDACTED]. The nursing staff documented that [MEDICATION NAME] 125 mg was given three times a day between 01-27-17 and 02-04-17, a total of 9 days. Then, no [MEDICATION NAME] 125 mg was given on 02-05-17 and 02-06-17. The nursing staff then signed off that [MEDICATION NAME] 125 mg was given at 9 PM on 02-07-17, at 7 AM on 02-8-17 and 2 PM on 02-08-17. On 03-06-17 at 5 PM, interview of the director of nursing revealed no additional information provided to explain why the nursing staff did not administer the antibiotic as ordered. c. On 03-06-17, review of the physician's order dated 01-23-17 revealed a neurology consult was ordered for resident #237. On the next day, an additional physician's order was written to arrange a renal consult for [MEDICAL CONDITION] and a [MEDICATION NAME] consult for loose stool. However, no neurology consult, renal consult, and [MEDICATION NAME] consult was arranged for resident #237. On 03-06-17 at 5 PM, interview of the director of nursing revealed no additional information. d. On 03-06-17, review of the clinical record revealed a physician order was written for resident #237 on 01-23-17 to administer Questran packet 2 gram daily for loose stool. The nursing staff signed off that Questran packet 2 gram was given as ordered on 01-24-17 at 9 AM. Then, the attending physician wrote another physician's order on 01-24-17 to administer Questran packet 4 gram three times a day. Further review of the MAR indicated [REDACTED]. However, a Questran packet was available in the facility since 01-24-17. On 03-06-17 at 5 PM, interview of the director of nursing revealed no additional information.
F 0329 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**1) Make sure that each resident's drug regimen is free from unnecessary drugs; 2) Each resident's entire drug/medication is managed and monitored to achieve highest well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident record review and interviews of resident and staff, it was determined that the facility staff failed to ensure that medications used were adequately assessed, indicated, not duplicated, and had coordinated monitoring. This finding is evident in 2 of 49 sampled residents selected in the stage 2 review. (#127 and #237) The findings include: 1. On 03-06-17 surveyor review of the clinical record revealed resident #127 was admitted with [DIAGNOSES REDACTED]. a. Surveyor review of the physician's orders [REDACTED].#127 revealed the following medications included: [MEDICATION NAME] (used to treat anxiety) to be administered as needed for anxiety

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A. BUILDING _____ B. WING _____	03/07/2017

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BETHESDA HEALTH AND REHABILITATION	5721 GROSVENOR 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0329 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) [MEDICATION NAME] (used to treat anxiety) to administered at bedtime for agitation [MEDICATION NAME] (anti-psychotic medication) to be administered at bedtime for [MEDICAL CONDITION] disorder [MEDICATION NAME] (anti-psychotic medication) to be administered every 12 hours for [MEDICAL CONDITION] Depaokote (used to treat [MEDICAL CONDITIONS] disorder, or prevent migraines) to be administered twice daily for mood [MEDICATION NAME] (used to treat [MEDICAL CONDITION], or [MEDICAL CONDITION] disorder) to be administered twice daily for [MEDICAL CONDITION] disorder [MEDICATION NAME] (used to treat [MEDICAL CONDITION], neuropathic pain, and [MEDICAL CONDITION] disorder) to be administered three times daily for neuropathic pain [MEDICATION NAME] (used to treat [MEDICAL CONDITIONS] disorder, or prevent migraines) to be administered three times daily for [MEDICAL CONDITION] However, there was no evidence in the clinical record of a [DIAGNOSES REDACTED]. On 01-15-17 a physician's orders [REDACTED]. However, the medication, [MEDICATION NAME] is not indicated to avoid falls and injury but instead the medication could increase the risk for falls and injury. Then on 01-19-17 a physician's orders [REDACTED]. Surveyor review of the the pharmacist review on 02-02-17 for resident #127 revealed that the pharmacist recommended clarification of the [DIAGNOSES REDACTED]. The attending physician clarified that the [MEDICATION NAME] was for the [DIAGNOSES REDACTED]. In addition, review of the attending physician's progress notes revealed that on 02-08-17 the physician documented that the reason that resident #127 was on [MEDICATION NAME] was to treat [MEDICAL CONDITION] with [MEDICAL CONDITION], not for [MEDICAL CONDITION] as documented on the previous medication order. b. Surveyor review of the January and February 2017 MAR (medication administration record) for resident #127 revealed that staff administered duplicate doses of the anti-anxiety medications to resident #127 on several occasions. Staff administered [MEDICATION NAME] both by injection and by mouth as well as [MEDICATION NAME] by mouth on 01-23-17 at 8:45 AM. In addition, staff administered both the [MEDICATION NAME] and [MEDICATION NAME] at the same time