

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

Regency Care of Silver Spring
9101 Second Avenue
Silver Spring, MD 20910

Characteristics:

- Limited Liability Corporation with 92 beds
- Legal Business Name – Regency Care of Silver Spring LLC
- Owner/Operator – Steven Womack and Melvin Woodward
- www.regencycaresilverspring.com

As of March 2021, Regency Care of Silver Spring, LLC is listed by the Centers for Medicare and Medicaid Services as a one-star facility on a scale to five at www.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 Regency Care of Silver Spring in Silver Spring, 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.

(link https://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 Regency Care of Silver Spring in Silver Spring, 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 NPIs. Some documents may not be accurately copied and some results may have changed upon appeal, which may not be noted here.

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AK) PLAN OF CORRECTION	(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215060	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/09/2020
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NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 9101 SECOND AVENUE SILVER SPRING, MD 20910
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PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY (EACH CORRECTIVE ACTION SHOULD BE PREFIX)	(X5) DATE COMPLETE
S 000	Initial Comments	S000		
	<p>On September 9, 2020 the Maryland Department of Health's Office of the Inspector General notified the Office of Health Care Quality that a review was conducted regarding your facility's compliance with the State requirements for nursing homes to complete universal testing. The Assistant Inspector General reported that your facility did not meet these requirements.</p>			
S 10	10.07.02.09 A-B Administration and Resident Care	I S 100		
	<p>.09 Administration and Resident Care.</p> <p>A. Responsibility.</p> <p>(1) The licensee shall be responsible for the overall conduct of the comprehensive care facility or extended care facility and for compliance with applicable laws and regulations.</p> <p>(2) The administrator shall be responsible for the implementation and enforcement of all provisions of the Patient's Bill of Rights Regulations under COMAR 10.07.09.</p> <p>B. Delegation to Administrator.</p> <p>(1) The licensee, if not acting as an administrator, shall appoint as administrator a responsible person who is:</p> <p>(a) Qualified by training and experience; and</p> <p>(b) Licensed by the Board of Examiners of Nursing Home Administrators for the State.</p> <p>(2) The administrator shall:</p>			

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

TITLE

(X6) DATE

Office of Health Care Quality

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S 100	<p>Continued From page 1</p> <p>(a) Be responsible for the control of the operation on a 24-hour basis: and</p> <p>(b) With the exception of §8(3) of this regulation, serve full-time.</p> <p>(3) With the Department' s approval, an administrator may serve on a less than full-time basis for a maximum of two nursing facilities, one of which shall have a licensed capacity of 35 beds or fewer.</p> <p>(4) The Department shall consider the following factors when deciding whether to approve an administrator to serve on a less than full-time basis:</p> <p>(a) Geographic location of the facilities;</p> <p>(b) Ownership of the facilities;</p> <p>(c) Organizational structure of the facilities;</p> <p>(d) Size of the facilities; and</p> <p>(e) Background and experience of the administrator.</p> <p>This Regulation is not met as evidenced by: Based on review of the information provided by the Maryland Department of Health, Office of the Inspector General, the facility failed to complete universal testing as required by the Governor and the Secretary of the Maryland Department of Health during a declared State emergency and healthcare pandemic. This deficient practice was</p>	S 100		

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S 100	<p>Continued From page 2</p> <p>cited on September 9, 2020.</p> <p>The findings include:</p> <p>This requirement was authorized by the Governor's executive order issued during a declared State emergency and healthcare pandemic on April 29, 2020, pursuant to the Public Safety Article and other legal authority, in which executive order by the Governor authorized the Secretary of the Maryland Department of Health to issue directives requiring each nursing home to increase testing of residents and staff for COVID-19. The Governor also authorized the Secretary to issue such other directives as the Secretary deemed necessary, to monitor, treat, prevent, reduce the spread of, and suppress COVID-19 in and around Nursing Homes. Furthermore, the Governor ordered all nursing homes to comply in good faith with all applicable directives of the Secretary issued in accordance with the executive order, including without limitation, participation in all disease surveillance, treatment, and suppression efforts required by those directives.</p> <p>Under this authority, the Secretary issued a directive on April 29, 2020 mandating that nursing homes perform COVID-19 testing or permit COVID-19 testing to be administered on residents and staff by the Maryland Department of Health, a local health department, or by designated Maryland Department of Health Response Team member(s). On June 19, 2020 the Secretary issued an amendment requiring all staff, volunteers and vendors who are in the facility regularly to be tested on a weekly basis for COVID-19 using a PCR assay type test pursuant to MDH guidance. According to the directive, "each facility shall be responsible for making</p>	S 100		

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S 100	Continued From page 3 appropriate contractual and financial arrangement for the testing of their staff, volunteers, and vendors." On July 24, 2020 the Secretary issued an amendment requiring, in part, for nursing homes to establish their own privately sponsored COVID-19 testing arrangements with laboratories by August 14, 2020, and provide their plans for continued weekly testing of staff to MOH for review and approval. The Secretary then issued an update directing nursing home to submit these plans for approval to mdh.covidlabresults@maryland.gov. Each nursing homes obligation was and is to comply with these universal testing requirements. The failure to prove compliance results in the imposition of civil money penalties. The Governor's executive order, the Secretary's directive and subsequent amendments are attached.	S 100		
S 160	10.07.02.09 L Administration and Resident Care .09 Administration and Resident Care. L. Availability of Information. The administrator shall make available to the Secretary such information as may be requested to insure that the facility is meeting the requirements of these and other applicable regulations. This Regulation is not met as evidenced by: Based on review of the information provided by the Maryland Department of Health, Office of the Inspector General, the facility failed to complete universal testing as required by the Governor and the Secretary of the Maryland Department of Health during a declared State emergency and	S 160		

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S 160	<p>Continued From page 4</p> <p>healthcare pandemic. This deficient practice was cited on September 9, 2020.</p> <p>The findings include:</p> <p>This requirement was authorized by the Governor's executive order issued during a declared State emergency and healthcare pandemic on April 29, 2020, pursuant to the Public Safety Article and other legal authority, in which executive order by the Governor authorized the Secretary of the Maryland Department of Health to issue directives requiring each nursing home to increase testing of residents and staff for COVID-19. The Governor also authorized the Secretary to issue such other directives as the Secretary deemed necessary, to monitor, treat, prevent, reduce the spread of, and suppress COVID-19 in and around Nursing Homes. Furthermore, the Governor ordered all nursing homes to comply in good faith with all applicable directives of the Secretary issued in accordance with the executive order, including without limitation, participation in all disease surveillance, treatment, and suppression efforts required by those directives. Under this authority, the Secretary issued a directive on April 29, 2020 mandating that nursing homes perform COVID-19 testing or permit COVID-19 testing to be administered on residents and staff by the Maryland Department of Health, a local health department, or by designated Maryland Department of Health Response Team member(s).</p> <p>On June 19, 2020 the Secretary issued an amendment requiring all staff, volunteers and vendors who are in the facility regularly to be tested on a weekly basis for COVID-19 using a PCR assay type test pursuant to MDH guidance.</p>	S 160		

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s 160	Continued From page 5 According to the directive, "each facility shall be responsible for making appropriate contractual and financial arrangement for the testing of their staff, volunteers, and vendors." On July 24, 2020 the Secretary issued an amendment requiring, in part, for nursing homes to establish their own privately sponsored COVID-19 testing arrangements with laboratories by August 14,2020, and provide their plans for continued weekly testing of staff to MOH for review and approval. The Secretary then issued an update directing nursing home to submit these plans for approval to mdh.covidlabresults@maryland.gov. Review of the findings from the Maryland Department of Health's Office of the Inspector General reveal that the facility failed to complete universal testing as required under the Governor's and Secretary's Order and therefore the facility is not in compliance with the requirements of COMAR 10.07.02.09(L) .	S 160		
S1410	10.07.02.33 A Infection Prevention and Control Program .33 Infection Prevention and Control Program. A. Infection Prevention and Control Program. The nursing home shall establish, implement, and maintain an effective infection prevention and control program that: (1) Investigates, controls, and prevents infections in a timely manner through a system that enables the facility to: (a) Analyze patterns of infected individuals; (b) Analyze changes in prevalent organisms;	S1410		

