FOIA Data Base - The Law Office of Jeffrey J. 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.

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

Bethesda Health and Rehabilitation
5721 Grosvenor Lane
Bethesda, MD 20814

Characteristics:

- For-profit Corporation with 200 certified beds
- Legal Business Name –SSC Bethesda Operating Company LLC
- Director – Amy Maxwell
- Managing Employees – Henry Akinseye and Jason Munro

As of September 2020, Bethesda Health and Rehabilitation is rated as a one-star facility 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 in Bethesda, MD. Periodically they do inspections as complaint surveys which should be public record.

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.

If you have a concern or complaint about a nursing facility, there are three ways to file your complaint:

1) Write to the Maryland Department of Health, Office of Health Care Quality, 7120 Samuel Morse Drive, Second Floor, Columbia, MD 21046-3422. (linkhttps://health.maryland.gov/ohcq/docs/complaint_form.pdf)

2) Fax : 410-402-8179

3) Online - https://fs30.formsite.com/OHCQ/OnlineComplaintForm/index.html

Having already researched Bethesda Health and Rehabilitation in Bethesda, MD 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.

Disclaimer: Information is built using data sources published by Centers for Medicare & Medicaid Services (CMS) under Freedom of Information Act (FOIA). The information disclosed on the NPI Registry are FOIA-disclosable and are required to be disclosed under the FOIA and the FOIA amendments to the FOIA. There is no way to 'opt out' or 'suppress' the NPPES record data for health care providers with active NPls. Some documents may not be accurately copied and some results may have changed upon appeal, which may not be noted here.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A. BUILDING_____ B. WING _ _ _ _ _ _ _ _ _ _	C 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH AND REHABILITATION	**5721 GROSVENOR LANE BETHESDA, MD 20814**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
F 000	INITIAL COMMENTS On January 27, 28, 29, 30 and 31, 2020 an annual recertification survey was conducted by the Office of Health Care Quality. The Facility is licensed for 195 comprehensive beds. At the time of this survey, the facility census was 170. Survey activities consisted of a review of clinical records, observation of residents and staff practices and interviews of residents, family memebers, the Ombudsman and facility staff. Administrative records and resident care policies were also reviewed. In addition to the standard survey protocols, five (5) facility reported incidents (FRIs) and four (4) complaints were investigated. Four (4) facility reported incidents (FRIs) MD00149662, MD00149240, MD00150493 and MD00150244 and two (2) complaints MD00148842 and MD00150387 were unsubstantiated. One FRI (MD00149871) and one complaint (MD00149535) were substantiated with no identified non compliance with Federal requirements. One complaint (MD00149759) was substantiated. This survey identified noncompliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities.	F 000		
F 580 SS=B	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident	F 580 1		

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/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A. BUILDING _____ B. WING _____	C 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH AND REHABILITATION	**5721 GROSVENOR LANE BETHESDA, MD 20814**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
F 580	Continued From page 1 representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A. BUILDING _____ B. WING _____	C 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH AND REHABILITATION	**5721 GROSVENOR LANE BETHESDA, MD 20814**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
F 580	Continued From page 2	F 580		

its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
Based on the review of the clinical record, interviews with legal guardians and facility staff, it was determined that the facility failed to notify a legal guardian of changes in a residents' condition. This finding was evident for 1 of 38 residents reviewed during the survey (Resident #139).

The findings include:

This finding was identified during the investigation of complaint MD00149759.

1. On 01-28-2020 at 10:00 AM, surveyor interview with Resident #139's legal guardian stated that on 12-13-2019 the facility notified her that the resident had an injury of unknown origin. Further interview revealed the resident's legal guardian was not notified that the facility investigated the incident and determined the injury was a result of Resident #139 falling.

On 01-29-2020 at 9:30 **AM,** surveyor interview with the Rosemary unit manager revealed Resident #139's roommate reported witnessing Resident #139 fall to the facility's staff during their investigation of Resident #139's injury of unknown origin.

On 1-31-2020 at 10:30 AM, surveyor interview with the Director of Nursing revealed no additional information.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A. BUILDING _____ B. WING ___ __ _ ___	C 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH AND REHABILITATION	**5721 GROSVENOR LANE BETHESDA, MD 20814**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
F 585 SS=D	Grevances CFR(s): 483.100)(1**)-(4)** §483.1OU) Grevances. §483.10U)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.100)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.100)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.100)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for	F 585		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A. BUILDING _____ B. WING _____	C 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH AND REHABILITATION	**5721 GROSVENOR LANE BETHESDA, MD 20814**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
F 585	Continued From page 4	F 585		

completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A. BUILDING _____ B. WING _____	C 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH AND REHABILITATION	**5721 GROSVENOR LANE BETHESDA, MD 20814**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
F 585	Continued From page 5 taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on the review of administrative documents and interviews with residents and facility staff, it was determined that the facility failed to ensure that residents who filed written grievances were informed of the findings and corrective actions taken. This finding was evident for 1 of 1 residents (Resident #56) reviewed for the personal property care area. The findings include: On 01-27-2020 at 2:59 PM, an interview with Resident #56 revealed the resident reported missing articles of clothing and blankets to the facility staff months ago, but did not receive a response from the facility about the status of the grievance. On 01-27-2020, a review of Resident #56's inventory of personal effects dated, revealed the resident brought multiple articles of clothing and blankets into the facility.	F 585		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A. BUILDING _____ B. WING _____	C 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH AND REHABILITATION	5721 GROSVENOR LANE BETHESDA, MD 20814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) DATE COMPLETION
F 585	Continued From page 6 On 01-27-2020 a review of a facility grievance report dated, 08-26-19, revealed Resident #56 complained that three articles of clothing and three blankets were missing. There was no documented evidence that the facility responded to Resident #56's grievance. On 01-30-2020 at 9:20 AM, an interview with the Administrator revealed it is the facility's policy to respond to all resident grievances within three business days. Furthermore, the Administrator stated he was unaware of the resident's concern.	F 585		
F 609 SS=B	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A. BUILDING _____ B. WING __ _ _ _ _ _ _ _ _	C 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH AND REHABILITATION	**5721 GROSVENOR LANE BETHESDA, MD 20814**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 7 designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on the review of a clinical record, interviews with legal guardians and facility staff, it was determined that the facility failed to report an incident of injury of unknown origin to the Office of Health Care Quality (OHCQ). This finding was evident for 1 of 38 residents reviewed during the survey (Resident #139). The findings include: This finding was identified during the investigation of complaint MD00149759. 1. On 1-28-2020 at 10:00 AM, surveyor review of Resident #139 's clinical record revealed a nursing progress note written on 12-13-2019 that documented the resident had a bruise to the left shoulder. Further review of the note revealed an x-ray was ordered on 12-13-2019. The results of the x-ray revealed Resident #139 had a left clavicle fracture. There was no evidence of a fall or other incident involving the resident documented in the record prior to 12-13-2019. The facility failed to report the injury of unknown origin to OHCQ. On 1-31-2020 at 10:30 AM, an interview with the Director of Nursing did not reveal additional information.	F 609		
F 657 SS=E	Care Plan Timing and Revision **CFR(s): 483.21(b)(2)(i)-(iii)**	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A. BUILDING _____ B. WING _____	C 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH AND REHABILITATION	**5721 GROSVENOR LANE BETHESDA, MD 20814**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
F 657	Continued From page 8	F 657		

§483.21(b) Comprehensive Care Plans
§483.21{b)(2) A comprehensive care plan must be-
(i) Developed within 7 days after completion of the comprehensive assessment.
(ii) Prepared by an interdisciplinary team, that includes but is not limited to--
(A) The attending physician.
(B) A registered nurse with responsibility for the resident.
(C) A nurse aide with responsibility for the resident.
(D) A member of food and nutrition services staff.
(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review and staff interview, it was determined that the facility staff failed to invite residents and/or their representative for interdisciplinary care conferences, and failed to review and revise residents' care plan as necessary. The finding was evident for 5 of 38 residents selected for review during the survey (#45, #78, #153, #104, #14, #37, and #137).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A. BUILDING _____ B. WING _____	C 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH AND REHABILITATION	**5721 GROSVENOR LANE BETHESDA, MD 20814**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 9	F 657		

The findings include:

MOS (Minimum Data Set) is part of the U.S. federally mandated process for clinical assessment of all residents in Medicare or Medicaid certified nursing homes. Quarterly review assessment is an assessment due no less frequently than every 92 days.

1. On 01-28-2020 the review of Resident #45's clinical record revealed that the resident had MOS quarterly review assessments with an assessment reference date (ARD) of 06-21-2019 . There was no evidence the resident's clinical record to show that the facility staff invited Resident #45 and/or the resident's representative to an interdisciplinary care conferences. The review and revision of Resident #45's care plans were completed in an absence of the resident and/or their representative.

On 01-30-2020 at 10:40 AM, interview with DON (Director of Nursing) revealed no additional information.

2. On 01-30-2020 the review of Resident #78's clinical record revealed the resident had MOS quarterly review assessment with an ARD of 03-20-2019. There was no evidence in the resident's clinical record to show the facility staff invited Resident #78 and/or the resident's representative to an interdisciplinary care conference conducted on 03-20-2019. Review and revision of Resident #78's care plans were completed in an absence of the resident and/or their representative.

3. On 1-29-2020 the review of Resident #153's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A. BUILDING _____ B. WING	C 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH AND REHABILITATION	**5721 GROSVENOR LANE BETHESDA, MD 20814**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID TAG PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) DATE COMPLETION
F 657	Continued From page 10	F 657		

clinical record revealed the resident had a MDS quarterly review assessment with an ARD of 07-29-2019. There was no evidence in the resident's clinical record to show the facility staff invited Resident #153 and/or the resident's representative for interdisciplinary care conference conducted after quarterly review assessment completed on 07-29-2019. Review and revision of Resident #153's care plans were completed in an absence of the resident and/or their representative.
On 1-30-20 at 10:40 AM, interview with DON (Director of Nursing) revealed no additional information.

4. On 01-27-20, a review of Resident #104's clinical record revealed the last care plan meeting held with the resident's surrogate decision maker was on 05-16-2019 . There was no documented evidence that the facility invited Resident #104's surrogate decision maker to participate in subsequent quarterly care plan review meetings.

On 01-30-20 at 08:12 AM, surveyor interview with the Social Services Director revealed no additional information.

On 01-30-20 at 10:52 AM, interview with the Administrator revealed no additional information .

On 1-30-2020 at 10:40 AM, interview with Director of Nursing (DON) did not reveal additional information .
5. On 1-28-2020 at 9:00 AM, a review of Resident #14's clinical record revealed the resident had a diagnosis of dysphagia (dysphagia is a condition in which a person's ability to eat and drink is disrupted). Additional review revealed a physician order on 1-8-2020 for nectar thickened

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A. BUILDING_____ 8 WING_____	C 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH AND REHABILITATION	**5721 GROSVENOR LANE BETHESDA, MD 20814**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
F 657	Continued From page 11	F 657		

liquids and no straws. Thickened liquids are used for individuals with dysphagia to improve the ability to safely swallow liquids to prevent aspiration and pneumonia. A review of Resident #14's comprehensive person-centered care plan revealed the plan was not revised to address the residents' use of nectar thickened liquids and without straws.

On 1-30-20 at 10:00 AM, surveyor interview with unit manager for Gateway/Freedom stated she did not see Resident #14's physician order dated 1-8-2020 for nectar thickened liquids and no straws.

On 1-31-2020 at 9:30 **AM,** surveyor interview with the DON revealed the unit managers are responsible for updating the nursing care plans.

6. On 01-30-2020, the review of Resident #37's clinical record revealed that the facility placed Resident #37 on contact precautions on 12-3-2019. There was no documented evidence to indicate that Resident #37's care plan was reviewed and revised by the interdisciplinary team and updated to reflect the resident's contact precautions until 1-2-2020.

On 01-30-2020 at 3:15 PM surveyor interview with the DON revealed no additional information.

7. On 01-30-2020, review of the clinical record for Resident #137 revealed that the facility staff failed to revise the care plan to accurately reflect alterations in skin integrity. On 12-07-2019, Resident #137 developed a blister on the right heel. The care plan initiated on 12-09-2019 stated resident #137 "has a blister to the right heel", and listed specific interventions applicable

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A. BUILDING _____ B. WING _____	C 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH AND REHABILITATION	**5721 GROSVENOR LANE BETHESDA, MD 20814**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
F 657	Continued From page 12 to the treatment of the wound on the right heel. On 01-30-2020Further review of the clinical record revealed that on _____ Resident #137 was transferred to the acute care setting [redacted], and was readmitted to the facility on [redacted]. At the time of readmission, the charge nurse assessed the resident as then having an unstageable wound on the right heel. An unstageable wound is covered by slough or eschar (dead tissue). On 12-31-19, facility staff initiated a care plan that stated Resident #137 "has potential/actual skin issues related to [omitted]." The care plan failed to clarify that Resident #137 no longer had the potential, but an unstageable wound to the right heel was present. The goal identified by facility staff in the care plan dated 12-31-19 was that the "skin will remain intact without signs of breakdown" although the documentation had already identified that the skin was not intact. The care plan also continued to reflect the presence of a blister to the right heel which was identified on 12-09-2019, which no longer accurately reflected the condition of the wound. The facility staff failed to accurately revise the plan of care for Resident #137 to reflect the actual skin impairment and to document interventions specific to the wound care needs at the time of the nurses' assessment on 12-31-2019. On 1-30-2020 at 3:15 PM surveyor interview with the DON revealed no additional information.	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A. BUILDING _____ B. WING _____	C 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH AND REHABILITATION	**5721 GROSVENOR LANE BETHESDA, MD 20814**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
F 684	Continued From page 13	F 684		

§ 483.25 Quality of care
Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.
This REQUIREMENT is not met as evidenced by:
Based on observations, a review of clinical records, and interviews with family members and facility staff, it was determined that the facility staff failed to follow a physician's order for 1 of 38 residents reviewed during the survey (Resident **#14),**

The findings include:

1. On 1-28-2020 at 9:00 AM, the review of Resident #14's clinical record revealed the resident had a diagnosis of pneumonia and dysphagia (dysphagia is a condition in which a person's ability to eat and drink is disrupted). Further review revealed a physician's order, dated 1-8-2020, for the resident to have nectar thick liquids and no straws with beverages. Nectar is a substance used to thicken liquids. Thickened liquids are used for individuals with dysphagia to improve the ability to safely swallow liquids to prevent aspiration, pneumonia and death.

On 1-30-2020 at 9:10 AM, observation of Licensed Practical Nurse (LPN) #7 during medication pass revealed the nurse administered Resident #14 medications using water that was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A BUILDING _____ B WING _____	C 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH AND REHABILITATION	**5721 GROSVENOR LANE BETHESDA, MD 20814**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
F 684	Continued From page 14 not thickened and with a straw. On 1-30-2020 at 10:00 AM, surveyor interview with unit manager for Gateway/Freedom stated she did not see Resident #14's physician order dated 1-8-2020 for nectar thick liquids and no straws. On 1-31-2020 at 9:30 AM, surveyor interview with the director of nursing revealed no additional information.	F684		
F 690 SS=D	Bowel/Bladder Incontinence , Catheter, UTI **CFR(s): 483.25(e)(1)-(3)** §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to	F 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A. BUILDING _____ B. WING _____	C 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH AND REHABILITATION	5721 GROSVENOR LANE BETHESDA, MD 20814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIF YING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
F 690	Continued From page 15	F 690		

prevent urinary tract infections and to restore continence to the extent possible.

§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
Based on surveyor observation, review of the clinical record, and staff interview, it was determined that that the facility staff failed to utilize appropriate measures to prevent complication related to an indwelling catheter for 1 of 3 residents reviewed for the indwelling catheter care area (Resident #12).

The finding includes:

On 01-28-2020 at 3:07 PM, observation during rounds revealed Resident #12 presented with an indwelling catheter, however further observation revealed that the catheter was not anchored. Keeping the catheter anchored is necessary to prevent excessive tension on the catheter which can lead to urethral tears or dislodging of the catheter.

Observation on 01-29-2020 at 9:50 AM and 4:35 PM also revealed Resident #12's catheter was not anchored.

On 01-30-2020 at 2:30 PM, a review of Resident #12's the treatment administration record (TAR) revealed the charge nurse, Staff #6, had signed the TAR on 01-30-2019 which instructed facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A. BUILDING _____ B. WING _____	C 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH AND REHABILITATION	5721 GROSVENOR LANE BETHESDA, MD 20814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
F 690	Continued From page 16 staff to "use catheter securing device to reduce excessive tension on the tubing and facilitate urine flow..." On 01-30-2020 at 2:45 PM simultaneous observation and interview of Resident #12 with staff #6 revealed that the indwelling catheter was not anchored, as the nurse had documented. Staff #6 was unable to explain the absence of the "catheter securing device" as documented on the TAR. Staff #6 acknowledged to that Resident #12 "should have it on to keep from pulling", but offered no explanation for of the device absence. On 01-30-2020 at 3:30 PM, interview with the Potomac nursing unit manager revealed no additional information..	F 690		
F 759 SS=D	Free of Medication Error Rts 5 Prent or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on surveyor observations, review of clinical records, and interviews with facility staff, it was determined that the facility failed to ensure that medication administration error were less than five (5) percent. This finding was evident for 3 of 25 (12%) medication administration opportunities observed during the survey. The findings include: 1. On 01-29-2020 at 9:00 AM, observation of	F 759		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A. BUILDING _____ B. WING _____	C 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH AND REHABILITATION	**5721 GROSVENOR LANE BETHESDA, MD 20814**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER 'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
F 759	Continued From page 17	F 759		

Resident #266's 9:00 AM medication administration revealed Nurse #1 administered 960 milligrams (mg) of acetaminophen to Resident #226. Acetaminophen is a medication used to treat aches and pains and to reduce fever.

On 01-29-2020 at 9:30 AM, surveyor review of Resident #266's clinical record revealed a physician's order to administer 1000 mg of acetaminophen at 9:00 AM.

On 01-29-2020 at 9:38 AM, the interview with Nurse #1 revealed no additional information.

On 01-31-20 at 10:00 AM, interview with the Director of Nursing revealed no additional information.

2. On 01-29-20 20at 9:00 **AM,** observations of Resident #266's 9:00 AM medication administration revealed Nurse #1 did not administer Metoprolol Tartrate to the resident. Metoprolol Tartrate is a medication used to treat high blood pressure.

On 01-29-2020 at 9:30 AM, a review of Resident #266's clinical record revealed a physician's order to administer 25 milligrams of Metoprolol Tartrate to the resident at 9:00 AM and 9:00 PM.
On 01-29-2020 at 9:38 AM, interview with Nurse #1 confirmed that he did not administer Metoprolol Tartrate to Resident #266 at 9:00 AM as ordered. After surveyor intervention, nurse #1 administered the scheduled 9 AM dose of Metoprolol Tartrate.