on 01-29-17 at 5:35 PM, 02-06-17 at 9:01 AM, 02-12-17 at 10:14 AM and 7:54 PM, and 02-26-17 at 6:24 AM and 2:44 PM . c. Further review of resident #127's clinical record revealed a 01-04-17 psychiatric consult note documented that resident #127 was seen by the psychiatrist to evaluate the patient's mental status and adjust medications if needed. However, the assessment of the current medications was inaccurate including medications that the resident was not even receiving, as well as the wrong dosages of medications were documented. The psychiatrist's documentation under plan revealed continue current medication. However, the list of current medication noted by the psychiatrist did not address the medications the resident was receiving at the time of the 01-04-17 visit. In addition, there was no documented indication for the use of multiple medications in the same drug classification. Additionally, further record review revealed on 02-09-17 a psychiatric consult revealed that resident #127 was seen by the psychiatric nurse practitioner for monthly follow up. Again, the assessment of current medications were incorrect and included medications that the resident was not receiving, including wrong dosages of the medications, Documentation under plan included reviewed side effects and risks/benefits analysis and tapering of medications not indicated at this time. However, the list of current medication noted by the practitioner did not address the medications the resident was receiving at the time of the visit. As before, there was no documented indication for the use of multiple medications in the same drug classification. On 03-06-17 at 3:30 PM surveyor interview with the Director of Nursing provided no additional information. 2. This finding was identified during an investigation of MD 829, which is related to the complaint allegation. On 03-02-17, review of the clinical record revealed a physician order [REDACTED].#237 complained of pain during urination. On the same day, a urine sample was collected to identify which bacteria was in the urine that caused the infection and confirm whether the current antibiotic therapy was appropriate to treat the bacteria in the resident#237's urine or not. On 01-25-17, a final laboratory report was faxed to the facility, which indicated that resident #237 had extended - spectrum beta- lactamase (ESBL) in the urine. ESBL is an enzyme that breaks down and destroys most of the antibiotics. In addition, the laboratory staff confirmed that there were 3 antibiotics including Ertapenem, Meropenem and [MEDICATION NAME] that would be effective to treat ESBL. However, review of the Medication Administration Record [REDACTED]. Based on a hospital discharge summary dated 02-13-17, resident #237 was admitted to the hospital on 02-08-17 for ESBL in urine. On 03-06-17 at 12:30 PM, interview of the director of nursing and Potomac unit manager revealed no additional information.
F 0366 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Offer other nutritional food to each resident who will not eat the food served.** Based on surveyor observation of dining, clinical record review and interview of a family member and facility staff, it was determined that the facility staff failed to accommodate an individual's food preference and failed to serve a diet as ordered. This finding was evident in 2 of 49 residents selected in stage 2 review (#155 and #185). The findings included: 1. On 03-01-17 at 12:45 PM, staff #1 was observed delivering a lunch tray to resident # 155, who was sitting in a chair at the bedside table in the room. The resident was alert to person, but required assistance to set up meals. Staff #1 served ground turkey, mushroom gravy, rice, apple sauce, salad, bread, coffee and prune juice to the resident. However, review of resident #155's lunch ticket revealed the resident's food preference is no pork/no turkey. Following surveyor's intervention on 03-01-17 at 1 PM, resident #155 received an alternative for lunch. On 03-01-17 at 2:30 PM, interview of director of nursing revealed no additional information. On 03-02-17 at 3:30 PM, interview of resident#155's family member revealed the resident could not consume pork and turkey based on religious practice. 2. On 03-01-17 at 12:55 PM, review of resident #185's lunch ticket revealed ground meat balls, carrots, mashed potatoes, gravy, apple sauce, fortified pudding and 8 oz nectar thickened water would be served. However, no mashed potatoes and fortified pudding were found on the lunch tray even though they were listed. On 03-01-17 at 1 PM, staff #2 delivered the lunch tray to resident #185, who was found sitting upright in bed in the room. Review of the clinical record revealed a diet order was written on 10-05-16 for resident #185 to have mechanical soft texture, nectar fluid consistency with double portion entree for lunch. On 03-01-17 at 1:30 PM, staff #2 explained that no mashed potatoes and fortified pudding was given to resident #185 at lunch on 03-01-17. Interview of director of nursing on 03-01-17 at 2:30 PM revealed no further information.