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S1410	Continued From page 6 (c) Analyze increases in the rate of infection; and (d) Obtain surveillance data for the prevention and control of additional cases; (2) Determines the procedures, such as appropriate precautions, that are to be applied to an individual resident; (3) Maintains a record of infections in the nursing home and the corrective actions that were taken related to infections; and (4) Monitors and evaluates the: (a) Effectiveness of the infection prevention and control program by surveying rates of infection, especially infection rates that are significantly higher than usual; and (b) Effective implementation of the policies and procedures that are outlined in §E(1) of this regulation. This Regulation is not met as evidenced by: Based on review of the information provided by the Maryland Department of Health. Office of the Inspector General, the facility failed to complete universal testing as required by the Governor and the Secretary of the Maryland Department of Health during a declared State emergency and healthcare pandemic. For a summary of the applicable orders from the Governor and Secretary please see the deficiency cited at COMAR 10.07.02.09l. This deficient practice was cited on (Date Sha Brown/OIG Notified OHCQ). The findings include:	S1410		

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S1410	<p>Continued From page 7</p> <p>Under this authority, the Secretary issued a directive on April 29, 2020 mandating that nursing homes perform COVID-19 testing or permit COVID-19 testing to be administered on residents and staff by the Maryland Department of Health, a local health department, or by designated Maryland Department of Health Response Team member(s). On June 19, 2020 the Secretary issued an amendment requiring all staff, volunteers and vendors who are in the facility regularly to be tested on a weekly basis for COVID-19 using a PCR assay type test pursuant to MOH guidance. According to the directive, "each facility shall be responsible for making appropriate contractual and financial arrangement for the testing of their staff, volunteers, and vendors."</p> <p>On July 24, 2020 the Secretary issued an amendment requiring, in part, for nursing homes to establish their own privately sponsored COVID-19 testing arrangements with laboratories by August 14, 2020, and provide their plans for continued weekly testing of staff to MOH for review and approval. The Secretary then issued an update directing nursing home to submit these plans for approval to mdh.covidlabresults@maryland.gov. Universal testing of staff and residents was mandated to enable facilities to monitor, treat, prevent, reduce the spread of, and suppress COVID-19 in and around Nursing Homes. Under COMAR 10.07.02.33, a nursing home is required to establish, implement and maintain an infection control and prevention program. The infection Control and prevention program must have processes in place to control, and prevent infections in a timely manner through a system that enables the facility to analyze patterns of infected individuals the rates of infection through monitoring the surveillance data. Universal testing</p>	S1410		

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S1410	<p>Continued From page 8</p> <p>of residents and staff is required to obtain the needed data to protect uninfected residents and staff from the spread of COVID 19 within the nursing home. Therefore failure to conduct universal testing represents a failure of the nursing home to comply with the requirement to have an effective infection control program as required by COMAR 10.07.02.33 Based on review of the information provided by the Maryland Department of Health, Office of the Inspector General, the facility failed to complete universal testing as required by the Governor and the Secretary of the Maryland Department of Health during a declared State emergency and healthcare pandemic. For a summary of the applicable orders from the Governor and Secretary please see the deficiency cited at COMAR 10.07.02.09L. This deficient practice was cited on September 9, 2020.</p> <p>The findings include:</p> <p>Under this authority, the Secretary issued a directive on April 29, 2020 mandating that nursing homes perform COVID-19 testing or permit COVID-19 testing to be administered on residents and staff by the Maryland Department of Health, a local health department, or by designated Maryland Department of Health Response Team member(s.) On June 19, 2020 the Secretary issued an amendment requiring all staff, volunteers and vendors who are in the facility regularly to be tested on a weekly basis for COVID-19 using a PCR assay type test pursuant to MOH guidance. According to the directive, "each facility shall be responsible for making appropriate contractual and financial arrangement for the testing of their staff, volunteers, and vendors."</p>	S1410		

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S1410	<p>Continued From page 9</p> <p>On July 24, 2020 the Secretary issued an amendment requiring, in part, for nursing homes to establish their own privately sponsored COVID-19 testing arrangements with laboratories by August 14, 2020, and provide their plans for continued weekly testing of staff to MOH for review and approval. The Secretary then issued an update directing nursing home to submit these plans for approval to mdh.covidlabresults@maryland.gov.</p> <p>Universal testing of staff and residents was mandated to enable facilities to monitor, treat, prevent, reduce the spread of, and suppress COVID-19 in and around Nursing Homes. Under COMAR 10.07.02.33, a nursing home is required to establish, implement and maintain an infection control and prevention program. The infection Control and prevention program must have processes in place to control, and prevent infections in a timely manner through a system that enables the facility to analyze patterns of infected individuals the rates of infection through monitoring the surveillance data. Universal testing of residents and staff is required to obtain the needed data to protect uninfected residents and staff from the spread of COVID 19 within the nursing home. Therefore failure to conduct universal testing represents a failure of the nursing home to comply with the requirement to have an effective infection control program as required by COMAR 10.07.02.33</p>	S1410		
S1470	<p>10.07.02.34 Employee Health Program</p> <p>.34 Employee Health Program.</p> <p>A. The nursing home's infection prevention and control program shall monitor the relevant health</p>	S1470		

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S1470	<p>Continued From page 10</p> <p>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:</p> <p>(1) Guideline for Infection Control in Health Care Personnel;</p> <p>(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</p> <p>(3) COMAR 09.12.31.</p> <p>B. Tuberculosis Exposure Control.</p> <p>(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.</p> <p>(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.</p> <p>(3) A new employee shall be assessed for risk of tuberculosis through:</p> <p>(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</p>	S1470		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215080	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. IMAGING _____	(X3) DATE SURVEY COMPLETED 09/09/2020	
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S1470	<p>Continued From page 11</p> <p>(b) An interferon-gamma release assay (IGRA) blood test.</p> <p>(4) The nursing home shall maintain written documentation of the following:</p> <p>(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</p> <p>(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.</p> <p>C. Measles, Mumps, Rubella, and Varicella.</p> <p>(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:</p> <p>(a) Documented evidence of administration of vaccine; or</p> <p>(b) Laboratory evidence of immunity.</p> <p>(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</p>	S1470		

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S1470	<p>Continued From page 12</p> <p>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.</p> <p>D. Hepatitis B. The nursing home shall require that all new employees receive immunization for Hepatitis B, 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.</p> <p>E. Influenza.</p> <p>(1) The nursing home shall require that all employees receive annual immunization for influenza, unless:</p> <p>{a} Medically contraindicated;</p> <p>(b) Against the employee' s religious beliefs; or</p> <p>(c) After being fully informed of the health risks associated with not receiving a vaccine, the employee refuses the immunization.</p> <p>(2) The nursing home shall:</p> <p>(a) Comply with Health-General Article, §18-404, Annotated Code of Maryland, regarding immunizations of employees;</p> <p>(b) Inform all new and current employees of the health risks of not being immunized;</p>	S1470		

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215060	(X2) MULTIPLE CONSTRUCTION A BUILDING: _____ B WING _____	(Y) DATE SURVEY COMPLETED 09/09/2020
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NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 9101 SECOND AVENUE SILVER SPRING, MD 20910
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(Y) 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)	(Z) COMPLETE DATE
S1470	<p>Continued From page 13</p> <p>(c) Document refusals; and</p> <p>(d) Require that any employee who is not vaccinated with the current influenza vaccine wear a mask when:</p> <p>(i) Within 6 feet of a resident; and</p> <p>(ii) During the influenza season as specified by the State 's Prevention and Health Promotion Administration, based on influenza activity in Maryland.</p> <p>F. Pertussis. The nursing home shall:</p> <p>(1) Require that each new employee receive a one-dose booster immunization for pertussis, unless medically contraindicated or against the employee ' s religious beliefs;</p> <p>(2) Inform all new and current employees of the health risks of not being immunized;</p> <p>(3) Document any refusals of immunization; and</p> <p>(4) Ensure that the immooization 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).</p> <p>This Regulation is not met as evidenced by: Based on review of the information provided by the Maryland Department of Health, Office of the</p>	S1470		