On 01-31-2020 at 10:00 AM, an interview with the Director of Nursing revealed no additional

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A. BUILDING _____ B. WING _____	C 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH AND REHABILITATION	**5721 GROSVENOR LANE BETHESDA, MD 20814**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S **PLAN** OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
F 759	Continued From page 18 information. 3. On 01-29-2020 at 9:00 AM, observations of Resident #266's 9:00 AM medication administration revealed Nurse #1 administered 10 milligrams (mg) of Metoclopramide Hydrochloride to resident #266. Metoclopramide Hydrochloride is a medication used to treat gastroesophageal reflux disease (GERO). GERO is a digestive disorder that affects the lower esophageal sphincter, the ring muscle between the esophagus and stomach. On 01-29-20 at 9:30 AM, the review of resident #266's clinical record revealed a physician's order to administer 10mg of Metoclopramide Hydrochloride at 5:30 AM, 11:30 AM, and 5:30 PM. There was no order to administer the medication at 9:00 AM. On 01-29-2020 at 9:38 AM, interview with Nurse #1 revealed no additional information. On 01-31-2020 at 10:00 AM, interview with the Director of Nursing revealed no additional information.	F 759		
F 791 **SS=E**	Routine/Emergency Dental Srvcs in NFs **CFR(s): 483.55(b)(1)-(5)** §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet	F 791		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A. BUILDING _____ B. WING _____	C 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH AND REHABILITATION	**5721 GROSVENOR LANE BETHESDA, MD 20814**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
F 791	Continued From page 19 the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on resident interview, surveyor observation, review of the clinical record and interview of facility staff, it was determined that the facility staff failed to provide timely intervention for a resident with dental problems. This finding was evident in 1 of 3 residents	F 791		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A. BUILDING _____ B. WING _____	C 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH AND REHABILITATION	5721 GROSVENOR LANE BETHESDA, MD 20814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
F 791	Continued From page 20 reviewed for the dental care area (Resident #32). The findings include: On 01-28-2020 at 8:59 AM, during resident interview, Resident #32 complained of a broken tooth on the right side which bleeds and causes pain during meals. Resident #32 stated staff were informed of complaint of the broken tooth, and advised Resident #32 that the tooth needed to "come out". Review of the clinical record revealed a dental consult was ordered on 01-07-2020. As of 01-30-2020 Resident #32's tooth had not been evaluated by the dentist. A review of care plan for Resident #32 revealed that the resident had dental issue identified in August 2019 as follows: Resident has oral/dental health problems, of no upper dentures related to poor nutrition and poor oral hygiene with a goal that the resident would be free of infection, pain or bleeding in the oral cavity, and to coordinate arrangements for dental care, and transportation as needed. On 01-28-2020 Further review of the record revealed that on 01-08-2020 the Dietitian was consulted related to Resident #32's decreased meal intake. The Dietitian documented the resident's problem with meal intake related to poor dentition, however the resident's diet texture had been recently upgraded by speech therapy from the pureed diet ordered in August of 2019. The dietitian also recommend sandwiches with lunch and dinner due to Resident #32's complaint of having trouble chewing meat occasionally. On 01-30-2020 the attending physician examined the resident and provided new interventions for	F 791		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A. BUILDING _____ B. WING_____	C 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH AND REHABILITATION	**5721 GROSVENOR LANE BETHESDA, MD 20814**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
F 791	Continued From page 21 facility staff to implement until the resident was seen by a dentist. On 01-31-2020 surveyor follow up with Resident #32 revealed that the interim interventions were effective in reducing pain during meals. On 01-31-2020 at 2:00 PM, interview with the Potomac unit manager revealed Resident #32 was scheduled for a dental exam in the facility between 02-03-2020 and 02-07-2020.	F 791		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60{i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on surveyor observation and staff interviews, it was determined that the facility failed to store, prepare, distribute, and serve food	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A. BUILDING _____ B. WING _____	C 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH AND REHABILITATION	**5721 GROSVENOR LANE BETHESDA, MD 20814**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
F 812	Continued From page 22	F 812		

using sanitary practices in accordance with professional standards for food services safety. This was evident in the main kitchen and the second floor dining room.

The findings include:

1. On 01-27-2020 at 8:30 AM, surveyor tour with the Dietary Manager of the walk-in freezer revealed a box of pork chops, a box of french bread sticks and a container of sausages opened without labels to identify when the food products were without use by dates.

On 01-27-2020 at 8:45 AM, an interview with the Certified Dietary Manager revealed the identified products should have a use by date on them but they did not.

2. On 01-27-2020 at 12:33 PM, surveyor observation of the lunch service of the second floor dining room revealed Kitchen Aide #2 checking temperatures of the lunch items on the dining room steam table with a thermometer. Kitchen Aide #2 did not sanitize the thermometer probe prior to inserting the probe into the various lunch items.

On 01-27-2020 at 12:35 PM, surveyor questioned kitchen aide #2 to ask if she used a sanitizing cleaner on the thermometer probe prior to use. Kitchen aide #2 did not respond and wiped the thermometer probe with a paper towel and proceeded to insert the thermometer probe into additional food items without sanitizing the probe.

On 01-27-2020 at 4:07 PM, surveyor interview with the administrator revealed no new information

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A BUILDING _____ B WING _____	C 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH AND REHABILITATION	**5721 GROSVENOR LANE BETHESDA, MD 20814**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
	F 926 Continued From page 23	F 926		
	F 926 Smoking Policies SS=D CFR(s): 483.90(i)(5)	F 926		

§483.90(i)(5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account nonsmoking residents.
This REQUIREMENT is not met as evidenced by:
Based on surveyor observations and interviews with facility staff, it was determined that the facility staff failed to ensure residents safely disposed of smoking cigarettes. This finding was evident during 1 of 4 smoking observations.

The findings include:

1. On 01-28-2020 a review of the facility smoking policy revealed ashtrays and sealed, fire-safe metal containers should be used for the disposal of ashes and other smoking products. In addition, facility staff should ensure that smoking materials are extinguished before they are discarded.

On 01-28-2020 at 11:10 AM, observation during the designated smoking time revealed Resident #26 was seated in the corner of the smoking patio smoking a cigarette. Furthermore, after Resident #26 finished smoking the cigarette, the resident threw the unextinguished cigarette into a grassy area where dozens of cigarette butts were lying.

On 01-28-2020 at 11:15 AM, observation during the designated smoking time revealed Resident #66 finished smoking a cigarette and threw their lit cigarette into a pot of plants. The assigned

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A. BUILDING _____ B. WING _____	C 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH AND REHABILITATION	**5721 GROSVENOR LANE BETHESDA, MD 20814**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
F 926	Continued From page 24 smoking monitor rebuked Resident #66 for throwing the cigarette into the pot of plants but did not go over to the pot to ensure that the cigarette was extinguished. On 01-28-2020 at 11:20 **AM,** surveyor observation revealed all the resident smokers left the smoking patio and the smoking monitor went back to the area to look around. On 01-28-2020 at 11:50 AM, an interview with the Smoking Monitor #3 revealed that she did not see Resident #26 throw an unextinguished cigarette into the grass, however, she always checks the smoking area after the residents leave to ensure that all the residents are back inside and there are no cigarettes still lit. On 01-28-2020 at 12:40 PM, interview with the Director of Nursing revealed all staff members assigned to monitor the smoking area are to provide direct supervision of the residents to ensure safety and they are to go back to check the smoking area after all the residents have left.	F 926		

Office of Health Care Qualih

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A BUILDING: _ _ _ _ _ _ _ _ B. WING_____	C 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH AND REHABILITATION	**5721 GROSVENOR LANE BETHESDA, MD 20814**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5} COMPLETE DATE
S 000	Initial Comments On January 27, 28, 29,30 and 31, 2020 an annual recertification survey was conducted by the Office of Health Care Quality. The Facility is licensed for 195 comprehensive beds. At the time of this survey, the facility census was 170. Survey activities consisted of a review of clinical records, observation of residents and staff practices and interviews of residents, family memebers , the Ombudsman and facility staff. Administrative records and resident care policies were also reviewed. In addition to standard survey protocols, five (5) facility reported incidents (FRIs) and four (4) complaints were investigated. Four (4) facility reported incidents (FRIs) MD00149662, MD00149240, MD00150493 and MD00150244 and two (2) complaints MD00148842 and MD00150387 were unsubstantiated. One FRI (MD00149871) and one complaint (MD00149535) were substantiated with no identified non compliance with State requirements. One complaint (MD00149759) was substantiated. This survey identified noncompliance with 10.07.02 of COMAR requirements for Long Term Care Facilities.	S 000		
S 580	10.07.02.18 C Nursing Services - Care 24 Hours a Day .18 Nursing Services. C. Nursing Care 24 Hours a Day. The administrator shall employ sufficient and	S 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A. BUILDING: _____ B. WING _____	C 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH AND REHABILITATION	**5721 GROSVENOR LANE BETHESDA, MD 20814**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETE DATE
S 580	Continued From page 1 satisfactory licensed nursing service personnel and support personnel to: (1) Be on duty 24 hours a day; (2) Provide appropriate bedside care; and (3) Ensure that a resident: (a) Receives treatments, medications, and diet as prescribed; (b) Receives rehabilitative nursing care as needed; (c) Receives proper care to prevent pressure ulcers and deformities; (d) Is kept comfortable, clean, and well-groomed; (e) Is protected from accident, injury, and infection; (f) Is encouraged, assisted, and trained in self-care and group activities; and (g) Receives prompt and appropriate responses to requests for assistance. This Regulation is not met as evidenced by: Refer to CMS 2567 F759	S 580		
S 610	10.07.02.18 **F** Nursing Services - Charge Nurses' Daily .18 Nursing Services. F. Charge Nurses ' Daily Rounds. The charge	S 610		

Office of Health Care QUalit\

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A. BUILDING _____ B. WING _____	C 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH AND REHABILITATION	**5721 GROSVENOR LANE BETHESDA, MD 20814**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETE DATE
S 610	Continued From page 2 nurse or nurses shall make daily rounds on all nursing units for which they are responsible, performing such functions as: (1) Visiting each resident; (2) Reviewing clinical records, medication orders, resident care plans, and staff assignments; and (3) To the degree possible, accompanying physicians when visiting residents. This Regulation is not met as evidenced by: Refer to CMS 2567 F684, F690	S 610		
S 670	10.07 .02.19 B Nursing Services - Hours of Bedside Care .19 Nursing Services - Staffing. B. Hours of Bedside Care - Nursing Home. (1) A nursing home shall employ supervisory personnel and a sufficient number of support personnel to provide a minimum of 3 hours of bedside care per occupied bed per day, 7 days per week. (2) Bedside hours include the care provided by: (a) Registered nurses; (b) Licensed practical nurses; and (c) Support personnel. (3) Only those hours which the director of nursing spends in bedside care may be counted in the	S 670		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A BUILDING: _____ B WING _____	C 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH AND REHABILITATION	5721 GROSVENOR LANE BETHESDA, MD 20814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 670	Continued From page 3 3-hour minimum requirement. (4) The director of nursing 's time counted in bedside care shall be documented. This Regulation is not met as evidenced by: Based on administrative record review and staff interview, it was determined that the facility staff failed to provide sufficient number of nursing staff to provide a minimum of 3 hours of bedside care per occupied bed per day (HPPD), 7 days per week. The findings were evident for 7 of 30 days reviewed for sufficient and competent nurse staffing facility task. The findings were: On 01-31-20, surveyor review of facility daily census and direct care nursing hours through 12-27-2019 to 01-26-2020 revealed that HPPD was below a minimum requirement on: 12-31-2019, with HPPD of 2.81 01-02-2020, with HPPD of 2.95 01-04-2020, with HPPD of 2.75 01-05-2020, with HPPD of 2.76 01-10-2020, with HPPD of 2.98 01-13-2020, with HPPD of 2.83 01-18-2020, with HPPD of 2.87 On 01-31-2020 at 2:00 PM, interview with the Director of Nursing revealed no additional information.	S 670		
S1300	10.07.02.29 Dental Services 10.07.02.29 .29 Dental Services. A Provision for Dental Care. Residents shall be assisted to obtain routine and emergency dental	S1300		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A. BUILDING: _ _ _ _ _ _ _ _ B WING _ _ _ _ _ _ _ _ _	C 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH AND REHABILITATION	5721 GROSVENOR LANE BETHESDA, MD 20814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETE DATE
S1300	Continued From page 4 care. B. Advisory Dentist. There shall be an advisory dentist who shall: (1) Recommend oral hygiene policies and practices for the care of the residents and for arrangements for emergency treatment ; (2) Assist in the formulation of dental health policies; (3) Provide direction for in-service training to give the nursing staff an understanding of residents ' dental problems. C. Assistance by Nursing Personnel. Nursing personnel shall assist the resident in carrying out routine dental hygiene. D. Arrangements for Dental Service. If dental services are not provided on the premises, there shall be a cooperative agreement with a dental service. E. Transportation. Arrangements shall be made, when necessary, for the resident to be transported to the dentist ' s office. This Regulation is not met as evidenced by: Refer to CMS 2567 F-791	S1300		
S1470	10.07.02.34 Employee Health Program .34 Employee Health Program. A. The nursing home ' s infection prevention and control program shall monitor the relevant health	S1470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A. BUILDING: _____ B. WING _____	C 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH AND REHABILITATION	5721 GROSVENOR LANE BETHESDA, MD 20814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETE DATE
S1470	Continued From page 5 status of all employees, as it relates to infection prevention and control. The nursing home shall refer to the following guidelines in implementing its employee health program: (1) Guideline for Infection Control in Health Care Personnel; (2) Immunization of Health Care Personnel: Recommendations of the Advisory Committee on Immunization Practices (ACIP) and the Hospital Infection Control Practices Advisory Committee (HICPAC); and (3) COMAR 09.12.31. 8. Tuberculosis Exposure Control. (1) The infection control program shall include a risk assessment program, including monitoring for tuberculosis infection for employees that is in accordance with the Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings. (2) The nursing home shall ensure that employees may not provide services that require direct access to residents without documented evidence that the employee is free from communicable tuberculosis. (3) A new employee shall be assessed for risk of tuberculosis through: (a) A two-step tuberculin skin testing at the time of hire following guidelines referenced in the Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings; or	S1470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVE Y COMPLETED
	215187	A. BUILDING : _____ B WING _____	C 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH AND REHABILITATION	5721 GROSVENOR LANE BETHESDA, MD 20814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER 'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETE DATE
S1470	Continued From page 6 (b) An interferon-gamma release assay (IGRA) blood test. (4) The nursing home shall maintain written documentation of the following: (a) Results of tuberculin skin tests, recorded in millimeters of induration with dates of administration, dates of reading, results of test, and the manufacturer and lot number of the purified protein derivative (PPD) solution used; and (b) Any previous tuberculin skin tests, chest x-ray, or blood test results, chemotherapy, and chemoprophylaxis that are the basis for certifying that the individual is free from tuberculosis in a communicable form. C. Measles, Mumps, Rubella, and Varicella. (1) The nursing home shall screen and maintain written documentation of each employee ' s proof of immunity to common childhood infections including measles, mumps, rubella, and chickenpox (varicella). Proof of immunity to these diseases shall be verified by: (a) Documented evidence of administration of vaccine; or (b) Laboratory evidence of immunity. (2) The nursing home shall require that employees who are not immune to measles, mumps, rubella, and varicella receive immunization for measles, mumps, rubella, or varicella, unless medically contraindicated or	S1470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A. BUILDING:_____ B. WING _____	C 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH AND REHABILITATION	5721 GROSVENOR LANE BETHESDA, MD 20814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETE DATE
S1470	Continued From page 7 against the employee ' s religious beliefs. If the employee refuses to be immunized, the nursing home shall document the refusal and the reason for it. D. Hepatitis 8. The nursing home shall require that all new employees receive immunization for Hepatitis 8, unless medically contraindicated, against the employee ' s religious beliefs, or after being fully informed of the health risks of not being immunized. The nursing home shall inform all new and current employees of the health risks of not being immunized. If the employee refuses to be immunized, the nursing home shall document the refusal and the reason for the refusal. E. Influenza. (1) The nursing home shall require that all employees receive annual immunization for influenza, unless: (a) Medically contraindicated; (b) Against the employee's religious beliefs; or (c) After being fully informed of the health risks associated with not receiving a vaccine, the employee refuses the immunization. (2) The nursing home shall: (a) Comply with Health-General Article, §18-404, Annotated Code of Maryland, regarding immunizations of employees; (b) Inform all new and current employees of the health risks of not being immunized;	S1470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A. BUILDING: _____ B. WING _ _ _ _ _ _ _ _ _ _	C 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH AND REHABILITATION	5721 GROSVENOR LANE BETHESDA, MD 20814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETE DATE
S1470	Continued From page 8	S1470		

(c) Document refusals; and

(d) Require that any employee who is not vaccinated with the current influenza vaccine wear a mask when:

(i) Within 6 feet of a resident; and

(ii) During the influenza season as specified by the State's Prevention and Health Promotion Administration, based on influenza activity in Maryland.

F. Pertussis. The nursing home shall:

(1) Require that each new employee receive a one-dose booster immunization for pertussis, unless medically contraindicated or against the employee ' s religious beliefs;

(2) Inform all new and current employees of the health risks of not being immunized;

(3) Document any refusals of immunization; and

(4) Ensure that the immunization is given in the form of Tdap (tetanus, diphtheria, acellular pertussis) vaccine, in accordance with the guidelines prescribed in Immunization of Health-Care Personnel: Recommendations of the Advisory Committee on Immunization Practices (ACIP) and the Health Care Infection Control Practices Advisory Committee (HICPAC).