F 0371 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Store, cook, and serve food in a safe and clean way** Based on surveyor observation and staff interviews, it was determined that the facility staff failed to store and prepare, and serve food under sanitary conditions. This finding was evident in the facility's kitchen during the surveyor's initial tour. The findings include: On 03-01-17 at 8:10 AM surveyor observation in the kitchen revealed the following: 1. a.Dark substance on the tip of can opener blade. The gear of the can opener was soiled, dirty with evidence of food residue. b. There was evidence of dried food residue on the underside of the univex mixer. c. Handwashing sink was nonfunctional. d. Walls behind cook line was filled with food debris. 2. Observation of the refrigerator in the kitchen revealed apple sauce stored in a pan covered with plastic wrap. However, there was no date to indicate when it was initially stored. On 03-01-17 at 8:30 AM, surveyor interview with the facility's dietary manager revealed no further information.

F 0425 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Safely provide drugs and other similar products available, which are needed every day and in emergencies, by a licensed pharmacist**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A. BUILDING _____ B. WING _____	**03/07/2017**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BETHESDA HEALTH AND REHABILITATION	**5721 GROSVENOR 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0425 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 4) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor review of the clinical record and interview of facility staff, it was determined that the facility staff failed to ensure an antibiotic was delivered to the facility timely. This finding was identified during an investigation of MD 829, which is unrelated to the complaint allegation. The findings included: On 03-02-17, review of the clinical record revealed a new physician's orders [REDACTED].#237 on 01-25-17 at 3 PM to initiate a 14 day course of antibiotic, Vancomycin 125 mg, three times a day because of an infection, Clostridium difficile (c-diff), in the stool. However, review of the Medication Administration Record [REDACTED]. The nursing staff documented on 01-25-17 and 01-26-17 that Vancomycin was not given as ordered because staff were awaiting for a pharmacy delivery. Review of facility policy and procedure revealed a pharmacy delivery is scheduled at 5 AM when a new order is submitted before 9 PM the night before. On 03-06-17 at 1 PM, interview of the director of nursing revealed no additional information.
F 0514 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Keep accurate, complete and organized clinical records on each resident that meet professional standards** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation, review of the clinical record, interview of a consultant and facility staff, it was determined that the facility staff failed to accurately document after [MEDICAL CONDITION] care was provided to resident #71. This finding was evident in 1 of 49 residents selected in stage 2 review. The findings include: A [MEDICAL CONDITION] is an opening on the trachea to allow an individual to breathe without the use of nose or mouth. On 03-01-17 at 11:30 AM, resident #71 was observed lying in bed. Due to physical and cognitive limitations, the resident required total assistance with activities of daily living. The resident appeared well-groomed with no discharge from the [MEDICAL CONDITION]. On 03-06-17 at 12:50 PM, resident #71 was observed sitting in a wheelchair and appeared to be well -groomed with no discharge from the [MEDICAL CONDITION]. On 03-06-17, review of the clinical record revealed a physician's orders [REDACTED].#71. Interview of a consultant respiratory therapist (RT) on 03-01-17 at 12 noon revealed RT provided [MEDICAL CONDITION] care to resident #71 five days a week. Other times, the facility staff were responsible to provide [MEDICAL CONDITION] care. Review of respiratory treatment records between January 2017 and March 2017 revealed RT documented that [MEDICAL CONDITION] care was done daily except 01-21-17, 01-22-17, 01-28-17, 01-30-17, 02-04-17, 02-05-17, 02-12-17, 02-18-17, 02-19-17, 02-22-17, 02-25-17, 03-04-17 and 03-06-17. Further review of the clinical record revealed no documented [MEDICAL CONDITION] care was done daily by the facility staff on the above days when RT was off. Interview of staff #3 and staff #4 on 03-06-17 at 5:30 PM revealed [MEDICAL CONDITION] care was done as needed regardless RT's visit. Telephone interview of staff #7 on 03-08-17 at 3 PM revealed [MEDICAL CONDITION] care was provided to resident #71 when the RT was off. On 03-06-17 at 5:45 PM, interview of the director of nursing revealed no additional information. Failure to document a treatment after administered could delay in continuity of care.