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215060	(2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(3) DATE SURVEY COMPLETED 09/09/2020
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WWE OF PROVIDER ORSU'PUER REGENCY CARE OF SILVER SPRING, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 9101 SECOND AVENUE SILVER SPRING, MD 20910
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(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) COMPLETE DATE
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S1470	<p>Continued From page 14</p> <p>Inspector General, the facility failed to complete universal testing of all available staff as required by the Governor and the Secretary of the Maryland Department of Health during a declared State emergency and healthcare pandemic. For a summary of the applicable orders from the Governor and Secretary please see the deficiency cited at COMAR 10.07.02.09L. This deficient practice was cited on September 9, 2020.</p> <p>The findings include:</p> <p>Under this authority, the Secretary issued a directive on April 29, 2020 mandating that nursing homes perform COVID-19 testing or permit COVID-19 testing to be administered on residents and staff by the Maryland Department of Health, a local health department, or by designated Maryland Department of Health Response Team member(s). On June 19, 2020 the Secretary issued an amendment requiring all staff, volunteers and vendors who are in the facility regularly to be tested on a weekly basis for COVID-19 using a PCR assay type test pursuant to MOH guidance. According to the directive, "each facility shall be responsible for making appropriate contractual and financial arrangement for the testing of their staff, volunteers, and vendors."</p> <p>On July 24, 2020 the Secretary issued an amendment requiring, in part, for nursing homes to establish their own privately sponsored COVID-19 testing arrangements with laboratories by August 14, 2020, and provide their plans for continued weekly testing of staff to MDH for review and approval. The Secretary then issued an update directing nursing home to submit these plans for approval to</p>	S1470		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215060	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/09/2020
NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 9101 SECOND AVENUE SILVER SPRING, MD 20910		
(JC4)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 15 mdh.covidlabresults@maryland.gov. Universal testing of staff and residents was mandated to enable facilities to monitor, treat, prevent, reduce the spread of, and suppress COVID-19 in and around Nursing Homes. Under COMAR 10.07.02.34, a nursing home is required to establish, implement and maintain an infection control and prevention program that monitors the health of employees as it relates to infection control. Universal testing of all available staff is required to obtain the needed data to protect uninfected residents and staff from the spread of COVID 19 within the nursing home. Therefore failure to conduct universal testing of all available staff represents a failure of the nursing home to comply with the requirement to have an effective employee health program as required by COMAR 10.07.02.34.	S1470		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215060	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/17/2020
NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 SECOND AVENUE SILVER SPRING, MD 20910		
(X4) 10 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	
E 000	InitialComments	E 000			
F 000	INITIAL COMMENTS ACOVID-19 Focused Infection Control Survey was conducted at this facility on June 15, 2020 - June 17, 2020, by the Office of Health Care Quality to investigate complaints MD00153131 and MD0015344. Surveyor conducted onsite survey activities on June 15, 2020. The licensed bed capacity for this facility is 92, the resident census at the start of the survey was 42 , and there were 3 residents included in the sample. Survey activities consisted of a review of medical records, facility documentation, interviews with staff, family members, and observations of resident and staff practices. Administrative reports and facility policies and procedures were also reviewed. The facility was in substantial compliance with 42 CFR §483.80 (Infection Control), Subpart-B-Requirements for Long Term Care Facilities. In fact, based on observations, interviews, and record reviews it was evident that the facility properly implemented infection control practices to prevent COVID-19 and followed infection control safety practices and guidance recommended by the Centers for Medicare and Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC,) during a COVID-19 pandemic.	F 000			

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.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 216060	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/17/2020
NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 SECOND AVENUE SILVER SPRING, MD 20910		
(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	Continued From page 1 This survey did not identify non-compliance with Federal requirements that were reviewed in relationship to MD00153131 and MD00153044 COVID-19 (Coronavirus Disease 2019), is a disease caused by the coronavirus SARS -CoV-2. COVID-19 spreads from person to person, mainly through respiratory droplets produced when an infected person coughs or sneezes.	FO00			

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215060	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/17/2020	
NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 9101 SECOND AVENUE SILVER SPRING, MD 20910		
(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	<p>Initial Comments</p> <p>A COVID-19 Focused Infection Control Survey was conducted at this facility from June 15, 2020 - June 17, 2020, by the Office of Health Care Quality to investigate complaints MD00153131 and MD00153044. Surveyor conducted onsite survey activities on June 15, 2020. The licensed bed capacity for this facility is 92, the resident census at the start of the survey was 42, and there were 3 residents included in the sample. Survey activities consisted of a review of medical records, facility documentation, interviews with staff, family members, and observations of resident and staff practices. Administrative reports and facility policies and procedures were also reviewed.</p> <p>The facility was in substantial compliance with 10.07.02.33 (infection control) of COMAR requirements for Long Term Care Facilities. In fact, based on observations, interviews, and record reviews it was evident that the facility properly implemented infection control practices to prevent COVID-19 and followed infection control safety practices and guidance recommended by the Centers for Medicare and Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC), during a COVID-19 pandemic.</p> <p>This survey did not identify non-compliance with State requirements that were reviewed in relationship to MD00153131 and MD00153044.</p> <p>COVID-19 (Coronavirus Disease 2019), is a disease caused by the coronavirus SARS-CoV-2. COVID-19 spreads from person to person, mainly through respiratory droplets produced when an infected person coughs or sneezes.</p>	S000		

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

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215060	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/17/2020
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NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 9101 SECOND AVENUE SILVER SPRING, MD 20910
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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 OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 9101 SECOND AVENUE SILVER SPRING, MD 20910
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(JC4) 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
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{F 000}	<p>INITIAL COMMENTS</p> <p>On March 20, 2020 an off-site survey was conducted to review the facility's plan of correction for deficiencies that were cited during the survey ending February 6, 2019. Survey activities included the review of the facility's plan of correction and credible evidence.</p> <p>Effective March 20, 2020, the facility was determined to be in compliance with the requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities.</p>	{F 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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 15 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.

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215060	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 03/20/2020
NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 SECOND AVENUE SILVER SPRING, MD 20910		
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{S 000}	<p>Initial Comments</p> <p>On March 20, 2020 an off-site survey was conducted to review the facility's plan of correction for deficiencies that were cited during the survey ending February 6, 2019. Survey activities included the review of the facility's plan of correction and credible evidence.</p> <p>Effective March 20, 2020, the facility was determined to be in compliance with the requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities.</p>	{S 000}			

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TITLE

(XO) DATE

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

P R I N T E D : 09/30/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215060	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/06/2020
NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 SECOND AVENUE SILVER SPRING, MD 20910		
(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO 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 On February 6, 2020, the Office of Health Care Quality conducted a survey at this facility to investigate five complaints. 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. All five complaints (MO00145623, MO00148783, MD00148887, MD00149432 and MD00150125) were unsubstantiated. This survey identified noncompliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities	FOOD			
F 580 SS=D	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 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	F580			

LA80RATORV DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

nnE

(X&J) DATE

03/02/2020

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 - made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215060		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/06/2020	
NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 9101 SECOND AVENUE SILVER SPRING, MD 20910			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 580	<p>Continued From page 1</p> <p>resident from the facility as specified in §483.15(c)(1)(ii).</p> <p>(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.</p> <p>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-</p> <p>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or</p> <p>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.</p> <p>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).</p> <p>§483.10(9)(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 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 surveyor review of the clinical record, interview of resident representative and the facility staff, it was determined that the facility staff failed to notify 1 of 5 residents' representative when there was a change in resident weight (Resident #1).</p> <p>The findings include:</p>			F 580			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215080	(2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X) DATE SURVEY COMPLETED C 02/06/2020
NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 9101 SECOND AVENUE SILVER SPRING, MD 20910		
(4)10 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)	(5) COMPLETION DATE
F580	<p>Continued From page 2</p> <p>This finding was identified during the investigation of Complaint #MD00148887.</p> <p>On 02-06-2020 at 1:30 PM, surveyor interview with Resident #1's representative revealed that on 10-15-2019 at around 4:40 PM, he/she observed that Resident #1 had lost weight and did not recall anyone calling him/her about the resident's weight loss.</p> <p>On 02-06-2020 at 2:00 PM, a review of Resident #1's clinical record revealed that the resident weighed 141 lbs on 08-28-2019. Further review of monthly weight record revealed that the resident weighed 129 lbs on 09-25-2019. This was a significant weight loss of 12 lbs in 28 days. There was evidence in the clinical record that the facility dietitian had identified the weight loss and measures were put in place to address resident #1's weight loss. However, there was no evidence that Resident #1's primary physician or the resident's representative were notified of the change in the resident's weight.</p> <p>On 02-06-2020 at 3:00 PM, surveyor interview with the dietitian revealed that he/she identified Resident #1's weight loss when he/she reviewed the weekly weights log. The dietitian stated that the resident's diet was changed and protein supplements were added to the resident's diet.</p> <p>On 02-06-2020 at 3:30 PM, surveyor interview with the unit manager revealed that per facility policy nursing were required to notify the dietitian, the primary physician and the resident's representative when there were weight changes. The notifications were to be documented in the resident's clinical record.</p>	F580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215060	(2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(3) DATE SURVEY COMPLETED C 02/06/2020
NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 SECOND AVENUE SILVER SPRING, MD 20910		
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F 580	Continued From page 3 On 02-06-2020, at 4:10 PM, an interview with the administrator and the unit manager revealed no new information.	F580			