This Regulation is not met as evidenced by:
Based on surveyor review of employee personnel files and staff interview, it was determined that the facility staff failed to monitor and maintain written documentation of immunization status of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A. BUILDING: _____ B. WING_____	C 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH AND REHABILITATION	5721 GROSVENOR LANE BETHESDA, MD 20814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S1470	Continued From page 9 for 2 of 8 employee files reviewed (Staff #4 and #5). The findings include: 1. Staff #4, a Geriatric Nursing Assistant was hired on 11-18-2019. A review of the employee's health file revealed that there was no documented evidence of administration of varicella vaccine or laboratory evidence of immunity to varice lla. Furthermore, there was no documented evidence in his profile that varicella vaccine was offered to him or his refusal to have it. On 01-31-2020 at 12:00 PM, interview with Staff #3, a human resources representative for the facility, revealed no additional information. 2. On 01-31-2020 a review of Staff #S's , a Housekeeping, personnel file revealed the employee was hired on 12-27-2019. Review of the employee's health file revealed that as of 01-31-2020, she had not received hepatitis B vaccine. On 01-31-2020 at 12:00 PM, interview with human Resources Staff #3 revealed no additional information .	S1470		
S1840	10.07.02.42 N Physical Plant- General - Smoking .42 Physical Plant - General Requirements . N. Smoking. (1) Resident Smoking Requirements.	S1840		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A. BUILDING:_____ B. WING _____	C 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH AND REHABILITATION	5721 GROSVENOR LANE BETHESDA, MD 20814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S1840	Continued From page 10 (a) A resident who smokes shall be assessed for safe smoking behaviors at admission and on significant changes in condition. (b) A resident assessed to exhibit unsafe behaviors shall have a care plan to ensure the resident is safe when smoking. (2) Nursing Home Smoking Requirements. (a) Smoking areas shall be designated. (b) Smoking shall be prohibited at the main entrance to all facilities. (c) All tobacco products shall be extinguished and disposed of in noncombustible containers with self-closing lids in accordance with the provisions of NFPA 101 Life Safety Code. This Regulation is not met as evidenced by: Refer to CMS 2567 F926	S1840		
S2720	10015 (Dietetic Service Area-Refrigerated Storage .55 Dietetic Service Area. K. Refrigerated Storage. (1) Adequate refrigerated storage, refrigerators, and frozen food storage cabinets shall be provided and regulated to maintain temperatures prescribed in COMAR 10.15.03. (2) Food in storage shall be arranged so that new food items are stored behind old food items.	S2720		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A BUILDING:_____ B. WING _____	C 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH AND REHABILITATION	5721 GROSVENOR LANE BETHESDA, MD 20814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S2720	Continued From page 11 (3) The oldest foods shall be used first, known as the first in, first out method. This Regulation is not met as evidenced by: Refer to CMS 2567 F812	S2720		
S2910	10.07.02.60 A Care Planning-Timing .60 Care Planning. A An interdisciplinary team shall complete or revise as necessary a resident-specific care plan for each resident within 7 calendar days following completion of assessments, including: (1) Admission assessment; (2) Annual assessment; (3) Quarterly assessment; and (4) Significant change in the resident's condition. This Regulation is not met as evidenced by: Refer to CMS 2567 F657	S2910		
S2920	10.07.02.60 B Care Planning-Meeting .60 Care Planning. B. Care Plan Meeting. The nursing home shall, with the resident's consent: (1) Give an interested and appropriate family member or resident's representative 7 calendar days advance notice, in writing, of the location,	S2920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A. BUILDING: _____ B. WING _____	C 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH AND REHABILITATION	5721 GROSVENOR LANE BETHESDA, MD 20814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S **PLAN** OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S2920	Continued From page 12 date, and time of a care planning conference for a resident; (2) Strive to accommodate the schedules of invited family members and resident's representatives when scheduling care plan meetings; and (3) Include an invitation for the family member or resident's representative to attend the conference. This Regulation is not met as evidenced by: Refer to CMS 2567 F657	S2920		
S6100	10.07.09.09 G Res Bill Rights;Implem, notifications .09 Implementation of Residents' Bill of Rights . A nursing facility shall: G. Consistent with State and federal confidentiality laws and, in a timely manner, notify a resident and, if applicable, the resident's representative or interested family member, of any: (1) Change in condition; (2) Adverse event that may result in a change in condition; (3) Outcome of care that results in an unanticipated consequence; and (4) Corrective action, if any;	S6100		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A. BUILDING: _ _ _ _ _ _ _ _ B. WING_____	C 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH AND REHABILITATION	5721 GROSVENOR LANE BETHESDA, MD 20814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S6100	Continued From page 13 This Regulation is not met as evidenced by: Refer to CMS 2567 F580	S6100		
S6322	10.07.09.15 C (1) (b) Abuse;Report to Dept .15 Abuse of Residents . C. Reports of Abuse. (1) A person who believes that a resident has been abused shall promptly report the alleged abuse to the: (b) Licensing and Certification Administration within the Department; or This Regulation is not met as evidenced by: Refer to CMS 2567 F609	S6322		
S6375	10.07.09.16 B Complaint procedure; facility procedures .16 Complaint Procedure. B. A nursing facility shall develop and implement the following complaint procedures: (1) A resident, the resident's representative, or an interested individual may present complaints to: (a) The nursing facility administration, (b) The nursing facility's staff, (c) The Office, (d) The Department, or (e) Other persons or groups; (2) A complaint may be made to the nursing facility in person, orally or in writing, by telephone or by mail, and may be reported anonymously; (3) A nursing facility may not require the signature	S6375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A BUILDING:_____ B WING _ _ _ _ _ _ _ _ _	C 01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH AND REHABILITATION	5721GROSVENORLANE BETHESDA, MD 20814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S6375	Continued From page 14 of the resident or, when applicable, the resident's representative or an interested individual on a complaint; (4) If a complaint is presented to a nursing facility, the nursing facility shall investigate within 30 days the allegations made in the complaint and advise the complainant of the action the nursing facility is taking to resolve the complaint; (5) A nursing facility shall send to the Office and the Department a copy of any complaint that a complainant indicates has not been resolved to the satisfaction of the complainant; (6) A nursing facility shall maintain a permanent record for inspection by the Office or the Department of all complaints concerning the nursing facility; and (7) A complainant may request a hearing from the Department within 30 days of receiving the facility's response to the complaint or within 60 days of filing the complaint, whichever is earlier. This Regulation is not met as evidenced by: Refer to CMS 2567 F585	S6375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A. BUILDING _____ B. WING _ _ _ _ _ _ _ _	C 02105/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH AND REHABILITATION	6721 GROSVENOR LANE BETHESDA, MD 20814

(X4)1D PREFIX TAG	SUMMARY STATEMENT OF OEACIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATI:
F 000	INITIAL COMMENTS	FOOO		

On February 5, 2020, a complaint survey was conducted at this facility by the Office of Health Care Quality to Investigate complaint #MD00150968. Activities included the audit of the residents' personal funds records maintained by this facility.

The specific complaint was unsubstantiated. This survey did not identify noncompliance with Federal requirements that were reviewed in relationship to the specific complaint.

This survey did identify noncompliance with Federal requirements that were reviewed pertaining to the management of residents' personal funds. (SEE F568 & F569)

F 568 Accounting and Records of Personal Funds
SS=B CFR(s): 483.10(f)(10)(iii)

§483.1O(f)(1O)(lli) Accounting and Records.
(A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.

(B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.
(C) The individual financial record must be available to the resident through quarterly statements and upon request.
This REQUIREMENT is not met as evidenced by:
Based on the review, on 2/5/20, of the residents' personal funds records, including individual resident's account statemen , bank statements,

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the mets alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provision of the fuderal and state laws requires it. The Plan of Correction serves as the facility's allegation of compliance.

F 56B

F 568

1. The resident pooled petty cash will be reconciled for 12/31/19.
2. The resident's personal fund account was furnished for quarter ending 12/31/19.
3. Resident withdrawals will be recorded on appropriate transaction ·receipts.
4. Resident 9A account was adjusted and resident withdrawals will be appropriately authorized and/or witnessed.

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE Administrator 2/20/2020

v be excused from correcting prov_____ etermined that

Any deflcle y statement ending with an asteris (") denotes a deficiency which the institution may be excused from correcting providing it Is det rmine that other sefe u rds provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are dlsclosable 90 days following I date of survey whether or not a plan of correction Is provided. For nursing homes, the above findings and plans of correction are dlsolosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plen of correction Is requisite to continued program partlclpatlon,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A. BUILDING _____ B. WING	C 02/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH AND REHABILITATION	5721 GROSVENOR LANE BETHESDA, MD 20814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 568	· Continued From page 1 reconciliation reports, and transaction receipts, this facllity failed to maintain a system that ensures a full and complete accounting of the residents' personal monies entrusted to this facility. Findings include: 1. As of 2/5/20, there was no evidence that the residents' pooled, petty cash checking account #XXX4309515 had been appropriately reconciled for the months ending 10/31/19 and 12/31/19. 2. As of 2/5/20, there was no evidence that statements of each resident's personal fund account had been appropriately furnished for the quarters ending 6/30/19, 9/30,19, and 1 2/31/19. 3. All withdrawals of residents' personal funds were not recorded on appropriate transaction receipts. 4. All withdrawals of residents' personal funds were not appropriately authorized and/or witnessed. Specifically, resident 9A expired on On 2/3/20, $80.00 was withdrawn from the resident's personal fund account.	F 568	All residents at the facility have the potential to be affeoted by the deficient practice. Business office staff will be in-serviced to ensure the resident pooled petty cash is reconciled timely, resident personal fund account are furnished quarterly, resident withdrawals will be recorded on appropriate transaction receipts and withdrawals are appropriately authorized and/or witnessed. Resident accounb will be revi-:wed to the resident pooled petty cash ts reconciled timely, resident personal fund account are furnished quarterly, resident withdrawals will be recorded on appropriate transaction receipts and withdrawals are appropriately authorized and/or witnessed monthly by the Administrator for 90 days and reviewed during monthly QAPI meeting.	2/25/2020
F 569 SS=B	Notice and Conveyance of Personal Funds CFR(s): 483.10(f)(10)(iv){v) §483.10(f)(10)(iv} Notice of certain balances. The facility must notify each resident that receives Medicaid benefits- (A) When the amount in the resident's account reaches $200 less than the SSI resource limit for one person, speclfied in section 1611(a)(3)(B} of the Act; and {B) That, if the amount in the account, in addition	F569		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A. BUILDING _____ B. WING _____	C 0210512020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH AND REHABILITATION	**5721 GROSVENOR LANE BETHESDA, MD 20814**

(X4)1D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F569	Continued From page 2 to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for **Medicaid** or SSI. §483.10(f)(10)(v) Conveyance upon discharge, eviction, or **death.** Upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on the review, on 2/5/20, of the personal funds records of deceased and discharged residents, including individual resident's account summaries, closed account summaries, and transaction reports, this facility failed to convey within 30 days, a resident's personal funds and a final accounting of those funds, to the Individual or probate Jurisdiction administering the resident's estate. Findings include: 1. Interest which was posted to the individual, personal fund accounts for residents 1A, 2A, and 3A, were not conveyed to the resipent or their estate, but was instead "forfeited" by the facility, without appropriate authorization. 2. This facility closed the individual personal fund account for 4A on 10/25/18, for resident 5A on 1/7/19, for resident 6A on 8/16/19, for another account for resident 6A on 9/23/19, for resident 7A on 9/18/19, and for resident SA on 9/24119.	F569	I. Resident interest will be conveyed to the resident's or their estate and will not be forfeited without appropriate authorization. 2. 4A funds was provide to the funeral home, *SA,* 6A and 7A funds were provided to the residents, and 8A is awaiting documentation prior to facility releasing the funds. All residents at the facility have the potential to be affected by the deficient practice. Business office staff will be in-serviced on positing interested to resident's accounts and on storing evidence of the final disposition of closed resident accounts. Resident accounts will be reviewed for posting of interest and disposition of closed accounts monthly by the Administrator for 90 days and reviewed during monthly QAPI **meeting,**	2/25/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A. BUILDING _____ .B WING _____	C 02/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH AND REHABILITATION	**5721 GROSVENOR LANE BETHESDA, MD 20814**

(X4)ID PREFIX TAG	**SUMMARY** STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 569	/ Continued From page 3 As of 2/5/20, there was no evidence as to the final disposition of each resident's closing balance.			

Office of Health Care Qualit

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A. BUILDING _____ B. WING _____	C 02/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH AND REHABILITATION	5721 GROSVENOR LANE BETHESDA, MD 20814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S6465	1 1 0.07.09.18D (1) Protect res funds; excess of $50,int bearing .18 Protection of a Resident's Personal Funds. 0. Personal Funds in Excess of $50. A nursing facility shall: (1) Deposit a resident's personal funds in excess of $50 in an interest-bearing account that Is: (a) Established and maintained by the facility under one of the following terms: (i) In the name of the resident only, (ii) In the name of the facility "In trust for" or as the "trustee" for the Individual resident, or (iii) In a residents' pooled account, with a separate accounting for each resident's share; and (b) Located in a financial institution whose accounts are insured by the: (i) Federal Deposit Insurance Corporation (FDIC), (ii) Federal Savings and Loan Insurance Corporation (FSLIC), or (iii) Other insurer approved by the Department; and (c) Separate from any of the nursing facility's operating accounts; and This Regulation is not met as evidenced by: SEE F569	S6465	SeeF *569*	
S6480	1 0.07.09.18F {1) Protect res funds;estab res acct .18 Protection of a Resident's Personal Funds. F. Establishment of Resident Accounts. When a nursing facility manages a resident's financial affairs, the nursing facility shall establish and maintain a system that: (1} Ensures a full, complete and separate	$6480		

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

Jason A. Mumo — Administrator — 2/20/2020

STATE FORM 111811 8ME911 If continuation sheet 1 of 3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	216187	A. BUILDING:_____ B. WING_____	C 02/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH **AND REHABILITATION**	**5721 GROSVENOR LANE BETHESDA, MD 20814**

(X4)1D PREFIX TAG	**SUMMARY** STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTM ACTION SHOULD BE CROSS-REFERENCEDTOTHEAPPROPRIATE DEACIENCY)	(X5) COMPLETE DATE
S6480	Continued From page 1 accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the nursing facility; and This Regulation is not met as evidenced by: SEE F568 & F569	**S6480**	**See F *568* and** F *569*	
S6505:	10.07.09.19 A (3) Recs pers Funds; qtrly statement .19 Records of Resident Personal Funds. A. Records. For all resident funds entrusted to a nursing facility, the facility shall: (3) Furnish each resident or, when applicable, the resident's agent or interested family member, with a quarterly statement of the resident's individual account not later than 30 days after the end of each quarter; This Regulation is not met as evidenced by: SEE F566	**S6505**	**SeeF 568**	
S6520	10.07.09.19 B (1) Recs Pers Funds;Receipts .19 Records ofResident Personal Funds. B. Receipts of Transactions. (1) If a transaction involves a transfer of funds between a resident and a second party, or between the nursing facility and the institution in which the resident's account is located, the nursing facility or financial institution shall: (a) Provide a receptor copy of a receipt to the resident, or retain the resident's copy of the	**S6520**		

STATEMENT OF DEFICIENCIES AND PLAN,OF CORRECTION	(X1) PROVIDERJSUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A B UILDNG _____ B WING _ _ _ _ _ _ _ _	C 02105/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH AND REHABILITATION	5721 GROSVENOR LANE BETHESDA, MD 20814

(X4) 10 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED aV FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVEACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XII) COMPLETE DATE
S6520	Continued From page 2 receipt as part of the resident's individual financial record; and (b) Maintain the original receipt and make it available for audit. This Regulation is not met as evidenced by: SEE F568	S6520	SeeF 568	
S6565	10.07.09.19 E (1) Recs Pers Funds; Death of Resident .19 Records of Resident Personal Funds. E. Death of a Resident. Upon the death of a resident for whom a nursing facility is holding funds, the nursing facility shall notify the resident's agent or interested family member and: (1) Convey within 30 days a final accounting of the resident's personal funds which are deposited with the nursing facility; This Regulation is not met as evidenced by: SEE F569	S6565	SeeF 569	

Office of Health Care Quali

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A. BUILDING:_____ B WING _ _ _ _ _ _ _ _	C 02/0512020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE. ZIP CODE
BETHESDA HEALTH **AND REHABILITATION**	**5721 GROSVENOR LANE BETHESDA; MD 20814**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTI ACTION SHOULD BE CROSs-REFERENCED TO THE APPROPRIATE DEFICIENCY)	( ) COMPLETE DAIc
S OOO	Initial Comments On February 5, 2020,, a complaint survey was conducted at this facility by the Office of Health Care Quality to investigate complaint #MD00150968. Activities Included the audit of the residents' personal funds records maintained by this facility. The specific complaint was unsubstantiated. This survey did not identify noncompliance with State requirements that were reviewed in relationship to the specific complaint. This survey did identify noncompliance with State requirements that were reviewed pertaining to the management of residents' personal funds. (SEE S6465, S6480, 6505, S6520, &S6565)	S 000		

OHCQ
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Jason J. Nunes

TITLE

Administrator

(X6) DATE

2/20/2020

STATE FORM 6899 BME911 If continuation sheet 1 of 1

STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOERJSUI'PUER/CLIA IOENTIFICATION NUMBER:	(X.I) MOLTIPIE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215167	A. BUILDING _____ 8.WING	C 07/18/2019

NAME OF f>ROVIOSR OR SUPPLIER	S"fREET ADDRESS, CITY, STATE. ZIP CODE
BETHESDA HEALYH AND REHABILITATION	5721 GROSVENOR LANE BETHESDA, MO 20814

(X4) 10 PREFIX: TAG	SUMMARY STATEMENT OF OEFICIENCIES (E'ACH DEF'ICISNCY MUST BE PRECEOEO BY FULL REGULATORY OR LSC IOENnFYING INFORMATION)	10 PREFIX TAG	PROVIDER'S PIAN OFCORRECTION (EACH CORRE:CTIVE ACTION SHOULO BE CROSS-REFERENCED TO THE APPROPRIATE OEF1CIENCY)	(X!>) C()MPIfIlON OATE
F 000	INITIAL COMMENTS	F 000i		

On 07-17-19 and 07-18-19, a survey was conducted at this facility by the Office of Health Care Quality to investigate complaint #MD 00142213, MO 00141871, and #MD 00141440 , and facility reported incident #MO 00142399, #MD 001-41028, #MD 00140776 and #MD 00140693. Sutvey activities included review of residents ' medical records, interview of facility staff, observation of resident and staff practices. The following deficiencies are the result of this visit.

F 641 Accuracy of Assessments
SS:::B CFR(s): 483.20(g)

§483.20(g) Accuracy of Assessments.
The assessment must accurately reflect the reslident's status.
This REQUIREM ENl ' is not met as evidenced **by:**
Based on sorveyor review of the clinical record and staff interviews, it was determined that lhe facility staff failed to ensure the accuracy of the MOS. This finding was evident in 1 of 8 residents selected for review during a complaint survey, (#2). The findings included;

The Minimum Data Set (MOS) 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 funcllonal capacity and health status to assist nursing home staff in identifying health problems. **MOS** assessments are required for residents on admi ssion to the nursing facility and then periodical!y, within specific guidelin es and time frames.

F 64i

F64 **641-What corrective action will** be **accomplished for those residents found to have been affected by** the **deficient practice:** Resident# 2 MOS section I was immediately corrected.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action wUlb taken. All residents who receive antipsychotic medication **have** potential to be affected. 100% **audit** of all residents receiving antipsychotic MDS section I will be completed by 8/23/19.

9/6/19

lA 3ORATORY DIRECTOR'S OR PROVIDER/SUPPLIE.R REP RESENTATIVE'S SIGNATURE .. TITLE (XG) OAl l:

Administrator 8/, ti

Any !ency $latement ending with an eri (•) denotes a deficiency which the institution *may* l>e e,ccused f,om correcting providing it is dele ined Uiat other reguards pro11ide sufficient protection to the patients. (See instructions.) Except ror nursing homes, the findings stated above are discfosable 90 d.iys follow the date of survey whether or not a plan of correction Is provided. For nursing homes, the above findings and plans of correction are disc.losable 14 *1ays* ro l(owlng the date these documents are made available to the facility. If deficiencies are ciled, an approved plan of correction is requisite to continued program partlcipalion.

STATEMENT OF Dffi CIENCIES ANO PLAN OF CORRECTION	(X1) PROV101:R/SUPPLIERJCLIA IDENTIFICATION NUM8ER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETED
	215187	A BUILDING _ -- B. V\IING	C 07/1812019

NAME OF PROVIDER OR SUPPLIER	STREET AOORcSS, CITY, STATE. ZIP CODE
BETHESDA HEALTH ANO REHABILITATION	6721 GROSVENOR LANE BETHESDA, MD 20814

(X4)10 PREFIX TAG	SUMMARY STATEMENTOF DEFICIENCIES (EACH DEFICIENCY MUST 8E PRECEDED BY FULL REGULATORY OR tSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFE ENCED TO THE APPROPRIATE DEFICIENCY)	(X) COI,,IPIETrON OATE
F 641	Continued From page 1 On 07 17-19 at 10:10 AM, surveyor review of the clinical record for resident #2 revealed that an MOS submitted on 04-16-19, section I indicated that resident #2 had no psychotic disorder. However. surveyor review of resident #2's physician order sheet (POS) and medication administration records **(MAR)** for the months of January February and March revealed that a psychotropic medication was administered to resident #2. Further record review revealed psychiatrist documentation in February 2019 which indicated the rational/diagnosis for Zyprexa (a medication used to treat psychosis) was psychosis. On 07/17/19 at 11:10 AM, surveyor interview with MOS coordinator and the Director of Nursing revealed no new additional infonnation.	F 641	**What** measures will be put into place or what systemic changes you will make to ensure that the deficient **practice** does not recur: All MDS staff will be in-serviced by the MDS Director on MDS section I completion and accuracy by 8/19/19. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: MOS director wiH randomly audit MDS section I for accuracy and report findings to the OA/OAPI committee monthly X 3.	3(fl
F656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21{b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive perS(Jn-centered care ·plt·n for·each resident. consistent with the resident rights set forth at §483_10(c)(2) and §483.10(c)(3), that includes measurable objectives and limeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following {i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as	F 6 56!		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	8 WING _____	C 07/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH AND REHABILITATION	5721 GROSVENOR LANE BETHESDA, MD 20814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F656	Continued From page 2 required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s) (A) The resident's goals for admission and **desired** outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on surveyor record reviews, and facility staff interviews, It was determined that the facility staff failed to develop and implement a comprehensive person.centered care plan to meet a resident's medical, nursing, mental and psychosocial needs. This was evident in 1 of 8 residents reviewed (#2) during a complaint survey. The findings include: On 07-17-19 at 10:30 AM, surveyor review of resident #2 medication administration record	F656	**&S6 What** corrective action will be accomplished for those residents found to have been affected by the **deficient practice:** Resident# 2 care plan was corrected immediately. **How will you identify** other **residents having the potential to be affected by the** same deficient **practice and what corrective action will be taken.** All residents who are on Psychotic medications have potential to be affected. 100% audit of care plans of these residents will be completed by 8/23/19. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur:** Residents on antipsychotic medications care plan will be reviewed weekly during the IDT "at risk" meeting for completion and individualization.	

S1ATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONS'TRUCTION	(XI) DATE SURVEY COMPIET D
	215187	A. BUILOIN<i _____ 6.WING –	C 07/18/2019

NAME OF PROVIDER OR SUPPUER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH **AND REHABILITATION**	6721 GROSVENOR LANE BETHESDA, **MO 20814**

()(4) 10 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES {EACH DEFICIENCY MUST BE PRECEDED 8Y FUU REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PI.AN OF CORRECTION (EACH' CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE.APPROPRIATE DEFICIENCY}	(X5) COMPt.ET101i OATE
F656	Continued From page 3 (MAR) revealed that resident #2 was taking multiple medications including, but not limited to. antipsychotropic medications (medications used to treat psychosis like delusions, paranoia hallucinations and disordered thoughts). Further record review revealed psychiatrist documentation in February 2019 which indicated that the rational/diagnosis for the medication was due to resident #2's psychotic symptoms. However, there was no evidence that the facility staff initiated a care plan to address resident #2's health condition. In addition, there was no care plan that addressed resident #2 antipsyehotropic medication use. There were no care plan interventions ta address the medication use. On 04-10 18 at 1 PM, surveyor interview with the Director of Nursing (DON) revealed no new information.	F656	How the corrective action(s} will be monitored to ensure the deficient **practice will not** recur: Nurse managers will randomly audit the care plans of residents on antipsychotic medication weekly and report findings to the QA/QAPI committee monthly X 3.	

SI"ATEMENT OF OEFICIENCIES AND PI.AN OF CORRECTION	(X1) PROVIDER/SUPPLIERICLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(XJ) OAI E SURVEY COMI'LETE;O
	215187	A BU| LDNG _ _ _ _ _ _ _ B WING _ _ _ _ _ _ _	C 07/18/2019

NAME OF PROVIOER OR SUPPLIER	STREET ADDRESS. CITY, SIATE. ZIP CODE
BETHESDA HEALTH **AND REHA.BILITATION**	**5721 GROSVENOR 1.ANE** BETHESDA, **MD 20814**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF OEFICIENCIES (EACH DEFICIENCY MUST SE PRECEDED BY FULL AEGUI.AI'ORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIOER'S PLAN OF CORRECTION {EACH CORRECT1\IEACTION SHOULO ue CROSS-REFERENCED TO THE **APPROPRIATE** DEFICIENCY)	(X5) I COMPLETE 01\Tr.::
s oo·o	Initial Comments	S000		

On 07-17-19 and 07-18-19, a survey was conducted at this facility by the Office of Health Care Quality to investigate complaints #MD00142213, MD00141871, and #MD00141440and facility reported incident #MD00142399, MD 00141028, M000140776 and MD00140693. Survey activities included review of residents' medical racords, interview of facility staff, observation of resident and staff practices. The following deficiencies are the result of this visit.

S2900 10.07.02.59Resident Status Assessment

SEE F641

.59 Resident Status Assessment.

A A nursing home shall use the following forms and procedures for resident assessment as described in the CMS Manual System, Pub. 100-07 State Operations Provider Certification and in the CMS Long-term Care Facility Resident Assessment Instrument 3.0 User's Manual:

(1) The Minimum Data Set (MOS) version as determined by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services·, referenced in '§8 ·of this regulation.

(2) MOS Care Area Assessment process: and

. {3) Care plans.

8. The nursing home shall complete all assessments in accordance with the provisions of 42 CFR §483.20, as amended .

C. A nursing home certified fo participation in , Medicare or Medicaid shall complete and

STATEMENT OF DEFICIENCIES ANO PLAN Of' CORRECTION	(Xl) PROVIOl=R/SUPPUERJCLIA IDENTIFICATION NUMBER:	(X2} MULTtPLE CONSTRUC1'I0N	(X3) DAfr SURVEY COMPLETED
	215187	A. BUILDING: _____ 8.WtNG _____	C 07/18/2019

NAME OF PROVIDER OR SUPPLIER	STREF.T ADDRESS, CITY, STATE, Zif> CODE
BETHESDA HEALTH A.NO REHABILITATION	5721 GROSVENOR LANE BETHESDA, MO 20614

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUI.L REGULATORY OR LSC IDENTIFYING INFORMATIONJ	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION {EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OE'cFICIENCY)	(IC61 CD!..ll'll,TI: DATE
S2900	S2900 Continued From page 1 electronically submit the assessment to the Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system. The assessment shall: (1) Use a standard record layout format; (2) Use a data dictionary as identified by the automated data processing requirements; and (3) Pass standardized edits as defined by CMS and the State. D. A federany certified nursing home shall: (1) Encode assessment data as specified in the CMS Long-term Care Facility Resident Assessment Instrument 3.0 User's Manual; and (2) Transmit assessment data as specified in the CMS Long-term Care Facility Resident Assessment Instrument 3.0 User's Manual except as excluded in §E of this regulation. E. A nursing home licensed as a nursing home but not certified for participation in the Medicare or Medicaid Program shall comply with the CMS Manual system, Pub. 100.:07 State Operations Provider Certification, and with RAI Instructions in the CMS Long-term Care Facility Resident Assessment Instrument 3.0 User's Manual, except that data *may* not be submitted electronically to the Department This Regulation is not met as evidenced by: Refer to CMS 2567 F641			

Office j:\.it11th Care Oualih

STATEMENT or OEFICIENCIES NO PLAN Of CORRECTION	(X1) PROVIDERISUPPLIERICL1A IOENTIFICAIION NUMOFR:	(X2) MULTIPLE CONSTRUCTION	(X3) OAIF. SURVEY COMPLf.TED
	215187	A. BUILDING: _____ 8 WING _____	C 07/1812019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS. Cl"fY, SIATE, ZIP CODE
BETHESDA HEALTH ANO REHABILITATION	5721 GROSVENOR LI.NE BET ESOA, MD 20814

(X4)10 PREFIX TAG	SUMMA.RY STATEMENT OF DEFICIENCIES (EACH DEFICll:NCY MUST SE PRECEDED 6Y FULL REGULAI'ORY OR LSC lOF.NTIFYING INFORMATION)	IO PREf'IX TAG	PROVIDER'S PLAN OF CO R REC TION (EACH CORRECTIVE ACTION SHOULO BF. CROSS•REFERfNCE0 TO THE APPROPRIITE DEFICIENCY)	(X5) COMPl. f Tt OATE
S2940	S2940 Continued From page 2 S2940 10,07.02.60 *D* Care Planning-Organization .60 Care Planning. D. Organization of Care Plan. (1} Resident's problems and needs shaH be identified, based upon the interdisciplinary assessment. The care plan shall address all of the resident's special care requirements necessary to improve or maintain the resident's status. The interdisciplinary team shall incorporate resident input into the care plan. (2) The team shall establish goals for each problem or need identified, or a combination thereof. The goals shall be realistic, practical, and tailored to the resident's needs. Goal outcomes shall be measurable in time *or* degree, or both. (3) Approaches to accomplishing each goat shall be established. Approaches shall indicate the work to bedone, who is to do it, and how frequently it is to be done. f This Regulation is not met as evrdenced by: !Refer to CMS 2567 F656	S2940	SEE F656	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A. BUILDING _____ B. WING _____	C 09/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH AND REHABILITATION	**5721 GROSVENOR LANE BETHESDA, MD 20814**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiency was the result of a survey that was conducted at this facility on September 23 & 24, 2019 by the Office of Health Care Quality to investigate complaints #MD00143450, MD00143713, MD00144814 and facility reported incidents #MD00144542, MD00144674, and MD00144931. Survey activities included review of residents' medical records, interview of staff and residents, and observation of staff practices. This survey did not identify noncompliance with federal requirements that were reviewed in relationship to these complaints and facility reported incidents.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established	F609		

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/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A. BUILDING_____ B. WING_____	C 09/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH AND REHABILITATION	**5721 GROSVENOR LANE BETHESDA, MD 20814**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE . DEFICIENCY)	(XS) COMPLETION DATE
F 609	Continued From page 1 procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and interview with facility staff, it was determined that the facility failed to report an allegation of resident abuse to the Office of Health Care Quality (OHCQ). This finding was evident for 1 of 12 residents reviewed for the complaint survey. (#6) The findings include: On 9-24-19, surveyor review of resident #6's clinical record revealed that, on 07-19-19, resident #6 alleged that another resident was threatening him/her. Resident #6 proceeded to call the local police department to file a report. The local police authorities came to the facility on 07-19-19 at 08:17PM and left. There was no evidence that the facility informed OHCQ of the alleged abuse. On 09-24-19 at 12:00PM, interview with the Director of Nursing revealed that the nursing staff did not inform them of the allegation.	F 609		

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A. BUILDING: _____ B. WING _____	C 09/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH AND REHABILITATION	5721 GROSVENOR LANE BETHESDA, MD 20814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETE DATE
S000	Initial Comments The following deficiency was the result of a survey that was conducted at this facility on September 23 & 24, 2019 by the Office of Health Care Quality to investigate complaints #MD00143450, MD00143713, MD00144814 and facility reported incidents #MD00144542, MD00144674, and MD00144931. Survey activities included review of residents' medical records, interview of staff and residents, and observation of staff practices. This survey did not identify noncompliance with state COMAR requirements that were reviewed in relationship to these complaints and facility reported incidents .	S 000		
S6322	10.07.09.15 C (1) (b) Abuse;Report to Dept .15 Abuse of Residents . C. Reports of Abuse. (1) A person who believes that a resident has been abused shall promptly report the alleged abuse to the: (b) Licensing and Certification Administration within the Department; or This Regulation is not met as evidenced by: Refer to CMS 2567 F609	S6322		

OHCQ

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A. BUILDING _____ B. WING _____	C 12/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH AND REHABILITATION	**5721 GROSVENOR LANE BETHESDA, MD 20814**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
F 000	INITIAL COMMENTS From December 3, 2019 through December 6, 2019, the Office of Health Care Quality conducted a survey at this facility to investigate two (2) complaints and five (5) facility reported incidents **(FRIs).** Survey activities consisted of observations of staff practices; interviews with residents, complainants, and facility staff; and the review of residents' medical records, administrative records, and resident care policies. Four **(4) FRIs (MD00146627, MD00147695,** MD00148024, and MD00148135) were unsubstantiated with no identified noncompliance with Federal requirements. Two (2) complaints (MD00146708 and **MD00146916) and one (1) FRI MD00147618** were substantiated. This survey identified noncompliance with Federal of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities.	F 000		
F 558 SS=E	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced **by:** Based on surveyor review of administrative records, and interviews, it was determined that	F 558		

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/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A BUILDING _ _ _ _ _ _ _ _ B. WING _ _ _ _ _ _ _ _ _ _	C 12/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH AND REHABILITATION	**5721 GROSVENOR LANE BETHESDA, MD 20814**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
F 558	Continued From page 1	F 558		

the facility administrator failed to consider residents' rights for accommodation and preferences by removing microwave ovens used by the residents. This finding was evident during investigation of complaint #MD00146708.

The findings include:

On 12-03-19 review of administrative records revealed that on 09-12-19 facility staff were informed that all microwaves for resident use had been removed with instructions that residents and/or facility staff on behalf of the residents were no longer allowed to heat or reheat any items for resident consumption in microwaves. The facility provided an in-service regarding the use of the microwave to all employees on 09-12-19.

On 12-03-19 at 1:00 PM, interview with the facility administrator revealed that he had made a decision to remove all microwaves based on an isolated incident that involved an alert and oriented resident who sustained a burn from some noodles the resident had heated up.

Review of the resident council minutes dated 10-05-19 revealed that the facility administrator attended the meeting and informed the residents that effective 10-03-19 microwaves were no longer available for residents "to warm their meals." There was no indication in the minutes that there was any discussion regarding any alternates for residents who wanted to heat food or whose family members bring in food.

On 12-06-19, at 2:00 PM, interview with Resident #11 revealed the resident's mother had been preparing food for the resident every week for the last 14 years. Resident #11 preferred to have

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A. BUILDING _ _ _ _ _ _ _ _ _ _ B. WING _ _ _ _ _ _ _ _ _ _	C 12/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH AND REHABILITATION	**5721 GROSVENOR LANE BETHESDA, MD 20814**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
F 558	Continued From page 2 those meals heated in the microwave instead of eating them room temperature. Resident #11 stated, "We need our microwaves back!"	**F** 558		

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A. BUILDING: _____ B. WING _____	C 12/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH AND REHABILITATION	**5721 GROSVENOR LANE BETHESDA, MD 20814**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S000	Initial Comments From December 3, 2019 through December 6, 2019, the Office of Health Care Quality conducted a survey at this facility to investigate two (2) complaints and five (5) facility reported incidents (FRIs). Survey activities consisted of observations of staff practices; interviews with residents, complainants, and facility staff; and the review of residents' medical records, administrative records, and resident care policies. Four (4) FRIs (MD00146627, MD00147695, MD00148024, and MD00148135) were unsubstantiated with no identified noncompliance with Federal requirements. Two (2) complaints (MD00146708 and MD00146916) and one (1) FRI MD00147618 were substantiated. This survey identified noncompliance with 10.07.02 of COMAR requirements for Long Term Care Facilities.	S 000		

OHCQ

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

Office of Health Care Qua/it'i

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A. BUILDING;_____ B. WING _ _ _ _ _ _ _ _ _	C 12/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH AND REHABILITATION	**5721 GROSVENOR LANE BETHESDA, MD 20814**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S5093	10.07.09.08 C (1) Right to reasonable accommodation .08 Resident's Rights and Services. C. A resident has the right to: (1) Reside and receive services in a nursing facility with reasonable accommodations of individual needs and preferences, except when accommodations would endanger the health or safety of the resident or other residents; This Regulation is not met as evidenced by: Refer to CMS 2567 F-558	S5093		

OHCQ

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CL J rr f'{S I Ol Mi::IJI . Af |_ & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PU1N OF CORf{[CTION	(X1) PROVIDER/SUPPLIER/CUA IDEI I If'ICATION NUMBER	(X2) MI!I1IPLf' CONSTRUCTION	r>' 1rv,1 11,, ,
	215187	A BUILDING B WING	05/10/20HI

NAME OF Pl1OVIDEH OR SUPPLIER	SrREr:T ADORF..SS, CITY, STATE, 7.IP COl)f
BETHESDA HEALTH AND REHABILITATION	5721 GROSVENOR LANE BETHESDA, MD 20814

(X4) ID PREF'IX T/1G	SUMMARY ST/\TEMENI OF OEFICIENCIES {EACI t DEFICIr:NCY MUST BE PRECEOED BY FULL . REGUIATORY OR I SC IDENTIFYING INFORMATION)	10 I"REFIX fAG	PROVIDfR'S Pl.JIN OF CORHf:CIION (EACH cor REC nv : ACTION SHOULD Br: CROSS-REFERENCED TO THE AI'PROI'RI/\TE DEFICIENCY)

F 000 INITIAL COMMENTS F 000'

On May 7, 8, 9 & 10, 2019, an on-site investigation was conducted at this facility by the Office of Health Care Quality (OHCQ) to investigate one facility reported incident MD00138759 and three complaints, MD00138541, MD00138071 & MD00139809. Survey activities included review of clinical records, interviews with Ombudsman, residents and the facility staff, observation of staff practices and review of administrative records. In addition, three additional facility reported incidents were investigated on site.

On 05 -09-10 at 12 PM, it was determined !licit the facilil \' failed to provide direct supe rvision in the :;moking arc;:; for unsafe sm okers, 'Nhich *v,ie r e* asse sse d and id ent fled based 011 the fa cility's safe smoking assessments . After the facility reported incident on 04 30 19, the facility failed to conduct a thorough investigation and to determine whether the current smoking monitoring system in the smoking area was effective or not. In addition, the tacIllty tailed to define the expectation of direct supervision in the smoking area and to offer training to the designated personnel who monitored the smoking area . Therefore, an immediate jeopardy to resident's safety in the smoking area was determined.

On 05-09-19 at 9 PM, the facility provided a plan of corrective action to OHCO . The immediate jeopardy was abated on 05-10-19 a(3 PM following the facility's implementation of corrective Actions to ensure that all unsafe smokers receive direct supervision in the smoking area.