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215060	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ 8. WING _____	(X3) DATE SURVEY COMPLETED C 02/06/2020
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NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 9101 SECOND AVENUE SILVER SPRING, MD 20910
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S6095	<p>10.07.09.09 F Res Bill Rights;Implem,inform legal repres</p> <p>.09 Implementation of Residents' Bill of Rights.</p> <p>A nursing facility shall:</p> <p>F. Inform the resident and the appropriate legal representative, or interested family member, and promptly consult with the resident's physician if any of the following incidents occur:</p> <p>(1) An accident involving the resident which results in injury;</p> <p>(2) A significant change in the resident's physical, mental, or psychosocial status;</p> <p>(3) A need to alter treatment significantly; or</p> <p>(4) A decision to transfer or discharge the resident from the nursing facility;</p> <p>This Regulation is not met as evidenced by: Refer to CMS 2567 F580</p>	S6095		

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TITLE

(X6) DATE

03/02/20

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215060	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(1)(3) DATE SURVEY COMPLETED C 02/06/2020	
NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 9101 SECOND AVENUE SILVER SPRING, MD 20910		
(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)	CXS, COMPLETE DATE
s 000	<p>Initial Comments</p> <p>On February 6, 2020, the Office of Health Care Quality conducted a survey at this facility to investigate five complaints. 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.</p> <p>All five complaints (MD 00145623, MD 00148783, MD 00148887, MD 00149432 and MD 00150125) were unsubstantiated.</p> <p>This survey identified noncompliance with 10.07.02 of COMAR requirements for Long Term Care Facilities.</p>	S000		

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

TITLE

(X6) DATE

03/02/20

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

PRINTED: 07/18/2019
FORM APPROVED
OMB NO. 0938-0391

STAFFMENT OF OFFICE HQES AND PLAN OF CORRECTION	(X1) PRMOERIU"PUERICUA IOIINTIFICATIONNUMBER: 215060	OC2t MULIPLE CONSRUCTION ABWLOING _____ I.WING	OCSDATEIURIEY COMPL.flo C 0111817D19	
NAME OF PROYOIOR OA SUPPUER REGENCY CARE OF Sii.YER \$PRING. LLC		8IREET ADDRESS, CffY, STATE, ZIP CODE 1101 SECOND AVENUE SILVER SPRING, MD 20910		
CX410 PREFIX TAG	&JMLWV STA1EMENTOP OFECIENCES (1:ACH DEFICIENCY MUST BE PRECEDED BY FULL REOUIATORV OA UC IOENTIFYING INFORfM110N)	ID PREFIX TAG	PROVIDER'S PIMI OP CORRECIOM (EACH CORRECI1VEACTION SHOULD IE CROSS-MFIA&HCI:D TO I'HEAPPROMATE DEFICIENCY)	DII1"1
<p>F561 Continued From page 1</p> <p>waking times), health care and providers of health care semces consistent with his or her Interests, . assessments. and plan of care and other appficable provisions of this part.</p> <p>§483.10(1)(2) The resident has a right to make choAS about aspects of his or her life fn the facility that are slgnlficant to the resident</p> <p>§483.10(f)(3) The resident has a right to interact with members of lha community and participate In community activities both Inside and outside the facility.</p> <p>§483.10(f)(8) The resident has a right to participate in other activities, including IOcial, religious, and community activities that do not Interfere with the rights of other residents in the lty.</p> <p>This REQUIREMENT Is not met as 8"11danced by:</p> <p>Based on surveyor review of the dlnical rec:on:I, surveyor observaUons and lnte,vlews with the resident's responable party and fadlily staff, it was determined that the facility failed to en.ure residents' rights of choice. This fl11dfng was evident for 2 OR 2 residents H1lcted for the Choice review. (#72, 146) The findings Include:</p> <p>1. On 06-11-19, surveyor review of the clnical I record for resident #72 revealed that. in April / 2019, lhe resident was hospftaliz.ed for chtonic anemia (laW blood count). Further review revealed that the resident was a Jehovah Witness and the resident's responsible party/sum,gate dedslon maker refused for the resident to receive any type of blood transfusions.</p> <p>However. review ol resident #72's Mary d</p>		F5811	<p>FS61</p> <p>There were no adverse actions due to this citation. Resident #72 MOLST did not reflect residents' responsible/pany surrogate decision-maker wishes to refuse any type of blood transfusion/products. The Medical Director contacted the responsible party/surrogate decision maker to confirm the choice to refuse any type of blood transfusion. The issue identified has been corrected on 7•2•19.</p> <p>All residents in the facllty have the potential to be affected by this deficient practice. An audit of 100"ofallMOLSTs has been completed and the Identified Issue has been corrected on 7-2a19.</p>	

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

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OMB No. 0938-0391

STATEMENTS OF DEFICIENCIES AND PLAN OF CORRECTION W.	OCIA PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215010	CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY I. WING	CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY C 0-1111120:19
0. PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: REGENCY CAR & OFF SILVER SPRING, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 SECOND AVENUE SILVER SPRING, MD 20910	
(M/JID) PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PR TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	Pii CGI PULLION DAR
<p>F 561 (Continued From page 2</p> <p>MOLST (Medical Orders for Life-Sustaining Treatment)" revealed that on 02-28-19, the attending physician documented a medical order, under the category for Blood Transfusion, that the resident may receive any blood product (whole blood, packed red blood cells, plasma or platelets) that was medically indicated. Maryland MOLST is a portable and enduring medical order form covering options for cardiopulmonary resuscitation and other life-sustaining treatments. The medical orders are based on the resident's wishes about medical treatments.</p> <p>On 06-11-19 at 3:15PM, interview with the facility's medical director revealed that follow up contact with resident #72's assigned attending physician in February 2019 needed to be done. Further interview with the medical director at 4PM revealed that an error had been made on the 02-28-19 Maryland MOLST. The medical director contacted resident #72's surrogate decision maker who confirmed the choice for no use of blood transfusions secondary to the resident being a Jehovah Witness.</p> <p>Following surveyor intervention, the medical director completed a corrected Maryland MOLST and identified the choice of "do not give any blood products".</p> <p>On 06-12-19 at 12PM, surveyor interview with the facility administrator and the Director of Nursing revealed no additional information.</p> <p>2. Based on surveyor review of the clinical record, surveyor observations and interviews with resident #48's family member and facility staff...</p>	F561	<p>The Medical Director will instruct service attending physicians and nurse practitioners the process of reviewing and honoring the resident/responsible party/surrogate/identified decision-maker wishes.</p> <p>Social Services will complete weekly audits on new admissions and readmissions MOLST to ensure resident/responsible party/surrogate/identified decision-maker wishes are honored. The results of the audits will be brought to the QAPI meetings monthly for a period of 3 months. The QAPI will determine what, if any additional interventions are needed at the end of the 3-month period.</p>	s-2-19 and On-soina