Any ' ci ncy sloti3111Cl1 ending with an asterisk (') *deno* ll lhe ms Gll!nLt oiccused rrom correcting provd,u g ı ,1: d% rn 11nd ,11 ••1 other safeguards provide sufficient protection to the pal le 1 (S c instruc tion s.) Except for nursing homes, lhc firrdings staled above ;Jr" 151.:l , Ilifl- % t.1, following the date of survey whether or not a plan of cor r tio 11 is provided For nursing homes, the ahove findings and plans of correctHJI' are rli",clo:, ;wie 11, Joys following the date lhese documents are made available lo lhe facility If deficiencies are ciled, an approved plan of conecl1011 is requ,siltc lo ,:0111nn:.•c <Jrogrnrn pa1ticipalion.

DEPArnMENT OF HEALTH AND HUMAN SERVICES
CENTERS For MH .JIG 'lli I & ll1W JIC/\/I) !..iU <VICC .i

STATf:MENT OF DEFICIENCI[S /IND PI AN OF COmffCTIO I

(X1) PROVIDL:R/SUPPLIER/CLIA IDEN r IFICAT ION NUMBER

215187

NN M OF Pf<O'v1DER 01 SUI-'PLILR

BETHESDA HEALTH AND REHABILITATION

(;<A) i!J PfHJIX 11\G

SUMMI\RY ST!,I EMENT OF DEFICIENCIES (EACH DEFICIENCY MUST OE PRECEDED BY FULL REGULATORY OR I.SC IDENTIl'YING INFORMATION)

F 000 Continued From page 1

On 05-10-19, an extended survey was conducted based on the determination *of* the immediate jeopardy to resident's safety in the smoking area on 05-09-19 at 12 PM.

This survey did not identify non-compliance **with** Federal requirements that were reviewed in relationship to the facility reported incident MD00138759 and lwo complaints, MD00138541 & MD00138071.

f C 1O Invesligale/Prevcnt!Correct Alleged Violation SS-"0 CF f (s): 48 3,12(c)(2) -(4)

§483 12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

§'183.12(c)(2) Have evidence that all alleged violations are thoroughly investigated

§48312(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress,

§483 12(c)(4) Report the re sults of all investigations to the administrator or his or *her* designated representative and to other officials in accordance with Slate law, including to the State Survey Agency, win1in 5 working days of the incident, and if th e alfeged violation is verified aµpropriate corrective action must be taken . This REQUIREMENT is not met as evidenced by:

Based *on* surveyo1 observations, review of the clinical record and interviews with the Ombudsman, residents and facility staff, it was determined that the facility staff faifed to investigate two fac ility reported inciden ts

f'i /N IH) 0li1) ·!/! ·,l : ı, :I 0 i, f:1 r,r>1,r:1(-'\!' 0MB t,iO YL:G 1) .,

(X2) MUL 111 'Ll CON: ; 1 IWC r !U I A riUll 011,ic;

t r,., 1,• l ı If f

B Vv'ING

0 5/ I W W 1 9

S i l U ,l , utm r.c;S , l:IIY, - ; J(d .f " tW (;(Jllf 5721 Gf<OSVENOR LAN E BETHESDA, MD 20814

Jf) PHCfl X T{ 1

I' HOV !{H 1 • ; ;i1 t t\ Ot C()f-"lt··c ii,>t,J (i J\CI I (:<Jl{i(i CI IVI ill:I I!JN ', t II)UI I Id! {n c,S-I(l: fT f\H iC"[ ) I () r, II ,,; '"'!' WI<JI ·, r1 u U 'lCl[NC , ı

;, 610 -What corrective action will be accomplished for those residents found to have been affected by the deficient practice:

Foop /i

All residents are directly supervised when in the smoking area.

F 610

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:

Any resident that has made an allegation of abuse has the potential to be affected. Education will be provided by the District Director of Clinical Services to the Director of Nursing, Admini trator, Assistant Director of Nursing, Staff Development Manager, and Unit Managers on completion of investigations. Following education, the Director of Nursing will educate nursing supervisors on completion of investigations. Following education the Director of Nursing will review all

3/19

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CEIıI I U ; I·01,: MI .1)IC:AI I A rVlt _12t<;_/\112-: ;U N IU :,

STATH v'!ENT Of llEFICJENCIF.S /\NO Pl.AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CI IA IDENTIFICATION NUMBER	(X 2) MUl.TIP LI::(' (.JN S r RUC I ION A UUII DING	
	215187	A WING	

NAME Or PHOVIDER OR SUPPLIER	STRFET /\ODR FS S C:17 Y S TAT F !IP (:()OF
BETHESDA HEALTH **AND REHABILITATION**	**5721 GROSVENOR LANE** **BETHESDA, MD 20814**

(X'1) IU PRI"-TIX iAG	SUMMARY S71\IEMENT OF DEFICIENCIES (8\Cli DErICIENCY MUST P.E PRECED CO tW ru1.L REGU tA TORY OR LSC IDENTIFYINGINI ORMAI ION)	10 Pi<EFIX TAG	PROVIDf::.H'S Pl.A1, OF COPf<I::CTIOt-i (rACi I CORRFCI 11/E AC [ION SIIDUI [) I \I•. CROSS-f EF[RI.:NCLO TO 11 il 1\I ' I ' I W PWAf I DE'FIC IF NCY)

F 610 Continued From page 2

thoroughly Till s finding was evident for 2 of 4 facility report ed incident reviews (#3 & #1). The find ings include :

1, On 05-07-19 at 4:30 PM , interview with resident #3 revealed that the resident reported to the facility on 05-01-19 that resident #4 touched him/her inappropriately in the smoking area.

On 05-08-19 at 2 PM, interview with the Ombudsman revealed that resident #3 alleged resident #4 touched him/her inappropriately in the smoking area on 05-01-19 The Ombudsman reported resident #3's complaint to the facility staff on 05-01-19 .

U! Yx ıf!-H . rev ww of \11e f2 ciiit)' , inve sWi,,t;;„ i Lipu : re-..e::iJ.:n ir :.! a t\ n vr:::< tg al:u , v, {s iii ua·,.: d on 05-01 -1Q Hie fJOiice wei e called Fwther rP.view of msident #3's sta tem ent , which was inade on 05-01-19,revea le d tha t res iden t #3 alleged that resident #4 touched him/her in the smoking area, but did not provide any specific e--amJii me W he-n--th-e-Btr-ee+et-e f-Nursiifl-Ef- (DON) asked resident *#4* on 05-01 -19 , resident #4 denied touching resident #3. Further review of resident #1's sta tem ent, which was made on 05-01-19, revealed that resident #1 observed resident #4 touched resident #3 in the smoking area_

On 05-08-19, review of resident #1's safe Silloking evc1lu ation. whict, was completed on 03-11-19 , revealed that resident #1 required direct supervision while smoking ill the smoking area .

On 05-08-19 *At* 1? noon, interview with the DON revealed that diffel ent department staff members

F 610 j allegations of abuse for the past 60 days to en sur e that a complete investigation was complet ed.

What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur:

11/5/19

The Director of Nursing and Administrator will review all investigations to ensure they are compi et e prior to submitting finai report .

How the corrective action(s) will be monitored to ensure the deficient practice will not recur:

Dist rict Director of Clinical Services will review all allegations of abuse investigations completed for the next 3 months. Results of these reviews will be presented to the QAPI committee monthly by the Director of nursing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV III ERISUI' PLIER/CI.I/\ IDENT IFICAI ION NUMBER	(X2) MULTIPLE CONS 1 flUCI ION A BUii DING	(15 / 1 1)/ ?11 I
	215187	13 WING	

NAME OF PROVIDER OR SUPPLIER	STR[CT ADDRESS CITY ST/ITE ZIP CODE
BETHESDA HEALTH AND REHABILITATION	5721 GROSVENOR LANE BETHESDA, MO 20814

(X) ID PRC:I·IX 1AG	SUMMARY STATEMENT Or DEFICIENCIES (E/,CH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR I.SC IDENTIFYING INFORMATION)	ID PRffIX TAG	PrJOI/IO[ffS PLAN OF COR/I[CTIOt: (F_ACh co,mcc·,1v1:: AC110t Si 1OIJ 0 ill : CHOSS-1,UTl UICUJ IG 111[Al'I'H/Jf'I<If\ IF Di: F ICIUCY)

F 610 Continued From page 3

F 610

were assigned to provide monitoring in the smoking area during smoking times. The DON provided a smoking schedule, which was listed as followed
7- 7.45 AM
9-9:45 AM
11 - 11:45 **AM**
i-1:45 **PM**
2:30- 3:15 PM
5:45- 6:30 PM
7:30-8:15 PM
9:15-10 PM
However, the facility investigation did not include interviews of the department staff members, who were assigned to monitor the smoking area on 05-01-19.

On 05-08-19 at 8 AM, interview with the DON and review ot the facility's final investigation report, which was dated 05-05-19, revealed that the facility was unable to substantiate resident #3's allegation because resident #3 told the police on 05-01-19 that resident #4 never touched him/her.

However, review of the psychiatrist's progress note, dated 05-03-19, revealed that resident #3 reported to the psychiatrist that "another resident rnached over and touched resident #3", Then, resident #3 "slapped that resident and left the smoking area and informed staff of the incident."

There was no evidence that the department staff members, who were assigned to monitor smoking on 05-03-19, were interviewed..

On 05-10-19 at 3:15 PM, interview with the Administrator and t11e Director of Nursing revealed no additional information.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTlt'ICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	
	215187	A BUILDING 8. WING	05/10/2019

NAM!: OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, Z!F' COOL
BETHESDA HEALTH AND REHABILITATION	**5721 GROSVENOR LANE** **BETHESDA, MD 20814**

(M)ID PII.ffIX lAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DErICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER.'S PL/IN OF CORRECTION (EACH CORRECTIVE ACTIDr SHOUl D IJC CROSS-REFERENCED TO THE APf'ROPRIAl f: DffICI[NCY)
F 61 O	Continued From page **4**	F 610	

2, On 05-07-19 at 11 **AM,** interview with resident #1 revealed that the residenl had an altercation at the smoking area on 04-30-19 with resident #4 As a result of the altercation, resident #1 had a laceration 011 the lower lip.

On 05-08-19, review of the facility's investigation report revealed that staff #4 was tt1e assigned personnel to monitor smoking on 04-30-19 between 1 PM and 1:45 PM Staff #4 documented that he/she watched resident #1 and resident #4 fighting in the smoking area through a video camera, which was located at the Potomac unit nursing station (122 feet away from the smokinq area)

Interview of stsff#/4 on OS"Oll-19 *at* 10 AM revc,c1k,c.i Jui slaff *+iLJ* couiu r10l toir..'rate cigaiettc sn1oke due to healtil issues, Therefore, staff *#L* was allowed to open the door for smokers at 1 PM Monda>1s throU\Jh Fridays, walk back to the Potomac unit nursing station and monitor through the video camera Staff #4 monitored smokers by s-i-tfnq-a-t--Po-lomae-tlm11t ff81ng-stttt-ien;-whielt-w8 122 feet away from the smoking area. Staff #4 stated that there were a lot of smokers in the smoking area on 04-30-19 between 1 PM and 1:45 PM, but he/she could not recall their names.

Review of the facility's investigation report revealed that resident #3 was present in the smoking area on 04-30-19. , Resident #3 could not provide any information about the incident because he/she could not recall the incident. Other residents who were in the smoking area on 04-30-19 were not interviewed.

On 05-03-19, the p;:;ychiatrist documented that resident #4 had "2 1 esident-resident altercations

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21 5187 | (X2) MULTIPLE CONSTRUCTION: A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED: 05/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH AND REHABILITATION	5721 GROSVENOR LANE BETHESDA, MD 20814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F610	Continued From page 5 and 1 inappropriate touching" between 04-28-19 and 05-01-19. Interview of the Director of Nursing (DON) on 05-08-19 at 12 PM revealed that all three incidents occurred in the smoking area during smoking times. However , there was no evidence that the DON who conducted the facility investigation toured and assessed the physical layout of the smoking area to determine whether the current monitoring system in the smoking area contributed was adequate. On 05-08-19 at 9 PM, interview of the Administrator and the DON revealed no additional infDrmation			
F689	Free of Accident Hazards/Supervision/Devices SS=J CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents . The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2.)Each resident receives adequate supervision and assistance devices to prevent accidents . This REQUIREMENT is not met as evidenced by Based on surveyo, observations. review of clinical records and interviews with residents and the facility staff, it was determined that the facility staff failed lo provide adequ.::ite supervision of unsafe smokers in the facility. On 05-09-10 at 12 PM, an immediate Jeopardy (IJ) to resident's safety in the smoking area was determined On 05-09-10 at 9 PM, l1e facility provided an IJ Removal Plan to Office of Health Care Quality	F689	**689-What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** Direct supervision is provided during smoking times to ensure that smokers remain safe. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:**	7/5/19

DEPAfHMENT OF HEALTH AND HUMAN SERVICES
I. t 1-11 1 1 !3 | Ml:I)IC/\I I _ 1"11-1 JIC/\IU SF I '!ICI<3

SI"fi1EMENT OR DEFICIENCIES M IJ r,I.J\t, OF GOHRECTION	(X1J PHOVIDER/SUI'I-'LIERICLIA IDENTIFICATION NUMBER	(X2) HUL1 IPL I CONS I F(IJC1ION /1 [3UILDING _	f'f INi1: u Wi121:,·,: " I (J \i1/I ,\Pl"!'{(y-.,,: 1; t)[Vf I '· f•,) I / I I" .; ii I i i . I Ill I·, r ! 1 11 1 1 I• I
N1\MI' Of- PFHWiD[R 01 SLJPPLIEfl,	215187		

BETHESDA HEALTH AND REHABILITATION

5721 GROSVENOR L/\NE

BETHESDA, **MD** 2013'\4

(X•l) !O Pf?U'IX "1/1(3	SUMMARY SIll1EMENT OF DEFICIENCIES (EACII DffICIENCY MUST BE PRECEDED BY FULL REGULATORY OR *U;C* IDENTIrYING INFORMAi ION)	ID l'fH 1·1x TAG	f>ROV!Oi:'I'S Pl.Ml (if co1rnu:. '1m: (u , , : H COf<Rl.C TIV*f',C* I 1:J,t, , i,)tJ, [; 1,: Cll OS!i - RfT t' R F' t•IC[-{ 1 Tr) 110" /\f> l 'IU'Ti?',1, 1, r:1, ,,:n inn

F 689 Continued From page 6

(OHCQ) The IJ WJs abated on 05-10-19 at 3 PM following the facility's implementation of corrective actions to *ensure* all unsafe smokers receive direct supervision in the smoking area Findings include:

On 05-08-19, review of the facility 1eµo1lecJ incident (FRI) revealed that triere was a resident to resident altercation between resident #4 and #5 on 04-28-19 at 1 45 PM in the smoking area.

On 05-08-19 at 11 JO **AM,** rnvlew of the facility's investigation report and interview of staff #1 revealed that staff #1 observed staff #2 opened the door for all smokers on 04-28-19 at 1 PM Tl,en, stafi *t/2* walked back to the Potomac unit nL,' ,;in'.J ft 21: ,n_ ,_,._,1-,,;i· wns 1 '2" fee,(C.1way i r om t:HJ -;i1 0 I ll I J J: t.::2, \ \lt i S it ,taff *it* I '·Ndi ,c d lO\':d:U:- lhe l.J1 eak 100111, striff t/1 heard ;;i cornrnotion corning frorn Ille smoking a1cH. Therefore, staff #1 walked towards the door and watched through a 11 in x 11 in window on the door *Staff* #1 observed resident #4 and #G fighting. Therefore, -.:t;,ff-#t-ealtoo-ot taff;---whe-were-ift-tMe-bfea- roorn, to help. Staff 11-1 told the surveyor that no staff was pi-esent in the smoking area on 04-28-19 at 1:45 PM when he/she entered the smoking area to separate resident #'1 and #5 .

On J5 08 19. review of resident #5's safe smoking evaluatio11, dated '.)1-30 19, revealed that resident #5 was assessed as an unsafe smoker who required direct supervision while smoking

Further review of resident #4's safe smoking evaluation, dated 02-27-19, revealed that resident *114* wr.1s assessed ;;;:.; a safe smoker No direct supervision was needed while smoking

F 689 Any resident in the smoking area that is assessed as unsafe is at risk. Direct supervision is provided during smoking tirnes to ensure that smokers remain safe.

What m as s will be put i to place or what systemic changes you will make to ensure that the deficient practice does not recur:

Direct supervision is provided during smoking times by a trained monitor to ensure that residents remain sa fe.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur:

Monitors are randomly supervised by the administrator or management designee to ensure that they are maintaining direct supervision in the smoking area. Any incidents or concerns in the smoking area are immediately communicated to the administrator or designee and noted on the smoking observation tool.

7/5/19

ST/ffCW : NT OF DEFICIENC Ii::S ANO 1' LAN OF CORI'\ECTION	(X1J PROVIDER/SUPPLIER/Cl IA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X:I: D/\'F. ,IJP\I!' v CUMP'. c-.1 C.,
	215187	A BUILDING B WING	05/10/2019

NAME OF PROVIDLR OR SUPPLIER	STREET ADDRESS. CITY STATE ZIP CODE
BETHESDA HEALTH **AND REHABILITATION**	**5721 GROSVENOR LANE** **BETHESDA, MD 20814**

(X,1) ID PREFIX TAG	SUMMAHY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID **PREFIX TAG**	PROVIDER'S PLAN *OF* CORRECI'ION (E/\CH CORRECTIVE ACTION SHOULD BI: CRO.SS-RHERLNCF.O TO rHE I\PP H 9 11\! i· DEFICIENCY)
F 689	F 689 Continued From page 7 On 05-08-19, review of the facility's smoker list, which was provided by the Director of Nursing (DON), revealed that resident #5 and #6. were listed as unsafe smokers. Based on the facility's investigation report, resident #6 was present in the smoking area on 1 04-28-19 at 1:46 PM Resident#6 was assessed i and determined to be an unsafe smoker based on the safe smoking evaluation, which was completed on 03-13-19. In addition, resident #6 required direct supervision and needed to wear a protective apron while smoking. There were two unsafe smokers, resident #5 and #6, in the smoking area on 04-28-19 between 1 PM and 1:45 PM without direct supervision by the facility staff On 05-08-19 at 12 noon, interview of the DON reve.=1led th;::it staff #3 was assigned to provide monitoring in the smoking area between 7 AM and 6:30 PM on the weekends and holidays The DON provided a smoking schedule to the surveyor, which was listed as followed: 7- 745 AM 9-9:45 AM 11-11:45AM 1-1:45 PM 2:30- 3:15 PM 5:45- 6:30 PM 7:30-8:15 PM 9:15-10 PM In addition, the DON clarified that the evening weekend supervisor was the assigned personnel to provide monitoring in the smoking area between 7 PM and 10 PM on the weekends and hol idays.	,F,fffill	Incidents are tracked and discussed in the monthly QAPI meeting. 7/5/19

STATEMEIH OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROI/IDER/SUPPLIER/CLI/\ IDENTIFICATION NUMBER	(X2) MUI lll'l.l: CONSTRUCTION A 13UILOING B WING	(Y,.) J I), \ I I ':-t; Jl- J (I COMf'lEf[ll C 05/10/2019
NAME OF PROVIDER OR SUPPLIER	215187	STREET ADDRESS, CITY. STAT[. ZIP CODF.	
BETHESDA HEALTH **AND REHABILITATION**		**5721 GROSVENOR LANE BETHESDA, MD 20814**	

(Xil)IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (E/\CH DEf'ICIENCY MUST BE PRECEDED BY FULL REGUI.A'l'ORY OR LSC IDENTIFYING INFORMATION)	10 Pl ffIX "fAG	r r OViOER 'S PLI\N 01' CORR[CTI OM (EACH CORRFCTIVE /\CTION SHOULD BE: CROSS -REFERENCf.O TO 1HE APPF<OP l11AI E DEFICIENCY)

F 6.89 Continued From page 8

F 689

On 05-09-19, review of the facility's investigation report and telephone interview of staff #2 on 05-09-19 at 9:30 AM revealed that he/she was not aware of any smoker list and did not know where the protective aprons were located for unsafe smokers On 04-28-19 at 1 PM, staff #3 told staff *tt2* to.ope11 the door. to. it1e smoking ar.ea for the smokers . After the door was opened for ttie smokers, staff #2 walked back to Potomac unit nursing station, which was 122 feet away from the smoking area.