STATEMENT OF DEFICIENCIES AND OF CORRECTION	CX(1) PROVIDER IDENTIFICATION NUMBER: 2110&0	0(2) MULTIPLE CONSTRUCTION A. BUILDING NO. _____ a. WING	(X3) DATE SURVEY COMPLETED C 06/11/2019
NAME OF PROVIDER/SUPPLIER REGENCY CARE OF SILVER SPRING, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 8101 SECOND AVENUE SILVER SPRING, MD 20810	
TAG	ID PACIFIED TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	IF COMPLETE IMT!
<p>F 561 Continued From page 4 on the scheduled shower days identified for Mondays and Thursdays during the 7-3 shift. Further review revealed that assigned Staff documented only that the resident had received bed baths on the assigned shower days,</p> <p>On 06-13-19 Interview with GNA #2 revealed that many days there is a shortage of Staff, especially among the GNA staff. Further Interview revealed that during the 7-3 shift there may only be 2-3 GNAs staffed for a unit with a census of 57-59 residents. Many of the residents on assignments require total/dependent staff assistance in providing personal care needs.</p> <p>On 06-17-19 at 2PM and 8PM, supervisor Interview with the facility administrator and the Director of Nursing revealed no additional information.</p> <p>F 608 SS=D Rape/Nighting of Reasonable Suspicion of a Crime CFR(s): 483.12(b)(5)(1)-(iii)</p> <p>§483.12(b) The facility must develop and implement written policies and procedures that:</p> <p>§483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 11508 of the Act. The policies and procedures must include but are not limited to the following elements. (I) Annually notifying covered individuals, as defined at section 1160B(a)(3) of the Act, of that individual's obligation to comply with the following reporting requirements. (A) Each covered individual shall report to the State Agency and one or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of a crime against any individual who is a resident of,</p>	<p>F561</p> <p>f 808</p>	<p>F608</p> <p>Resident #47 did not have any adverse outcomes as related to this citation. No other residents were affected.</p> <p>All Residents in the facility have the potential to be affected by this citation. No other residents were identified to be affected.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(JC) PROVIDER IDENTIFICATION NUMBER: 1150BG	(X) MULTIPLE CONSTRUCTION A. BUILDING _____ a. WING _____	(CX) DATE SURVEY COMPLETED C 01/18/2019
NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC		STREET ADDRESS, CITY, & STATE ZIP CODE 101 SECOND AVENUE SILVER SPRING, MD 20910	
(IC) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL NARRATIVE OR LSC WITH NO INFORMATION)	ID PREFIX TAO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DEFICIENCY)
F810 Continued From page 9 SS-0 CFR(s): 483.12(c)(2H4)	<p>§483.12(c) in response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must</p> <p>§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.</p> <p>§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.</p> <p>§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:</p> <p>Based on record and administrative policy interviews and interviews with facility staff, it was determined that the facility failed to thoroughly investigate facility reported incidents. This finding was evident for 2 of 2 residents reviewed for abuse during the survey. (#71 and #47) The findings include:</p> <p>1. These findings were identified during the investigation of facility reported incident #MD001415156.</p> <p>On 08-11-19 at 09:47 AM, surveyor interviewed with resident #71 revealed that he/she was treated roughly during routine care by facility staff. Resident stated that he/she had a bowel movement during wound care and the staff</p>	F610	<p>F610</p> <p>#47 and #71 were affected by this deficient practice.</p> <p>All residents in this facility have the potential to be affected by this deficient practice.</p> <p>All allegations of abuse will be investigated property with interviews with any of the staff members as necessary.</p> <p>• There was no staff member who matched the alleged description of the employee. Leadership staff did try to identify the person, to no avail.</p> <p>All Self-reports/allegations of abuse will be investigated to include staff and resident interviews as outlined in the regulation. All reports will be reviewed by the Administrator to ensure compliance. Final investigations will be brought to the QAP meetings as necessary.</p>
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/18/2019
FORM APPROVED
OMB No. 1638-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215160	MULTIPLE CONSTRUCTION ADDRESS: I. WING	(a) DATE SURVEY COMPLETED C 0811"2019
NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1111 SECOND AVENUE SILVER SPRING, MD 20910	
(C) M I 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)
F 610	<p>Continued From page 7</p> <ul style="list-style-type: none"> slapped his/her buttocks. Resident #71 stated that this happened 8 week ago during the morning shift. On 06-11/19 at 10 AM, surveyor notified facility administrator about resident allegation. <p>On 06-17-19 at 09:27 AM, surveyor review of the facility reported incident A4D00141656 record revealed that resident #71 was assessed and interviewed by the social worker and the administrator about the alleged abuse. Further review of the incident record revealed 'administrator', documentation indicating that resident #71 could not describe the person or give a date of the alleged incident.</p> <p>However, review of social worker's investigation notes revealed that resident #71 reported to the social worker that the staff member, who slapped his/her buttocks was a nurse on day shift end that the staff member with a darker complexion, short, wearing Upstick and glasses. The notes further indicated that the resident stated that staff member was a nurse and the person that gave him the pills and not a nursing assistant</p> <ul style="list-style-type: none"> There was no evidence in the facility investigation that the facility staff interviewed any nurse on any shift nor did they try to identify a staff member that fit the description given by resident #71. On 06-11-19 at 1 PM, surveyor interview with the facility administrator confirmed there were no interviews conducted with any staff members. No additional information was provided. <p>2. These findings were identified during the investigation of facility reported incident</p>	F610	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER IDENTIFICATION NUMBER: 2150tt	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ 8. WING _____	(S) DATE SURVEY COMPLETED C 06/11/2019
NAME OF PROVIDER DRIUPPER REGENCY CARE OF SILVER SPRING, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 9101 SECOND AVENUE SILVER SPRING, MD 20910	
(X4) ID PREFIX TAG 1	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE
F 610. Continued From page 8 r #MD00138826. On 06-10-19, surveyor review of facility reported incident #MD00138626 revealed that resident #47 reported to their family member on 03-29-19 that a staff member was allegedly rough with them while providing personal hygiene care and allegedly hit their hind and shoulder. The facility initiated an investigation and suspended the alleged staff member. Surveyor review of the facility investigation revealed that only the resident, resident #47's roommate, and the alleged staff member were interviewed and abuse could not be substantiated based on those interviews and physical assessment of the resident. Review of the facility policy regarding abuse revealed facility protocol for the investigation of alleged abuse, neglect, and exploitation involves interviewing all witnesses separately, which includes roommates, resident & in adjoining rooms, staff member in the area, and visitors in the area. There was no evidence that other people were interviewed to investigate the resident's allegation of abuse. Surveyor review of the incident record revealed that on 03-29-19, staff performed a head to toe assessment on resident #47 and there were no injuries noted. On 04-01-19, staff documented that resident 1147 was observed with a bruise to the back of their left hand. However, there was no further investigation into how the resident may have acquired the bruise. On 06-10-19 at 03:20 PM, surveyor interviewed with the administrator revealed the facility staff did not	F610		

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

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STATEMENT OF DEFICIENCIES MD PLAN OF CORRECTION		OC> PROW>ERIUUPPIRICUA IDENTIFICATION NUMBER: 215080		CX2) MULTIPLE CONTAUCTION A. BUILDING _____ 8. WING		(U) Te SURIEY COMPLETED C 0111812011	
NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC				SETTING ADDRESS, CITY, STATE, ZIP CODE 9101 SECOND AVENUE SILVER SPRING, MD 20910			
CA ID PIEFDC TAG	SUMMARY STATEMENT OF DEFICIENCIES (A CN DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR ISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			DATE	
	F 610 Continued From page 9 Interview other residents, staff members, or visitors during their investigation.	F610					
	F 640 Encoding/transmitting Resident Assessments SSaB CFR(s): 483.20(f)(1)(4) §483.20(f) Automated data processing requirement §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility. (i) Admission assessment. (ft) Annual assessment updates. (iii) Significant change in status assessment. (M) Quarterly review assessments. (v) A & Ubaet of items upon a resident's transfer, reentry, discharge , and death. (vi) Background (faCCHheet) information, if there is no admission assessment. §483.20(t)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be able of transmitting to the CMS System Information for each resident contained in the MOS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MOS data to the CMS System, including the following: (i) Admission assessment (ii) Annual assessment. (iii) Significant change in status assessment. (IV) Significant correction of prior full assessment	F640	F640 There were no adverse actions due to this citation. Resident #2 MDS was immediately identified and modified to reflect the discharge status. Done on 6-17-19 All residents upon discharge have the potential to be affected. All other records of discharged residents were reviewed on 7-25-19 and none were found to be deficient with this citation. The MOS coordinator was in- served on 7-25-19 by the Regional MOS Coordinator on accurate codings with transfer and discharged residents in the assessments. The MOS department will conduct audits bi-weekly for 3 months to ensure compliance. Findings will be brought to the QAPI for review and further follow up.				