On 05-09-19, review of the facility's investigation report and telephone interview of staff #3 on 05 09-1fol al 10 AM reveale cl tl1at ll e /s l1e was th e design ated r,el·so n11el to monitor the smok,ng 1rea on tne weekenas, but he/she was not aware o f an)' srnok er list ::ind did not know where the protective apron s were located for unsafe smokers On 04-28 -19 at 1 PM, staff #3 was busy in the dining room with other residents. Therefore, staff #3 asked staff #2 to open the door to the E;mol-',ing area for smokers, While stc1ff #?i w;:is still in the dining room, other staff reported to him/her that resident #4 and #5 had a fight in the smoking area.

On 05-09-19 at 10 AM, the surveyor toured Potom;:ic nursing unit with the DON. There were 6 protective aprons found in a transparent plastic bag.

Interview of the staff development nurse, on 05-08-19 al 3 PM, revealed that there was no documented evidence that staff #2 and #3 received in-services related to safe smokin g/tobacco use when offered by the staff development nur sl. on 03-19-19 ihe staff

S'IAI EME I T OF DEFICIENCIES AND PLAN OF CORR ECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) 0/\TE SURV['; COMf>l l'lFD
	215187	A BUILDING B. WING	C 05/10/2019

NAME OF PROVIDER OR SUPPLIER	srnEET ADDf ESS, Cl l"Y, ST/\TE, ZIP CODE
BETHESDA HEALTH AND REHABILITATION	5721 GROSVENOR LANE BETHESDA, MD 20814

(X4) 10 l""hEr IX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR I SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(E,\Cl l COF<•slC1 IV[/\Cf IOM :::;i 1<1U, (': t,, !'ROVIOEf,'S Pu\N OF CCH<fffC I ION Cl<O'., ,-H[i"lPl"cNCr=D l O '11!.: Al'PIUJl'lW1! I DEFICIENCY)
F 689	Continued From page 9	F 689	

development nurse further stated that he/she expected the personnel, who was assigned to monitor the smoking area, to stay in the smoking area for direct supervision . See F 867.

After the resident to resident altercation on 04-28-19, there was no evidence that the facility staff addressed the issue of no direct supeNision in -the smoking -area for unsafe smokers; In addition , there was no evidence that staff #3 received in-services /training to understand his/her role while in the smoking area. There was also no evidence that staff #3 knew how to identify unsafe smokers and what level assistance each unsafe smoker might need

On 05-07-19 at 11 AM, inter '1iew of resident #1 revealed that he/she had an altercation in the smoking area on 04-30-19 with resident #4 As a result of the altercation, resident #1 had a laceration on the lower lip.

On 05-07-19, review of resident **#1's** safe smoking evaluation, which was completed on 03-11-19, revealed that resident #1 was assessed as a safe smoker, but required direct supervision while smoking.

On 05-08-19, review of a facility reported incident revealed that resident #1 and resident #4 had a fight in the smoking area on 04-30-19 at 1:40 PM.

Further review revealed that staff #4 was the designated personnel to monitor smoking on 04-30-19 between 1 PM and 1:45 PM Staff #4 reported that he/she watched resident #1 and resident #4 fighting in the smoking area through the video camera. The video monitor was located at Potomac unit nursing station, which was 122

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Cl ,,n I H!; ·11 m MEDICAHE & MEDICAID SEIW IC[::_

PRINffU 0512 !/f.C>".l r-
ORM M-'l' r<O' tC:.\ urvill
I\JO :::;,-,-:: , 11::•,1

$TAl l'.M['NT or 01:f ICIENCIES AND 'I/\N OF cormF.CTION	(X1J PRCJVIOL:R//;LJPPLIER/CLI/\ IDENTIFICATION NUMBER:	IX:!) M I H' I I PL E. C.l) N:';'I IJI T10 N A l-IUILO ING	1)(.1\ IJ1\I I: S i: ▸I \, Y CC‖ •| ·' [· 111
	215187		C 05110/2019

NAME 01' PfWYIDER OR SUPPLIER

BETHESDA HEALTH AND REHABILITATION

snu:rr /\D!1RC: S (' I T '(Slll fl 211" **I'.!'f'\r**
5721 GROSVENOR LAN(

BETHESDA , MD 20814

!X4) ID PREFIX TAG	SUMMAI Y STAI EMENT OF DEFICIENCIES (fACH DEFICIENCY MUST BE PRECEDFD BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	Il) l' flrt- IX TAG	l'I-C(NInl·fl S PIJ\N Or • Oi'llil (; I ION (f-/1(;1-i COIWLC rivr N;110N SIIOUU.> l'!F CROSS-RfffRf.NCF.O TO IHE t,PPROl'HIA-. [: DEF ICIENC ".	t▪ n ı ı

F 689 Continued From page 10

F 689 1

feet away from the smoking area. Therefore. staff #4 asked other staff to help

Interview of staff #4 on 05-08-19 at 10 **AM** revealed that staff #4 could not tolerate cigarette smoke due to health issues Therefore, the Human Resource (HR) department allowed staff #4 lo open the door for smokers at 1 PM Mondays through Fridays, walk back to Potomac unit nursing station (122 feet away from the smoking area) and monitor through the video camera. Staff #4 told the surveyor that there was only one unsafe smoker in the facility, but he/she did not know his/her name .

On 05-08-19 at 11 15 AM, surveyor observation and i11terv1e\'1 with '.,laff #G ,,,vealed that staff #G '.va <:J SUU}) t1: d tt :: .-:ri-u}-.:JL J rnu:nt.:;· nuG.':liit:c :;1c designated perso1111el, who was assigned to monitor smokin between 11 AM and 11:45 AM, was out of the building Therefore, staff #6 stood behind the door and watched through the 11 in x 11 in window on the door to monitor the smoking. Stoff #6 told the Burveyor that there **were** 3 unsafe smokers in lhe facility, who were required to wear protective aprons. However, staff #6 did not know their names or what level of assistance they needed while smoking

On 05-08-19 at 11 2.0 AM. the surveyor took a tour of the smoking area and stood in a few blind spots, where staff #6 could not see the surveyor through the 11 in x 11 in window on the door

On 05-08-19 at 11:30 AM, the surveyor watched the video camera, which was located at Potomac unit nursing station, and was only able to see the legs (lf ll1e residents that were smoking on the video carne1a.

STATf:MI:NT OF DF'FICIENCll:S AND PLAN OF CORRECTION	(X1) PROVID ER/SUPP LIER/CUA IDEN1IFICATION NUMBER	(X2) MULTIPLE CONSTHUCTION	\, ' I 11 ·I ; I \ f,1 I I •,
NAME or· Pr<OVInrn 011 SUPPLIER	215187	A BUILDING [l WING	)!.J/1 /i!Ul 1

BETHESDA HEALTH AND REHABILITATION

Sl REET /\DOHESS, CITY, S !'/\ff, ZIP COD[

6721 GROSVENOR LANE
BETHESDA, MD 20814

(X) liJ PP.IFIX TAG	SUMMARY STAI EMENT OF DEFICIENCIES (EACH OFFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	I D PRffIX lAG	PROVIDER'S Pl.AN OF CORRI: CT ION (F.ACH CORRECTIVE ACTION SHOULD 8E CROSS-REFERENCED TO THI: /\PI'ROPRI/\T[DEFICIENC Y)
F 689 Continued From page 11		F 689	

Facility staff, who were assigned to monitor smoking, had different methods to monitor smokers and different information about unsafe smokers who required supervision and who needed to wear protective aprons .

On 05-08-19 at 12 PM, interview of the DON revealed that the assigned personnel could watch smokers through the 11 in x 11 in window on the door or monitor smokers from the video camera, wl1ich was located at Potomac uni! nursing station (122 feet away from tt1e smoking area).

After 04-30-19, there was no evidence that the facility addressed the issue related to direct supervision in the smoking area for unsafe smokers -, here was no evidence that staff #4 and #6 knew who the unsafe smokers were ;:ind what level of assistance the unsafe smokers needed In addition , there were different expectations from the staff development nurse and the DON related to the definition of "direct supe rvision" and the role and function of the designated personnel to monitor smoking in the smoking area.

On 05-08-19 al 3 PM, interview with the DON and the staff development nurse revealed that there was a total of 23 smokers in the facility based on the safe smoking evaluations . Of the 23 smokers , there were 12 unsafe smokers, who required direct supervision. Of the 12 unsafe smokers who required direct supervision, 4 needed to wear a protective apron while smoking.

On 05-08-19 at 6 PM, staff *it* 7 was observed standing in the smoking area and monitoring the smokers. Interview with staff #7 revealed that

STAI EMENT OF DEFICIENCIES ANO PLAN OF COFrnECTION	(X1) PROVIDER/SUPf>LIERtCLIA IDF.NTIFICATION NUMBER:	(X2) MULTIf'LE CONI-i I HU(;I ION	(X3 ·, Ji1 ff !::UINF Y COMf': I'. ,IT>
	215187	A BUILDING B WING	C 05/10/2019

NAME OF PROVIDER OR SUPPLIER	STREEI ADDRESS, CITY, STATE, i".Ir CODE
BETHESDA **HEALTH AND REHABILITATION**	**5721 GROSVENOR LANE** **BETHESDA, MD 20814**

(X4J 10 PREr'IX TAG	**SUMMARY** ST/\TEMENI 01' DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED fIY FUtl. REGULA10RY OR LSC IDENTIFYING INFORMATION)	10 Pl·H.:FIX ·1AG	PROVIDEH'S PIJ\N OF COHRECTION (EACI I CORRECTIVE ACTION SHOUI D lIE CROSS-RF.FF.RENCED TO THE APPROPRI/,TE DEFICI[NCY)

F 689 Continued From page 12

F 689

he/she did not know who t11e unsafe smokers were or what level of supervision those unsafe smokers needed.

On 05-08-19 at 9:15 PM, interview with the administrator and DON revealed no additional information.

On 05-09-19 at 12 PM, an immediate jeopardy to resident's safety at the smoking area was determined.

On 05-09-10 at 9 PM, the facility provided an IJ Removal Plan to the surveyor

Based on the plan of corrective action , the taci1Ity educated al! the facility slaff, ·Nho v,ere des;gria *k :d* lo I nor,i tcr srno H19 foi \VeekJa·:,- s, weekends and holidays about the responsib1lit1es of the assi nment The smoking monitor duties include reporting to and picking up a smoking book from the nursing home administrator or management designee. The smoking book containE:o a list of all the smokers with the level of supervision and assistance required, and a tool to document the monitoring of the smokers. The nursing home administrator or management designee are to visit the smoking area periodically to ensure that the monitor is physically present in the smoking area. The smoking monitor is to document any issues during the smoking sessions and report the issues to the nursing home administrator or management designee. The nursing home administrator will bring any issues to the monthly Quality Assurance Performance Improvement (QAPI) meeting

On 05-10-19 at 3 PM, the I*J* was abated following

SrATE:MUH OF LJU'ICIENCI[S /\Nil PIAN 01 cor<HECTI0N	(X 1) PROVIDERISUPPLIEWCl.11\ fDENTIFICATION NUMBER	(X2) MULTIPLE CONSIRUCTION	(X3) I) t,1 L '.oUl•;\'f,· · r,(\fi.11·' F TF 1
	215187	A BUii DING B WING	C 05/1012019

NAM[OF Pf<OVI0En cm SUl'f'UEH	STREEl ADrJr,ESS Clrv . s f/\T[, ZII' com:
BETHESDA HEALTH AND REHABILITATION	5721 GROSVENOR LANE BETHESDA, MD 20814

(X4) !D P :Ei'IX IN3	SUMMARY STA/"EMEN I 01' llEFICIENCIES (LACH DEFICIENCY MUST BE PrlECE'DED BY r-ULL Rr:.GUI.ATORY OR I.SCIDENTIFYING INFORMATION)	IU PHfflX rA1:;	r'fl.0'/iDFf<'5 PLNI Of' COl<IH'.C; ;()t J IE/\CH COl,!ll.'C flVE 1\C nor1 SHO\JU, m Cf 0 SS-REFEP f:NCED ro 1HL: f,f"-'Pi\(; Dt. FICI I:.N•;
F 689	Continued From page 13 the facility's implementation of corrective actions to ensure that all unsafe smokers receive direct supervision at the making area.		
F 867	QAPI/OAA Improvement Activities SS==E CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assuranr,e committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies: This REQUIREMENT is not met as evidenced by !3ased on surveyor review of the Quality Assurance & Performance Improvement (QAPI) program and the monthly OAPI Committee meeting and minutes, and interview with the facility staff, it was determined that the facility's OAPI C9mrnittee failed to implement appropriate plans of corrective actions . The findings include: On 05-10-19 at 1 PM. interview of the staff development nurse revealed that monthly QAPI meP.tings were held on 03-28-19 and 04-25-19 after the annual recertification survey was completed on 03-15-1 9. On 05-10-19, review of the QAPI program revealed that the QAPI committee must maintain documentation and demonstrate evidence of its ongoing implementation. Documentation shall include, but is not limited to, QAPI meeting agenda/summary form, the root cause analysis form and pertormance improvement Project Form. Further review of the April 2019 QAPI committee	F 867	867 -What corrective action will be **accomplished for those residents found to have been affected by the deficient practice:** Smoking in services have been provided to all staff who are monitors of the smoking area **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** Any resident who is in the smoking area has the potential to be affected. Smoking in services have been provided to all staff who are monitors of the smoking area. 7/5/19

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215187 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING

NAME OF PROVIDER OR SUPPLIER: BETHESDA HEALTH AND REHABILITATION

STREET ADDRESS, CITY, STATE, ZIP CODE: 5721 GROSVENOR LANE, BETHESDA, MD 20814

F 867 Continued From page 14

meeting and minutes revealed that in services/training related to "safe smoking/Tobacco use "was provided to the facility staff after the annual survey On 03-19-19, the staff development nurse provided safe smoking/tobacco use training to the facility staff

However. interview of the staff development nurse on 05-10-19 at 2 PM revealed that there was no plan established to determine when the next safe smoking/tobacco training would be offered to staff who could not attend on 03-19-19

[illegible] smoking [illegible] monitor's schedule. the evening nursing supervisor, who worked Mondays thru Fridays, was responsible to [illegible] sessions [illegible] supervisor was assigned to monitor smoking sessions between 7 AM and 6 30 PM for the weekends and holidays. The weekend evening nursing supervisor was assigned to monitor smoking for 3 smoking sessions between 5 /45 PM and 10 PM for the weekends and holidays

However . no plan of corrective action was developed by offering in services/training to the designated staff members, who monitored the smoking area during the weeknights and weekend nursing supervisors. See F 689

On 05-08-19 at 2 PM, interview of the staff development nurse revealed no evidence that the weekend evening nursing supervisor received in services/ training related to safe smoking in March 2019

On 05-08-19 at 3:40 PM, interview of the evening

F 867

What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur:

All staff who are smoking monitors will receive education by the Staff development Manager on the smoking policy and procedures prior to monitoring smoking sessions and biannually. An AD HOC was completed on 5/22/19. Any issues noted concerning safe smoking will be brought to QAPI monthly for root cause analysis and resolution.

7/5/19

How the corrective action(s) will be monitored to ensure the deficient practice will not recur:

Director of Nursing will maintain a list of all smoking monitors that includes the date of their initial training and biannual training. This list will be updated as needed by the Staff Development Manager. The ongoing education, safe smoking concerns and monitor list will be discussed monthly during QAPI meeting.

F 867 Continued From page 15 F 867

nursing supervisor, who worked Mondays through Fridays, revealed that he/she did not receive in-services/training related to sate smoking.

On 05-09-19 at 9 AM, telephone interview of staff #3 revealed that he/she was the designated personnel to monitor smoking between 7 AM and 6;30-P-M.for:.the.-weekends.and holidays. However, *staff* #3 did not receive In rl.esttra11fn!1 r-elaled,-lo safe:,sln oklng.

On 05-10-19 at 2 PM, interview of the Administrator and the Director of Nursing revealed no additional information .

Office, of [l ;;J [1:c: clni A!! lll y

S TATCMEIH 01' OF.FICIC:NCI(:) ANO PIAN OF CORRECTION	(X1) r n OVIOER/SUPPLIER/CLI/\ IDENTIFICATION NUMBER	(X:>) MUI TIPLE CONSl RUCTION	;/.:: IIId {. ¡ I!' (;(HJI•·:
	215187	fl WING	C 05/10/2019

NAME or PROVIDER OR SUPPLIER	S1REE1 ADDRESS Cll Y SlA1 E'. ZIP COLJI:
BETHESDA HEALTH AND REHABILITATION	**5721 GROSVENOR LANE BETHESDA, MD 20814**

(X) 10 PREFIX TAG	SUMMARY SIATF.MENT OF DEFICIENCIES (EACII 01:FICIENCY MUST BE PRECEDED Y FULL REGUU\TORY OR LSC IDENTJrYIN G **INFOR MAI** ION)	**ID** PREFIX lAG	PROVIDER'S PLAN OF CORRECTION **(EACH** CORn ECTIV I:. ACT ION SHOULD 0£:: CROSS-REFERENCED TO THE APPHOPfllfll (·_ DEFICIENCY)
s 000	Initial comments	S 000	

On May 7, 8, 9 & 10, 2019, an on-site investigation was conducted at this facility by the Office of Health Care Quality (OHCQ) to investigate one facility reported incident MD00138759 and three complaints, MD00138541, MD00138071 & M 00139809. Survey activities included review of clinical records, inteNiews with Ombudsman, residents and the facility statf, observation of staff practices and review of administrative records. In addition, tliree adc1iti6nal facility reported incidents were investigated on site.