7-25-19 and On-going

STATE OF DEFICIENCIES ANOP&.N Of eoRAEC110N	(p\l) PRCDMEMPUPPERICUA IDENTIFICATIONNUMBER: 21&0&0	CX2J MULTIPLE CONSTRUCTION AL LDING _____ B.WING	CXJ1 DATE SURVEY COMPLETED C 0�	
NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 SECOND AVE NUI SILVER SPRING, MD 20110		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATOR OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PRCDM8'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
F 640	<p>Continued From page 10</p> <p>(v) Significant correction of prior quarterly assessment</p> <p>(vi) Quarterly review.</p> <p>(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.</p> <p>(viii) Background (face-sheet) information for an initial transmission of MOS data on resident that does not have an admission assessment.</p> <p>§483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in that format specified by the State and approved by CMS.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on surveyor review of the clinical record and staff interview, it was determined that the facility staff failed to complete a discharge assessment within 7 days as required. This finding was evident in 1 of 2 residents selected for the resident assessment review. (#2). The findings include:</p> <p>The Minimum Data Set (MDS) is a mandated process for clinical assessment of all residents in Medicare or Medicaid certified nursing homes. This process provides comprehensive and accurate assessment of each resident's functional capacity and health status to assist nursing home staff in identifying health problems. Additionally, facility must submit a MOS assessment within 7 days upon a resident's, reentry, discharge or death.</p> <p>On 06-17-18 at 2:30 PM, surveyor review of resident's clinical record revealed that resident #2 was discharged from the facility on-</p>	F640		

C
N11812018

215060

8. WING

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

REGENCY CARE OF SILVER SPRING, UC

1101 SECOND AVENUE
SILVER SPRING, MD 20910

CM) 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 IDENTIFIED AS APPROPRIATE TO THE DEFICIENCY)

Other Completion Date

F 640) C On Unued From page 11

HCMeVel', there was no documentation in the MOS record to indicate that the resident was discharged. surveyor, review of resident #R. MOS on 08-17-19 revealed that resident #2 was still active affnor he/she was discharged to the hospital on . The facility staff failed to complete a discharge assessment for the resident within 7 days of transfer as required.

On 06-17-19 at 3:10 PM, surveyor interviewed with MOS coordinator and Director of Nursing

revealed no additional information.

F 656 Develop/Implement Comprehensive Care Plan SS, .O CFR(s): 483.21(b)(1)

§483.21(b) Comprehensive Care Plans

§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan 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 timeframes 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 required under §483.24, §483.25 or §483.40; and (j) 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).

(iD) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR

F 640,

F 656

F&S&

There were no adverse actions due to this citation. A total house audit of all residents who have a Fall Risk Assessment and to initiate the appropriate care plan and interventions will be

done. All residents have the potential to be affected by this finding.

Unit Manager or Supervisor will randomly audit all new Admissions and quarter Y

assessments of Fall Risks and necessary are plans will be put into place.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(JCI) IDENTIFICATION NUMBER: 215060	C/A MULTIPLE CONSTRUCTION BUILDING 8. WING	COMPLETION DATE C 08/11/2019
NAME OF PROVIDER OR SUPPLIER REGIONAL CARE OF SILVER SPRING, UC		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 SECOND AVENUE SILVER SPRING, MD 20910	
IMD ID PREFIX	800 MARV 8 TA 1 EMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CORRECTIVE PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DEFICIENCY)
F 656	<p>Continued From page 12</p> <p>recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(8) 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.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on surveyor review of the clinical record and facility staff interview, it was determined that the facility staff failed to develop a comprehensive resident centered care plan that addressed the resident's risk for falls. This finding was evident in 1 of 25 residents selected for review during the survey. (#20). The findings included:</p> <p>On 06-11-19 at 11:10 AM, surveyor interview with resident #20 revealed that he fell from the bed a couple of weeks ago. Review of the clinical record revealed that resident #20 was admitted to the facility with multiple diagnoses including, but not limited to, multiple falls.</p> <p>Further record review revealed that a fall risk assessment was done on the resident when he was admitted. The assessment result indicated that resident #20's risk for fall was very high.</p>	F656	<p>Weekly audits will be completed for 3 months and results reported to the QAPI monthly.</p> <p>The Director of Nursing is responsible for monitoring for compliance.</p> <p style="text-align: right;">8-15-19 and On-Going</p>

STATEMENT OF DEFICIENCIES MIO PREFIX OF CORRECTION	(X1) PROVIDER IDENTIFICATION NUMBER 211060	(X2) MULTIPLE BUILDING & CONSTRUCTION B.Y.M.Q.	(X3) DATE SURVEY COMPLETED 08/18/2010
NAME OF PROVIDER / SUPPLIER REGENCY CARE OF SILVER SPRING, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1111 SECOND AVE SILVER SPRING, MD 20910	
"4" PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
F 657	<p>Continued From page 14</p> <p>not possible for the development of the residents care plan.</p> <p>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</p> <p>(G) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly telephone assessments.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on 5/11/19 surveyor review of the clinical record interview with facility staff, it was determined that the facility failed to ensure that residents' participated in their care plans and reviewed residents' care plans quarterly. This finding was evident in 2 of 32 residents selected for review during the survey. (20 and 56). The findings include:</p> <p>1. On 06-11-19 at 9:30 AM, surveyor interview with resident #20 revealed that he/she had not had a care plan meeting in a while.</p> <p>On 06-12-19 around 1 PM, surveyor review of the clinical record revealed that the last care plan meeting for resident #20 was in October 25, 2018. Further record review revealed that resident was his/her own responsible party for his/her health care decisions.</p> <p>There was no evidence that a quarterly review of resident #20's care plan was done by the interdisciplinary team as required. Resident #20 was not given the opportunity to participate in the review of his/her plan of care.</p> <p>On 06-12-18 at 2:10 PM, interview with social worker revealed she was new, hired and was</p>	F657	<p>All residents have the potential to be affected by the same deficient practice. 100% audit of care plan reviews was completed to identify other residents potentially affected by this practice. Audit was completed 6/18/19. No further deficient plans were found.</p> <p>The MOS coordinator will provide a long-term calendar by the 18th of the month for all care plans the following month within 7 days of comprehensive assessments due.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/CLIA IDENTIFICATION NUMBER: 215080	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ I. WING: _____	(X3) DATE SWIMV COMPLETED C 09/18/2011
NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 SECOND AVENUE SILVER SPRING, MD 20910	
CX4Jm PREFIX TAG I	aJr, IMAR'S M&N OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	PRC/DIR'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
F857	<p>Continued From page 15</p> <p>unable to answer why quarterly care plan meetings were not done in January April as required.</p> <p>On 06-02-18 at 2:30 PM, surveyor interview with the director of nursing did not reveal any further information.</p> <p>2. Based on surveyor review of the clinical record for resident #48 and interview with facility staff, it was determined that the facility failed to ensure a timely care planning conference. This finding was identified during the investigation of complaint MD 00141134.</p> <p>On 13-19, review of the clinical record for resident #46 revealed that a quarterly MOS (Minimum Data Set) assessment was due on 01-10-19. 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 functional capacity and health status to assist nursing home staff in identifying health problems. MOS assessments are required for residents admission to the nursing facility and then periodically, within specific guidelines and time frames.</p> <p>However, further record review revealed that an interdisciplinary care conference, that included a review of the care plans with resident #46, was not completed until 02-08-19. There was no documented evidence for the delay in the care planning conference.</p> <p>Interview with the Director of Social Services on 17-19 at 10:45AM revealed no additional information.</p>	F657	<p>Social services will complete monthly audits of the calendar with the resident care plan log to identify residents that may not have been captured on the long term calendar. Results of the audits will be reported to QAPI for a period of 3 months. The QAPI committee will determine, what if any additional interventions are needed at the end of this time period.</p> <p>Social Service Director is responsible for compliance.</p>
		8-2-19 and On Going	

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

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OMB NO. 0938-0188

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	CX1) PROVIDER SUPPORT IDENTIFICATION NUMBER: 215080	MULTIPLE CONSTRUCTION A.BUADINO I.WING	CICD DII & SUMMARY COMPLIANCE C I&/18'2019
NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, UC		STREET ADDRESS, CITY, STATE, ZIP CODE 9101 SECOND AVENUE SILVER SPRING, MD 20910	
CJW-101 PRELDC TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY A REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PRVIX TAG	PRC MOU PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)
<p>F 6581 Services Provided Meet Professional Standards SS=01 CFR(s): 483.21(b)(3)(I)</p> <p>§483.21(b)(3) Comprehensive care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must:</p> <ul style="list-style-type: none"> (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview with facility staff, it was determined that the facility failed to administer medication according to professional standards of practice. This finding was evident for 1 of 7 (#65) residents selected for medication regimen review during the survey. The findings included: According to the National Coordinating Council for Medication Error Reporting and Prevention, medication orders should include the drug name, exact metric weight or concentration, and dosage form (https://www.nccmerp.org/recommendations-enhance-accuracy-prescription-writing). On Q&.13-19, surveyor review of resident #85's clinical record revealed that a physician's order was written on 05-18-19 for a bowel regimen medication to be given twice a day. There was no strength or dosage indicated on the physician's order. On OS.13-19 at 12:50 PM, surveyor interviewed with nurse #8 revealed that he/she administered the 100mg dosage of the medication. however, the order could not state what dosage should be given. <p>Review of resident 165's medication administration record revealed that the facility</p>	F858	<p>F658</p> <p>There were no adverse actions due to this finding to any resident. A total house Audit of all orders for Oocutate Sodium will be completed to ensure the dosage/strength are included.</p> <p>All residents have the potential to be affected by this finding.</p> <p>Unit Manager or Supervisor will randomly audit from each unit and audit medications for dosage/strength weekly x 3 months and clarify if needed. This will be reported monthly to QAPI for 3 months or as often as needed.</p> <p>Audits will be completed and reported and acted upon to QAPI as needed. This item will be included in the education session with all licensed nurses. The Director of Nursing is responsible for monitoring and compliance.</p> <p style="text-align: right;">8-15-2019 and On-Going ;</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215060	CX2) MULTIPLE CONSTRUCTION A. BUILDING a. WING	(X3) DATE SURVEY COMPLETED C 08/18/2019
NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 SECOND AVENUE SILVER SPRING, MD 20810	
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (WHICH CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DEFICIENCY)	CXSJ COMPLETION DATE
<p>F684 f Continued From page 18</p> <p>• ensure that residents attain or maintain the highest practical well-being. This finding was evident for 2 of 25 residents selected for review during the survey. (#183 and #72). The findings include:</p> <p>1. The finding was identified during the investigation of complaint #M000138464.</p> <p>On OEM8-19 at 08:20 AM, surveyor review of the clinical record revealed a physician's order for an antiviral medication used to treat HIV infection. Further review of the medication administration record (MAR) revealed that the antiviral medication was to be administered once a day at 9AM.</p> <p>However, surveyor review of the 2019 March and April MAR revealed that the medication was not documented as administered on March 26, 28, 29, 30, 2019 and on April 1 and 2, 2019. There was no evidence in the clinical record to indicate that resident #183 received the antiviral medication as ordered.</p> <p>On 06-18-19 at 09:10 NA, surveyor interview with the director of nursing and the administrator revealed that the resident ran out of the antiviral medication on those days and was not administered the medication until a new bottle was provided. No additional information was provided.</p> <p>2. On 08-12-19, surveyor review of the clinical record for resident #72 revealed that, after a hospitalization, the resident had a readmission to the facility in April 2019. The attending physician at the time of the readmission ordered the administration of the medication Epogen and to</p>	FCSM	<p>F684</p> <p>Resident #72 and #183 did not have any adverse outcomes related to this deficient practice.</p> <p>.. #183 did show evidence of receiving medication on April 1, 2019, in the MAR.</p> <p>All residents have the potential to be affected by this practice.</p> <p>"•licensed nurses will be in-serviced about the protocol to use when the medication is unavailable.</p> <p>Daily review of medication orders/administration will be completed and followed up on as necessary. System reports will be utilized to assist in the identification of such medications also.</p> <p>A monthly review will be completed and reported to the QAC. The Director of Nursing is responsible for compliance.</p> <p style="text-align: right;">8-2-19 and On-going</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	OC1) PROVIDER IDENTIFICATION NUMBER: 21511&0	(X2) MULTIPLE CONSTRUCTION BUILDING: 8.WING	CXII ⁹ TEUIWIV COMPIEa> C 0111812019
NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC		ADDRESS, CITY, STATE, ZIP CODE 1101 SECOND AVENUE SILVER SPRING, MD 20910	
ROW ID TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGISTRATION OR LSC IDENTIFICATION NUMBER)	PREFIX TAO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DEFICIENCY)
F 684	<p>Continued From page 19 follow up with blood test,</p> <p>Epogen is a medication that acts like the hormone erythropoietin, which helps the body create more red blood cells, that raise the hemoglobin (Hgb) level. Hemoglobin is the part of the red blood cell that holds the oxygen. The medication is used to treat anemia (low red blood cell count). While a resident is receiving Epogen, it's important to monitor the hemoglobin levels via blood tests regularly to ensure that the Hgb remains within the therapeutic range.</p> <p>Record review revealed that, on 05-17-19, the attending physician ordered the administration of the Epogen medication once a week on Wednesdays. In addition, the order included that the medication should be held (not to be administered) when the blood test results for Hgb were >9. This physician's order was to be initiated on 05-22-19. In addition, the blood test to check the hemoglobin and hematocrit was to be completed weekly on Fridays, with the test results faxed to the pharmacy.</p> <p>On 08-12-19, review of the May and June 2019 Hemoglobin and Hematocrit blood tests for resident #72 revealed the following results: 05-25-19 Hgb 9.1 g/dl 06-01-19 Hgb 9.2 Wdl 06-01-19 Hgb 10.5 g/dl</p> <p>However, review of the May and June 2019 MAR (Medication Administration Record) revealed staff documentation of the administration of the Epogen on 05-29-19, 06-05-19 and 06-12-19 by LPN (Unlicensed Practical Nurse) #5 when the Hgb was >9.</p>	F684	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(1) PROVIDER IDENTIFICATION NUMBER: 215060	APC MULTIPLE: CONSTRUCTION BUILDING _____ B. WINO	DATE & TIME COMPLETED C 06/18/2019
NAME OF PROVIDER OR CA SUPPORTING AGENCY REGENCY CARE OF SILVER SPRING, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 9101 SECOND AVENUE SILVER SPRING, MD 20910	
TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAO	SHOW FULL PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE REFERENCED TO THIS SPECIFIC DEFICIENCY)
F 694	<p>Continued From page 21</p> <p>Surveyor Interview. on 08-17-19 at 3PM, with the Director of Nursing revealed that resident #48's midline was a non-valved catheter that was inserted while the resident was hospitalized and prior to the June 2019 readmission to the facility.</p> <p>On 06-17-19, review of the facility's policy and procedure for Infusion Maintenance revealed that the care for a midline non-valved catheter includes: an initial administration of a 10 ml of normal saline flush, then the infusion of the medication, then after the medication is infused, another 10 ml of normal saline flush, which is then followed with a 3 ml of 10 units/ml of heparin flush.</p> <p>Review of the June 2019 MAR (Medication Administration Record) for resident #48's midline revealed staff documentation of the administration of 10 ml of normal saline flush every 8 hours before and after the IV medication as of 08-02-19. However, further review of the June 2019 MAR revealed no documented evidence of staff administration of the use of the 10 ml heparin lock flush every 8 hours as required, until 06-08-19.</p> <p>On 06-17-19 at 5PM, surveyor Interview with the facility administrator and the Director of Nursing revealed no additional information.</p> <p>2. On 04-13-19, surveyor review of the clinical record for resident #53 revealed that the attending physician ordered the placement of an intravenous access for IV antibiotics administration. Staff documentation revealed that, on 04-23-19 at 10:30PM, a midline catheter was inserted in the resident's left posterior forearm.</p>	F694f	

STATEMENT OF OFFENSE AND PLAN OF CORRECTION	(IC) IDENTIFICATION NUMBER: 215060	(Q) MULTIPLE CONSTRUCTION A.8U. DING _____ I.WINO	(13) DATE RECEIVED COMP. NO. C 0811812019
NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, L1.C		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 SECOND AVENUE! SILVER SPRING, MD •10	
PREFIX TAG	SUMMARY STATEMENT OF EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSG IDENTIFYING INFORMATION	PREFIX TAG	PROWJER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
F 694	<p>Continued From page 22</p> <p>further review <u>revealed</u> 04-24-19 physician orders to initiate the administration of the IWO antibiotic via the N. One of the antibiotics was to be given once daily for 6 weeks, and the other was every 6 hours for 6 weeks.</p> <p>A midline catheter is inserted in a larger vein used for IV therapy greater than 5 days and less than 28 days. The catheter, which is 8 inches long for adults, is advanced until the distal tip rests in the upper arm, at or below the axillary line.</p> <p>On 06-17-19, review of the facility's policy and procedure for Intrusion Maintenance revealed that the care for a midline non-vented catheter includes: an initial administration of a 10 ml of normal saline flush, then the infusion of the medication, then after the medication is infused, another 10 ml of normal saline flush, which is then followed with a 3 ml of 10 units/ml of heparin flush.</p> <p>However, review of the April 2019 MAR (Medication Administration Record) revealed no documented evidence of the administration of either saline and/or heparin flushes to resident #53's midline from 04-4-19 to 04-27-19 at each antibiotic infusion.</p> <p>On 06-17-19 at SPM, SLIVEY Or Interview With the facility administrator and the Director of Nursing revealed no additional information.</p> <p>Sufficient Nursing Staff CPR(s): 483.35(a)(1)(2)</p> <p>§483.35(a) Sufficient Staff.</p>	F694!	
F 725		F725	