On 05-09-10 at 12 **PM,** it was determined that t11e faciiity failed lu pr uvide cJfrect supervision in the smoking area for unsafe smoke rs, which were assesf;erl 2ncJ identified ba sed on the fa cilit y's safe smoking assessments. After the facility reported incident on 04-30-19, the facility failed to conduct a thorough investigation and to determine whether the current smoking monitoring system in the smoking area was AffP.Gtive or not In 9ddition, the facility failed to define the expectation of direct supervision in the smoking area and to offer training to the designated personnel, who monitored the smoking area . Therefore, an immediate jeopardy to resident's safety in the smoking area was determined

On 05-09-19 at 9 PM, the facility provided a plan of corrective action to OHCQ The immediate jeopardy was abated on 05-10-19 at 3 PM following the facility's implementation of corrective actions to ensure all unsafe smokers receive direct supervision in the smoking area.

On 05-10-19, an extended survey was conducted ! **ased** on the determination of the immediate

OHCQ
LA Olt ATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Ora d'Nelle Hoffman — Administrator — 6/3/19

- /\1EIORM — FHNITH

Jf111:(: o f 1le:rnlll_lt:.i1, II,111111

-TAf U iIENI OF DEFICIENCIES - (X1) PROVIOER/SUPE- ERICLIA MBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY
- NI) p L.ANOf CORRECTION IDENTIFICATION A IJUILDING: ON,\n111cr10N COMPLETED

215187 , B WING

NAI.IfOF PROVIDER OR SUPPLIER -S iR€Ei ADDRES S

B tiESOAl lEALTH ANO REHAB LITATION : 7 21 GROs v EN ·;; 'f, STATE Zif' CODE E_THesoA fv1D LANE 20814

SUMMARY STATEMENT Or DEFICIENCIES (FA.CH DEFICIENCY MUST EH: f' RECE OED O'y- HE.GUI.ATORY OK UC IDENTIFYING INrORM -.-- 4l.J -1.... I_ I0 F'TI(:"FJ TJiG <=>rv; (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

S 000 Con ti nued From page 1

jeopardy *to* resident's safe ty at tl1 on 05-09-19 at 12 PM. smok:, r-, 9 area S 000

This survey did nol identify non-co mplla n c:e Federal requirements that were reviewect n relationship to the facility reported incident MD00138759 and IWO complaints , MD0 O 1 3,85 & M000136071 'vvitr, .q 1

S 506 10.07.0 2.12 0 Nsg Svcs;Care 24 Hrs per Day S 506

12 Nursing Services.

O Nursing Care-- 2i1 H our s a Day. T here shau suHcienl licensed and supportive n ur sin g s e rv · be personnel011 duly 24 hours a day to provide tee / appropria te bedsicic care to assure that *each* patient:
(1) Receives treatments, medications, and diet pescribed; q s ,
(2) Receives rehabilitative nurs ing care as needed; J
(3) Receives proper care to preven t dccub it u s ulcer s and deformiti es;
(4) Is kept comfo rt able, clean, and w ell-gro o rne d-
(5) Is protected from acci dent, inj ury , and infection:
(6) Is encouraged, assisted, and trained in self-care and group activities

E F610

This Regulation is not met as evidenced by:
Refer to CMS 2567
F 689

5 1836 10.07 02.45 D QA Pgm;Committee duties s 1s 36

l!Cl1.!_l l}l/,1(1(•:
EfICICNCI!:S- ilRECTION

(.X1) Pl<OVtOERISUPf>ll ER/ •.;11/\ I01:NTlr IC.ATION NUMBER

215187

1'?) MU, TIPU: COI S'TRUC1101/ A BU!LOING U WING

(05/10/2019

1DCR OR SUPPLIER

HEALTH ANO REHABILITATION

STREET ADDRESS, CITY. ST/fff., ZIP cont
5721 GROSV ENOR LANE
BETHESDA, MO 20814

SUMMARY ST1,lEM!:Nl OF 01:TICIENCICS (EAC 1 OEI IC:ILNCY MUSl IJ · l'l Cr, I ill'O IIY FULL REGU l;. rt m y OR LSC !LIEN fll Yfl I 1111 ORM/11ION)

10 PR!:FI>' T>\G

prmv10ER'S rl AN ur COi 1<t:C1'i()N (C·A<,H COl'?RE(;i /C /ICTION SIIOULD fl . cnoss-RffERENCEO TO fHf-: APl'R(JPRl,llc fJLF'IC\CNCY)

Continued rro111 page 2

S1836

.45 Quality Assurance Program.

0 The Quality Assllrance Cammi lee. "fhe qualfty assurance C<Jmmillee shall:
(1) Designate a chairperson to manage committee aclrvitie s;
(2) Meet m onthly to accomplish quality assurance ac tivi ties,
{3) Assist in developing and approve the facility's quality assurance µtan;
t•i) : 1ll1n1t th, qu·-hl y assurance plan lo the l)'"!p;:irtm0nt· Of!icf' of Hcallh are Ots:ah(at Ille • of H ,1w urPc, at the 1111,e of license renewal;
(ti/ ' u 111 t , 1 <-' · y, in the quahty assurance plan lo U1e Ofkc ul I It.,,. r- lli,Cjlity ' /ll.lJin 30 Jays of the U1ange,
(G) Review and apprnve the facility's quality as urnnce plan at least yearly; and
(7) rrcpare monthly report.s for the ombuds1,1rn. family council, and r esidents' council

SEE F689

Th is Regulation is not met as ewJenced by
Refer to CMS 2567
F 867

S6350 10 07 09 15 D (I) lnve,st g <'!t1on s,lhorough

S6350

SEE F867

15 Abuse or Residents

D lnvest1gatIons. A nursing facillly shall.
(1) Thoroughly investigate all allegations of abuse.and

This Regulation is not met as evidenced by.-
Refer to CMS 2567
F 610

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215187

(X3) DATE SURVEY COMPLETED: 05/10/2019

NAME OF PROVIDER OR SUPPLIER: ... HEALTH AND REHABILITATION

STREET ADDRESS, CITY, STATE, ZIP CODE:

5721 GROSVENOR LANE

BETHESDA, MD 20814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

DEPARTMENT OFHEALTHANDHUMANSERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

ST/11(.u(Nr M OUUHCICS N' iO Pu.NOI' CORRCCTION	(Xlt PROV,OCR/SOPPuCIVCUA IO£ NflnCAI l()Ntt,,IU8(R 21518 7	001UUlflPIEcomrmucTION "- Ou:u)(NG o v, 10	fXI) 0.-.TE S UR\'tY COU.PtCICO C 1012412018

tu..u(OITffiO'DCft00 SIJA't ft BETHESDA HEALTHANO REHABILITATION	S 1lt((!I Cff Y.:}11,lf. "lJPCOOC m1 GROSVl:!.NOR LAH[! BETIIESOA. MD 2081-4

()(,(j10	{£,\ SOw.i.AAYS IAT(M(.Nl Of OUU.UOCS CH OUlCICNCYMUl t OCPRCCCOCO OY rutl RCG TORYORLSCIOEtffIFYIHOtNfQfflUITIO"l	10	PRO'roCltS PI..NiQr COAAECTIOU (f.l,Cti COOAECl M;;J.C1'0tl $HO\.ltO OE Clt0 $ s.¥tC/(kt HC(O TO 111(APPAOf>RIAlC OErlCIEt«:Y)	(Olol"\l. l

F 000 **INITIAL**COMI.IEITTS — FOOO

On 10124/18, o survey wos conduct ed nt lh ls facikty by tho O !f!C(!of Hoalt h C-aro Oualtty to lnvcst,gatocompl.!tnt #MOO013 1155. Activtiies lndudcd the lntcivlcw of the focility'sbus.!nc,.s office personnel and an oudit <1f the 1e i ldc n1s person.al fund s rCC()(d S mntntil 1ncd by !his fal ity woro aud1t0d to dotomllnc *it* any rcsidenrs p<?rsona l fundshad bconmisused or misapproprfatedby this facility.

The compl,1lnt W.1$ sub s.tanti 11tod . lh ! s SUt\'Oy ldonti fted noncomptianco with Fedcml rcquircmon1s tho1wore rcvicwc-din rcl.".llionsh!p lo the complaint. (SEE F5GB& F509)

F 568 / unling r,.nd Reco rd s of Personal Fund s — F 568
SS,,O CFR (s) : 483 . 10(ij (10) ("')

§483.10(f)(10)(itt) Accounting ond **Re<:0tds**,
(A) The fociltty mustcslabhsh nnd mainlnln n s-r-;lem lhm assures a lull ondcompk!tc and :scparalo aceoor1ling,3ccordmg to goneraUy 3cccp!cd 3ccounting principles,of each res.idenl's pe rsona l fund s en trusted101he focilt1yon tho re s.lde n1's be half,
{B) TM sys?Orn mu !it precl ude any co mm ingling of ro sklontfunds'Mth facilityfundsor with the funds of ony person other than anolhcr rc'S-idc n t.
(C)Thc lndivlduol financialroço d must bO nvai!.'lb!o 10u,c rosldonl through quarter1y stnrnm onts ond upon reque st
This REQ U IREMENT is not me! as evidenced by;
B.osod on u,o rovlcw, *on* 10/24 /18 of the rcskt cnt r.'personal funds records. including lnd1vlduJorcsl donl's account S!atomentG. tran1.1ctlon ,opo, ts, tra nsactionreceipts. undon tho lntoMOW of the facility's bu siness off

l.AtlORATQRY OIACCl OO'SOR f>F(M O(Jt/S VPP\ .l{ R Rt P fl(!;(HIA1M'S WlU-U: 1ULC (X6) DATE

A.try ncy nt Cl Wlhat'!-11'W l'l,kl') dcnc)t.M., 4el Wf'Iu,,eln m.-,be!>e, C-1,/1,C0 tromC,O1«t#IIJprov,dr,:iCIS tcmlnoc:I N t olt>ef wr0, i)tO'ride,..trdt-nl P!ott-«iOl'I10 lJlCtp, t,ona (Scio ,.} E,«P(IOf nurw-,g the , m!c<I.a -e.vcd 904.:1,, 1 :oora...-w,y...r-.«heror nQt.apunoe cor1ectJOnb. pt ror nutlW,,J . the f.t'IO"O\ al"<lo&,a,ns OIOQlt ealon.1,0c, 1 d the le 1,eoo(•10 av 0 tho IQl,ty ll d¢!;denoos.arc« ed at\ .ipprcn<edpb.t\Clf cor,ectonb.1 \.IMe0 ClOl'lbrlued P,O!)Wfttltdc»tlQn

DEPARTMENT OF HEALTH ANO HUMAN SERVICES
CF.NTERS FOR MEDIC ARE & I.IEOICAIO SERVICES

SI AI S,II; N't Of OEflO EUG-lfS AHOP\.NI Of COAA(C JKIH	(X1) Pfl0"',".o(R.1$ I.IA 1oc, m r 1CAnoN NUIAIC.R 215137	('(11IAlll lPl(COUSTAI.IC IIO N' A..OVIl,l)IPl(l, 6 WING	0(1) 0,,\TCSUfM:Y COIJP\fT[.0 C 1 012412018

, w.ic.or PROV.OCR OR su r PU(R	STRUT"1)()ftE-SSCftV. $1All5:,D fl C:OOf:
BETHESDA HEALTH ANO REHABILITATION	5721GROSVENORLANE BETHESDA, MO 20814

PR(flX IIIO	SUUJI .ARVSI AIfl .lUIT Of"DCf1CltNICES (l:..U:!:1 D(I ic.:uc:vw r DL Att:C(O(OOY (LU R!CUV.TORY 00 I.5C1oc,mn'INOI."'10RLAI()H)	IO M\UlX IIIO	l>RQ'."IO(R'$ P\A '4 Qr C() IUll;C tl ON lt!ACUCOAACC IM: ACl lOH •OUU>0[! CROss.ffErtn ENCf.O10 THCAf'f'nOPRl<TI; O(f.C.:,,CY)	W I
F568	Continued From page 1 personnel.this fnciJ1y foiled to main1ain o syslom thnt ensures a full and complc!o accounting ol u,o residon1·pcr na!moiresortru5tcdtoUl-s fo cilrty. Findings inciudo: 1. All withdrawals ol rosldonts· pc1$0a1funds ....-ere not oppropriatotyauthorizedand/or witnessed, 2. All withd rnw.:t!!lof ro:sidon ts· P<lsonal funds were no t recordedon oppropri.otc tro.ns.ociion receipts , 3. Thfs Ino lrtyd o d the indlvidul'.11,in t<HOSt carnJng, por sonol fund occount for resident 4Aon 1119/1,7 The reside nt's $200 .28 closing botoncc WDS tronsfc m x:I by lh c facility lo o non•intercst bcnring, poo5od. pall y cash chocidng account A.s of 10/24118, tho rosldcnr s pcr"..onal funds rcma!ocd in the non,intercst bearing account	F568		
F 569 SS•B	Notice and Conveyonce of Personal Funds CFR(s): 483,10(n(10}(iv)(v) §483.10(1){10}{iv) No!lCCot cc ,u, ;n bolanc cs . T h o facl tlty m ust notifyeachros cnl thol receives Uedic{Jkl benefits· (A) VVhcn !he nmounl in the rc-sldonrs ou, t , coehcs S200 less than the SSIresource limi1tor one person. spccifM:d lo section 1G11{o)(3){B) of u,oAct: and (6) That.if tho amount in the ;:iccount, in addition to tho value of the resident's other nonc x:cmp ! resources.rc3chcs the SSI rcs.ourcc limit for one per son. the ros ldont may k)S.Q cbgibdy for Mt?-dic.11d or SSL	F 569		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) OVIDEr,ir.;uf'\f'"IJffi!'C cn l(:.!!. 1 , 215187	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED C 1Of2412018
NAME OF PROVIDER OR SUPPLIER BETHESDA HEALTH AND REHABILITATION		uu: (IT A.D,C. CITY, STATE, ZIP CODE 5121 GAOSVEHOR LAUE BHM B:SDA. **MD WB1,t**	

(X4) ID PREFIX TAG	SUMMARY STATEME!ff OF IX fl CIU S (EACH DEFICIENCY MU:!ii I"f i:; !JttUTII F-1,11. REGULATORY OR I.SC IDB ff lf 'Y! , OR.MA	ID MU lliG	I!!R O'II'I()[;R"S flt.AN Q COFIfilCTION I CO m:c;ffl:'f: I5 MOIJ.D I:. IU:.J" R Ii 0 iH i.IJ CIJ;lfU/1, - DEI. CVJ	(X5) COMPLETION DATE
F 9	Con'!In dl F tom pa - - §45310(1}(1 il)M Con'.'cyancc upon dJS1Coorao. t.on or dea.Ui, Upon tl'i.e, d oo 9 , . ..'cooo, or.- -11Jl llra , sld{!ln\I.;'.:ith a pe- oruu I'" a: dcip0 s d wi,11the fIllci1i1y. the raei.My m111s1 oon flt 'Wim :I(I11. rS Ua e re si.dc-nr". f1m d . ar1d a ftnal eco1J1nfng o .. ·" f ulfllj _ 'to h,e ont r In the c.a c:Qf doolh, e nd l'.llu Iio, f!cl(l'b te, uris didicin a;gmn-, .e" ng th e m s.ldort'!l. .. tlllc, m accoroa wilh SIattl' lIliw This REQUIREMENT is.nol. met as. c d'i:mood li Based on "o tJNJ·., oo 1Clf2411e,-ci1 lt o !JC onal ftmcf.. re-cords Or dee.ea 00 and d sch rgoo' r - de:n s.,. rlni:lu d'in;g i:ndivfdual le k!c1l1r acc oufll u mmmi cs, closed aecolJlnt ..Ulrrtrn,lni !ii, fedom or, ummi:ui . limnsac6on mport'i arid on it r; c, (I in; nc ty's ttu ne5,.. c:flm p rSCJn n I, th,,. rai:i!tty ,rasoo to COfL'!,i'.[j '!Mthi n JO days . a f r.l!1onl' il'SOn<lli runds filn.d. u rill .ccouncinH or tho c ruind 10 tho ili:livid ilil o-i p r oba1 juirM liCtion d.'minis. fing the m'" ci' nl';. os!□.1.e _ **Findings include:** 1 R d: flt tA.rnqi roo on ______ On 12J2/U3. thi 5 f - 1.mm,f erroo S1'19 00 rrom th r ec•r:s pa On.iii (und ai:.c,cu n.t le a fm:i ty aci:ou,nl - a co,,,.\ 0·1c re p,.i] r11ori !i>r 12/10 Toe m ap,p op atcd rc ent - m:!l-0 n rumi \!/Cr ot de - ted oocil: in-nc lh e n:is d':mu's pO i;l!ri, I f,,lnij .gC¢C! qt Ul'!til 111.27/17. 2 Resld□il'U. 2A . -pmdon ______ Oni [redacted] **this facility** lmlfl sferred $4:2'7. OD rrom ttta n: Sid' 11t' oruil f 00: !I r:cctmt o a far:ilitl'f aceaun s _to t r care p,a:,im ; llil for, e. Th, cost or cm o rp.a □il'Il. ror 6118'!N.lls nol. _8iJKI i>1:cd oocii:: i n.to th ms. d',1mll personal rund	F 009		

DEP/\RI M ENT OF 1-l EALT AND HUfc.tAN SE!IR\!'ICES
CENTERS FOR MEDICARE & MED1Ch ID_$ E ..3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT lftt.il,'ff'J N NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1151.1117	A. BUILDING ll WING	C 1Cl12412£11 B

NAME OF PROVIDER OR SUPPLIER

BrnllESDA HEALlH AND Rl:HAOILITATION

5 REET CIT'I', n\ra Zll' ootl.
I G1R05.VERCR LiUH:
9E1Ht!SOA. M'D :20814

SUWi.AAY STATEMENT OF DEFICIENCIES CEA!:• IO[flCIENCY MUST BE PRECEDED BY FUL EGLI OR'I" OR LSC IDENTIFYING INFORMATIOI		PROVIDER'S PLAN OF t: o«mll: I (EACH CORRECTM M:1IDN :jJ IOu W CROSS-REFERENCED TO THE APPR l,ol;T DEFICIENCY)	(X5) COMPLETION DATE
F OO'lil Continued From page 3 51CCOt,irl\ ui:l bl 1011at18. 3. Res dont 3A ,ex red tm On 311 . nd 312/113, ,. . ffi r:ilr 'i ttn f-l< tette!;J lCU o1$932.5.1 r,om m fiO',i; d1,1nr :si p r$(1n a1 fund a:ococunl o a ra ,1 mcoou 1. as ,m co;,.t ,of cm [P-l])'m ifll for 3l'18 . 01 i 0'2 116 there vm5, no '.'iden lh:ait ll'!e cost ,o1 ctii'e, 0._icrpr1:,1n4!nt O 3/18 lrnd oo n depot:ll;Uo,d b -ck JUo Um ri!! ldo:n.t .. pcri1Cl:rl81 ,Uind ;mcco1J1U re undcd rta the r frS tll.tc .	F509		

Olf.ico ofH ca!thC are Ounlit

S MH:UCN' OI OUICCNCICS /l);QPI.NIOf COA:RCCTION	1X1) PRCMOCRISumJCA.Cu,, IO(Hl lr lCAflOH NUutl(R.. 215187	00,MULTIP\.C COH!lTRUCnc>H A l)lJllOtNO I) \',\NG	(X.))OAJE SUR\ftY COUPt.61ED C 10124/2018

I t,\J,tf Qrf'ROW)(RQRSVf' Pl.l(R	S 1Rt l; I NlOFlt.::S,Clt Y, OlAl,ll ZIP COOC
BETHESDA HEALTHANO REHABILITATION	5721GROSVENOR LANE BETHESDA. MD 20814

()(4) 10 PRl,:Jot TAG	S Y S IATCJ.\CJH Of"o(IICl(HC1c:: lf.J,CIIOCflCOICYMIJ!lf 0C PRCCCOC.OUYnJ LL R((lU I_Al ()flYOft L$CIOOHlfYIOOtUf' 1JON)	''' PRmx	PAOV2DCA'S Pl.NiOf COA:RCCl lOH (E,\Ctf COfUtCClfV(.-.Cll ONSttOULO6E. C»o IU'.f(HtHC:CO t0 1u t N'AA III l)(nc,cNCV)	();1t c:,()l.n.Ctr, OM<
S000	In1il)I commenl$ On 10/24118, n survay was conduc.1cxs a1thi s fociMy by me Otncc or Hc.ohh Core Ou3Uty 10 in ves tlgo le com ploinl t:M000131155. Activities i luded the in:crvicw of the h1cll1y's business o!hcep(H$0nnleondan tluddot tt1c rcsid ent1f pc1:o na1funds records maintained by this toc.llly were oud1cd to determine if ony 1cskfenrs per$0nt1l funds hod been misused or misapproptiatOdby Lhi s focahly. The com pla i nt wossubs1antiJ!c.d This survey identifiednoncomptioncc with Sto:c requirements tmll were,cviC\\'Cd in relationshipto lhe compl alnl. (SEE S(V,GS $6480, S6520, S6525 $6540. 56565 & S6580)	$000		
so-co.s	10 .07 . 00 .18 O(1) Ptolcetro-1lun<fs: ox cc1sof $SOnt bcDring .18,P oicction or a Rosidonl's Personal Funds. 0. Personal Fundsin Execs::. of SSO.A nursing facili1ySholl: (1) Deposit o residen't s pcr$0nul fundsln cxcoss ol SSC in an i n tcr st-bonting account thatls: (3) E::stnblishc-d andn,olnm!ned by tho facaity under one *of* tho lollowing terms: (i) In tho nameof the t0$ldenton!)'. {II) In the nameof u,c focaMy·m tiu a tor" 01n.s tho -Uu:Uoo" for thoIndividual resident.or (iii) In o resident$ pooled -.1ccount. with -.1 jse ?{lm!Coccounlingforctieh ro-:il.dont's shoro: and (b) LocatedIn a finonci:Jl institu1ionwhose occoun1smo insuredbylho; (,)Fodera! Depositlmi.urancc Co1p0an,on(FDIC), (11) f edora ! Savings andLoanInsurance Corporolion(FSLIC). or (iii} Otherinsurer approved by !he Dcp.1r1mcn1:	5040.5		

'''1CO
1I- ROffAlOFIY()Ut,:c, ()A PHOVIOf ... 4 Ht r SC•1r1,l l\'('$$1GJ,t.l,lU«tf T ITl (

::rArO.tWr or OUlCIC.HCICS NfO Pl.NfOf COORCCTIOU	!XI) PRO'.l'OUVSUPPUC IOCm nc;AllON1'VU8ER. II. 2151B7	O:, ,MU.Tll'U.COl ISTRUCTOH A 0Vl0C40 n v.\HG	(X)) O,\TE SUINl:Y COMl'UHl D C 10124/2018

WJ.IE Qr f>ft(MO(ROffSUPf'UtH BETHESDA HEALTH ANO REHABILITATION	SIR(llt AODHJ!.$S.C11Y. :; 11,1e_ DPCOO(5721 GROSVENOR LANE BETHESDA. MD 20814

At r IX TA()	SIM VARY S I.AICNl.HT0(OUICICNCIC lCACIIOCJlClc.ttCYUOSTOCf'n t Cf OEOIJVr\ll.l H(OULATO HVOH l$C 10Cut lf.YINC ltif OfW AI IOf >	,O PAE.rot TA()	PAOYIOCR'$ Pl.AHOf COAACCTION (CORRt:CTMACT)()NSHOUlOOE CRO ·RU CR(UCCO TO111; APPR 1C OCf'lCIENCY)	tlo'IU.
56405	Con1inuc-o Frompage 1 Ond (c) Separate from onyof tho nurtiing tocility's opcrntingoccount:sond This RogulOtlon fr.not molas ovldonccdby: SEE F566	50405		
$6480	10.0 7.09.18 F' (1) Protc-ct res rund s;estob res OCCI ,18 Prolcctk>n of a Rcsidcnr s Personal f und . F. Establishment of Resident Accounts. When o nursing tacifityman-09cs a reside nt's fina ncia l n ffnirs, the nurs.ng faci li ty shaUbsU1blsh and ma!ntoin a system that: (1) Ensurc.s o fulf. completeand scp,iu:i:o accounting. according to gcncrollyaccepted accounting principles,of each resident'spersonol funds.c ntrur,ed to the nursing tttc1lty: and This Regulation Is not met os cviclcnccd by: SEE F 568 t F569	So-180		
50520	10.07.09.19 8 (1) Recs POI$ Fund s;Rcceipls . 19 Re cords of Resident Personal Fund5-. B , R C!GCipts of Tr t1ns.1ctlons. {1)11a u ons.actlon Involves a uonMer of funds bot'Necn a rosldoni and o s.econd party. or botv.wn the nur5,lng focil 11yand the institution In which lh c i esldcnr s a-ccounl is Socn:cxt, th e n u rsing foo l11y or linanclol lnstitullon $hOII. {a) P, ovido a receipt or copyof a teceipt to the resident.0t rctn!n tho res,ldcnt's copyof the rcccipl as part o! thornsldcmrs in dr. ldu ol f,naocial	Sllsi<>		

Office of Hctrl1h C{lro Ouali1

S TATCK UT Or Df nc,fNCICS AtiO l"V,.N Or C OfUt(CIK>N	(XI) l'ftCMO(HISUPPl.lt t«;.I.IA 100 I lrlCAlION PiUUO(ll 21$187	()O')MULl lPl,[COHSI RUCIIOlf A OUll OIHG B. WING	(X3) DATE SURVEY COMPLETED C 1012.412018

NAME OF PROVIDER OR SUPPLIER	!ll R(fl AOOOC . CITY. $1Al f. ZJP COOC
BE THESDA HEALTH ANO REHAOIUTATIOH	$721 GROSVENOR LANE BE THESDA. MD 2081C

"" t nx l Ml	(C,.Qi OG ICI: HCY UU$I oc PA:CCC.OCI) OY rut t SUu.t.t.ARVSTAl l;.Ut'Nf Of l)(nt: l(NOt S R(G IA.AI OR'T'OR LSC:ll)fKTln'I NOi, l'f()fW.A.T)OU}	Gutot IIII	(CAC I! COAA!C.I M ACIIOH S IIOUIO OC Pfl O'i,l',0(.lfSI'IAN Of COfUtl;CI ION CRQS,S,.At;r ERt::NCED10 1li E APPHOPfl.Vl.f; OU>COC<)	(X5) COMPLETE DATE
sosi o Continued From pago 2 record; nd {b) Moinla!n the original receiptnnd m:,ite it availablefor nud1L This Regulation tSnot mo1as ovldonccd by: SEE F568 56525 10.07.09.19 B (2) Recs Pors Funds Ro-ce!pts.signcd . 19 R CC,Qr d s o f Rcs.ldcn1 P c rso n aJ Fun d s, 8. Receipts or Trn n s.nctlons. (2) Except asprovide-cl i n §8(3)of thls regulation. a nursing focilt1y shall require tho: coch receipt tor Wflhd rnwaloffundsf,omnrcs.kfont's i'aCC:Ount bo slgnOd by tho , o-sktont or. when applicablo, tho ,osldont's agent This Rcgu13tlon Is not mc1os cvldcnccd br, SEE FS68 SG540 10.07.09.19 6 (5) R ecs Pers Funds.:2 signatures wi hdrOW(-.11 . 19 Reco,<1s of Rosklont Personal Funds. B. Rocelpt.sof Tr {)n c:ion,s (5) A withdu:rwal under §0(4) o1 th1sregulation requires witness sign.atures of two focitity cmplo)'CC-S outhorizCd by tho filciJrty •dministra!or.	SGS20 S6S2S $0540			

STAI ISU.Gn Qr O(FICI(NC¢S AUOP\AA()(COAA!C UOU	(I(I I f'ftO",...otMUPPtl(RICUA IOOHWICAOOHN\.WOCR. 215187	(XJ)MUll lf'\ECONSTRUCUO H A OUllDu,IG B \',"'G	00) OATE SURVEY COUPU1l l!D C 10/2412018

w.l.l£or PRQVIOCHORSUPf'Uf.Jt
BETHESDA HEALTHANDREH.A.BIUTATION

Sl R((;l AOORtSS.CrTY. STATE.Zif'COO£
5721 GROSVENOR LANE
BETHESDA. MD 2081.t

1):.4) 10 Pl<[f ,X TAG	SI.MIAARY:n AT(Mrn r O' O(rIOEHCJU (U.C II OCrlCICNCYMU:lt BCPACct OC0 0Yr u LL	,0 PAD'IX	f'ROVIOf:R'S l'IJJfQf' CORECI l()H (CACH CO RRCClrVCAl:.TIONSltOu l.O CC OEn<;l(NCY)	COOMU:«
SG5-<0	Co n tinuC<l F ro m pngc 3 This R ogut.ntlon is not mc13s evidencedby; SEE F568	$6 5,,(0		
S056	10.07.09.19 E (1) Roes Pe,s f' und ;Ocau, of Resident ,19 Records of Ros.ldon1Personnl Funds. E. Dcnth or a Ros.icfont Upon tho doa1h of a rcskjc nt for whom a nursing facility is holding funds. tho nurzing fac:il.ity s.hnU notify tho rosidcmr s ag n t 01 lnt o rostod family member nnd: (1) Convey within 30 dnys a finnt accounting or tho ro$kfon1's person.ti funS:wh ore depo $1ted with tho nursing faci!1ty: TorSR&guli'.1b on Is no t m e t as a vidonCOd by : SEE **F569**	SGSM		
SGSSO	10 .0 7. 09.20 M ur..o R o-sldo nt Funds ,20 Misuse of Rcskfonr s Funds. A A por5an may no! m!soppropr1a10a rosldon't s assets or income, Including spondfng lhc r es.lcfonr s a ssets orincome nga!nst Of withoutthe residentorrcS4dent's ag en t's co n s-ent.exceptos pormittc-d by Regulation .1DB(4) o f this chap:or. 8 . A person whobehoves thol lhe, o hos been an abus.c of a rcsldcnrs funds maymake a complaint lo tho: (1) Localdopa1tmon1ol al oMCOs: (2)) Oirec1or of the Office on AgingIf the resident is 65 ycnrs oldor okfor;o	**SOSSO**		

STATE NTOf' IXf'lCIEHCIES ANO PI.AN Of' C()AA:(CI ION	(XII VRO..-tt>C PPU(J IOC.tm n CATIOU NVUBCR 21 5187	()0)t.tUll IPL(COOSIAUCflOH "' Wit.Omo 0 \' ,100	00) 0,\ 1(SURvCY couru:TtO C 10/2412018

Of'Pf.U)Vo0£ R OR !)U f'PI(R	Sffi([ilAOORfSS.CfTY. STATE. Vf'COOE
BETHESOA HEALTHANO REHAOLIITATION IIIIIIIO S UIIILIAR"I'Sl ATl}:U{ NTOr Ot nc;J(N S	5721GROSVENOR LANE OEIHESDA.MD,20814 PRO\'IO(lf$ *PVJ4* or COAA(ClIO N 00)

PffEFIX TMl	(f.AC.HD(fl Cll'.HCYUU!'.1OC M! CCOCO OYf Ull R(Guv.TOR'I'OR1SC l()f m rvmo INfDIU,I.AT°' ()	• • • TAG	(CAGII COAR[C OVCACTION $110\A.0O(! CRO$S-R{ f'"ER{ NC£ 0 l O TH[; Al"PR()f>RIAt E O(f,C,WCV)	COl#'\tl C '''_''
soseo Co nMued From page 4 (3) Director of the licensing and Certificatio At.1m!nis1ro 1X1n. rc-go:d Jess of the resident's 090. This Rc9ut:1tion is not met M cvx!encoo by: SEE F569		S6$80		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A. BUILDING _____ WING _____	C 08/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH AND REHABILITATION	5721 GROSVENOR LANE BETHESDA, MD 20814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiencies are the result of a survey that was conducted at this facility on August 15, 2018. by the Office of Health Care Quality to investigate complaint #MD00129907. Survey activities consisted of the review of residents' records and administrative records, observation of resident care and staff practices, interviews of residents, and facility staff. In addition to standard survey protocols, the following facility reported incidents were investigated: #MD00129671 and #MO00129672.			
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60{d)(4}(5) §483.60(d) Food and drink Each resident receives and the facility provides-)§483.60(d)(4} Food that accommodates resident allergies, intolerances, and preferences: ; § 483.60(d }(5) Appealing options of similar nu tritive value to residents who choose not to eat food that is initially s erved or who request a different meal choice; This REQUIREMENT is *not* met as evidenced by: Based on surveyor observation, interviews with facility staff and resident, and review of the residents' clinical records. it was determined that th e facility failed to provide residents food in accordance with the resident's preferences and physician's prescribed therapeutic diet This was evident in 1 of 3 (#3) residents selected for review. This finding was identified during the investigation of complaint#MD00129907. The findings include:	F806	**Corrective action accomplished for resident found to be affected by the deficient practice:** MealTracker diet order was updated to read dairy free diet with the exception of cheddar cheese per residents preference. The residents care plan in Point Click Care was also updated with note that this resident is known to change her dietary preferences frequently. CDM has int erviewed resident and **reviewed** most recent dietary preferences. At this time, she wishes to receive water instead of milk and is uninterested in dairy free milk alternatives offered at this time. Resident will continue to receive gluten free, dairy free diet per her request. **How will you identify other residents having the potential to be affected by the same deficient practice:** The registered dietiti an completed an audit comparing the diet orders for all residents listed in Meal Tracker versus the orders in Point dick Care. Dietary recommendation s were given to nursing unit managers, CDM, ADON and DON to ensure recommendations are transcribed. A meeting with dietary staff was held regarding t he importance of following the meal ticket to ensure all diet orders are beingfollowed correctly.	FOOD 9/131201f

Any deficiency stat emenl en ding wilh an aster isk r) d e n otes a dt:llciency which lh e i11s lil uti o11may be excu se d fro m co rrecting providin,g t is determ i ned lh al other safeg uards p rovid e sulfi cient prol ecllon 10 lhe palients. (See instruction s,) Except for nu1sin9 ho mes, the findings stated ab ove are di sclosable 90 days folio -.,i1 g the date of survey whether or not a plan of correction is provid ed. For nursing hom es. lt,e above findings and plans or co11e c ti on are di sclosable 14 days following the date these documents are made a voilable to the facility. 1r d efic l e11cies are cited. an approved plan or cocreclion is requisite lo continued program participation.

STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION	{X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215167	A. BUILDING _____ B. WING _____	C 08/15/2018

NAME OF PAOVIOER OR SUPPLIER	STREET ADDRESS, CITY, STATE. ZIP CODE
BETHESDA HEALTH **ANO REHABILITATION**	**5721 GROSVENOR LANE BETHESDA, MD 20814.**

(X4) 10 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGUIATORY OR LSC IOENTIFYING INFORMATION}	ID PREFIX TAG	PROVTDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION OATE
F 806	F 806 Continued From page 1 Surveyor review of resident #3's clinical record revealed an intolerance to gluten flour and wheat which was added to the resident's record on 03-16-18. Additionally, a diagnosis of Celiac disease was added to the resident's record on 05-03-18. Geliac disease is an autoimmune disorder that primarily affects the small intestine. the treatment for Celiac disease is a gluten free diet. On 06-14-18, a physician's order was written to change resident #3's diet to gluten free and dairy free. On 08-15-18 at 10AM, surveyor observation revealed that resident #3's breakfast tray was still at the bedside with a carton of whole milk present. Interview with resident #3 revealed that he/she cannot have milk products due to his/her medical condition, however, staff keeps sending milk on the meal trays. On 08-15-18 at 10:15AM, surveyor observed, with staff nurse #1 present, a carton of milk present on resident #3's breakfast tray and his/her prescribed diet is dairy free. The carton of milk was replaced by staff after surveyor intervention. On 08-15-18 at 1PM, surveyor obseivation revealed a cup of orange sherbet on resident #3's lunch tray. The ingredients listed on the label of orange sherbet stated it contains milk. On 08-15-18 at 1:30PM, surveyor interview with the Director of Nursing revealed no new information.	F 806	**Systemic changes to ensure the practice does not recur:** COM and RO will document in Meal Tracker and Point Click Care each time the resident changes her dietary preferences. **How will corrective actions be monitored:** Dietary will be continue to audit completed assessment during admission after the 72 hours hour care plan. The preferences done by their dietitian wHI be compared to Point Click Care frequently to prevent occurrence. Changes will be monitored to ensure residents preferences are being followed through and updated accordingly. Dietary will audit Point Click care vs. meal tracker for accuracy frequently.	

Office of Health Care Qualill

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLI/\ IDENrIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215187	A BUILDING:_____ B/WING _____	C 08/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET' ADDRESS. CITY, STATE, ZIP CODE
BETHESDA HEALTH **ANO REHABILITATION**	**5721 GROSVENOR LANE** BETHESDA, **MD 20814**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER"S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETE 0/\IE
	S 000 Initial comments The following deficiencies are the result of a survey that was conducted at this facility on August 15, 2018, by the Office of Health Care Quality to investigate complaint #MD00129907. Survey activities consisted of the review of residents' records and administrative records, observation of resident care and staff practices, interviews of residents, and facility staff. In addition to standard survey protocols, the following facility reported incidents were in vestigated: #MD00129671 and #MD00129672. This survey did not identify noncompliance with Federal or State requirements that were reviewed in relationship to these incidents.	S000		
	S 550 10.07.02.13 E Dietetic Svcs;Adequacy of Diet .13 Dietetic Services. E. Adequacy of Diet. The food and nutritional needs of patients shall be met in accordance with physicians' orders. To the extent medically possible, the current "Recommended Dietary Allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences", adjusted for age, sex, and activity shall be observed. Agency Note: The "Diet Manual for Long-Term Care Patients" as published by the Department, which contains food allowances and guides for regular and therapeutic diets may be used. This Regulation is not met as evidenced by: Refer lo CMS 2567 F806	S550	Please refer to f806	9/13/2018

OHCQ
LABO r Y 0'. E<;J")I ·s OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Admin5/6/18

'f,C-CYJ4 r7I)

uation sheet 1 (

STATE FORM om 11JT11 If continuation sheet 1 ol 1