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

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OMB NO. 0938-0111

STATEMENT OF DEFICIENCIES MOPLU OF CORRECTION	(X) PROGRESS SUPPLEMENT IDENTIFICATION NUMBER: ZtIG80	02) MULTIPLE CONSTRUCTION A BUILDING NUMBER: 8.WICG	03) DATE SURVEY COMPLETED C 08/11/2018	
NAME OF PROVIDER OR INSTITUTION REGENCY CARE OF SILVER SPRING, UC		STREET ADDRESS, CITY, STATE, ZIP CODE 9101 SECOND AVENUE SILVER SPRING, MD 20910		
04) PR & FIC TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR UC IDENTIFYING INFORMATION)	10 PR & FIC TAG	PRC MDR'S PLAN OF CORRECTION (EMPHASIS ON CORRECTIVE ACTION REQUIRED CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	OATI
	<p>F 725 Continued From page 23</p> <p>The facility must have sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).</p> <p>§483.35(8)(1) The facility must provide HNCs by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with I resident care plans:</p> <p>(i) Except when waived under paragraph (8) of this section, licensed nurses; and</p> <p>(II) Other nursing personnel, including but not limited to nurse aides.</p> <p>§483.35(8)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to be in charge of each tour of duty.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on surveyor review of the clinical records, surveyor observations, review of the facility assessment and facility schedules and assignments, interviews with residents, residents' responsible parties and facility staff. It was determined that the facility failed to assure there is sufficient nursing staff available to provide personal care needs to residents in a timely manner. This finding was evident for 4 of 4 units. The findings include:</p>	f 725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	CX1J PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21508D	BUILDING CONSTRUCTION L WING		CROSS-SECTIONAL SURVEY COMPLETED C 11/18/2019
NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, UC		STREET ADDRESS, CITY, STATE, ZIP CODE 9101 SECOND AVENUE SILVER SPRING, MD 20910		
CX, 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 CORRECTIVE ACTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	OCS, CG, U, N, I, P, R, S, W, H, M, I, V, I, I
<p>F725 Continued From page 24</p> <p>a. Based on surveyor review of the clinical record, 1 surveyor observations and interviews with resident #46's family member and facility staff, it was determined that the facility failed to ensure that resident #46 was provided with showers as scheduled secondary to an insufficiency of nursing staff. This finding was identified during the investigation of complaint MD00141134.</p> <p>On 06-10-19 at 3PM, surveyor interviewed with resident #46's family member revealed that visits are made to the resident almost daily by many of the resident's family members. During the visits, family members have observed that the resident was incontinent of urine, including the bedding, with no evidence that a staff member had attended to the resident in a timely manner. Family members had to search for a staff member to attend to the resident. In addition, the family expressed concerns to staff regarding the resident's scheduled showers that went supposed to be given on Wednesdays and Saturdays, but not completed due to staff shortages.</p> <p>On 05-11-19, review of the clinical record for resident #46 revealed that the resident was totally dependent on staff assistance in all aspects of her personal care needs.</p> <p>On 06-13-19, review of the April, May and June 2019 GNA (Geriatric Nursing Assistant) documentation for resident #46's care needs revealed no documented evidence that resident #46 had received showers on the scheduled shower days identified as Mondays and Thursdays during the 7AM-3PM shift. Further review revealed that assigned staff had documented that the resident received bed baths</p>	<p>F725!</p>	<p>F725</p>	<p>There were no adverse actions due to this finding. The facility will continue to ensure there is adequate staffing to meet the residents' daily care needs.</p> <p>All residents have the potential to be affected. The facility will continue to monitor the daily staffing/PPO to census and monitor for effective care delivery.</p> <p>Continued creative recruitment and expedited hiring to ensure adequate staffing levels are delivered. Change in facility policy to only allow one nurse or one nursing assistant off on paid leave per unit at a time. Educate staff on call out policy and adhere to attendance policy. Facility will continue to utilize company nursing leadership to assist on the nursing floor when necessary.</p> <p>The Director of Nursing is responsible to ensure compliance for Nursing Staffing.</p>	<p>11</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIVE ACTION	(PU) PROVIDER IDENTIFICATION NUMBER: 2150&0	(OC2) MULTIPLE CONSTRUCTION A. auxiliary _____ B. G _____	(c,tl) DATE SURVEY COMPLETED: C 01118/2019
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NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 9111 SECOND AVENUE SILVER SPRING, MD 20910
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(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 CORRECTIVE ACTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	EFFECTIVE DATE
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<p>F7251 Continued From page 25 during the assigned shower days.</p> <ul style="list-style-type: none"> • • b. On 06-19 at 9:20AM, surveyor observation of the posted staffing board to, the Jamestown/Wilmington/Charleston unit revealed a total of 4 GNAs assigned for a census of 59 residents that defined a ratio of 1:16-1:17 (GNA to resident), while the Charleston had a GNA to resident ratio of 1:10 residents. c. Surveyor observation on 08-10-19 at 10:30AM revealed a staffing posted for the Yorktown unit of 1 GNA assigned for a total census of 24 residents on the mostly rehabilitation unit. This was a ratio of 1:24 for GNA to residents for 7AM-3PM care. Care needs for the unit included personal care needs for residents as well as getting residents up and ready for therapy services. d. On 06-10-19 at 2:45PM, interview with resident #151 responsible party revealed that many times the Yorktown unit had only 1 GNA assigned and not the required 2 GNAs assigned for the 7AM-3PM shift. Due to the reduction in staff, this often led to a delay in staff responses to call lights, and getting assistance for resident #151 in a timely manner. e. Interview with LPN (Licensed Practical Nurse) #5 revealed that the facility's units are "always short staffed", especially the GNAB, who have had difficulty in meeting the residents' personal care needs, even when the nurses were able to assist. The nurses also work short staffed. Many staff members, especially the nurses, are not able to leave at the end of the shift secondary to needing to chart or other duties that were unable to be completed during the shift. 	F725		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/10/01A
FORM APPROVED
MA No. 191

STATEMENT OF DEFICIENCIES D PLM Oit CORRECTION	(X1) PROVIDER IDENTIFICATION NUMBER: 215060	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ 8, WDIQ	(X3) DATE SUMMARY COMPLETE C 08/18/2011	
NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 9101 SECOND AVENUE! SILVER SPRING, MD 20910		
TAO	STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR UC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ION DATE
F 7251	<p>Continued From page 26</p> <p>f. On 06-11-19 at 12:04 PM, during an interview with resident AS, she stated that not enough staff are available during the day shift on the Rehabilitation Unit. In addition, on 08-11-19 at 07:38 AM, resident #71 verbalized that more staff are needed, as it takes a while for staff to respond to call light. Resident 171 was dependent on staff for assistance with personal care.</p> <p>g. On 08-10-19 at 11AM, and 06-11-19 at 1PM, surveyor observed resident 53 was up in the wheelchair watching television in his/her room. Further observation revealed that the resident had the same shirt and pants on both days with some food stains on the clothes.</p> <p>J Record review revealed that resident 153 required staff assistance for care needs, including bathing and dressing. However, further review revealed no documented evidence that bathing needs, including showers for the resident, were done since April 2019.</p> <p>h. Surveyor observation of the Staffing board for 06-1-19 at 11:45AM for the Jamestown/Villiamsburg/Charleston unit revealed the census was 59 residents, with only 2 charge nurses assigned and 3 GNAs assigned.</p> <p>On 06-13-19, interview with GNA #2 revealed there was a shortage of staff on many days and shifts, especially among the GNA staff. Further interview revealed that, during the 7AM-3PM shift, there could be at times only 2 GNAs staffed for the Jamestown/Villiamsburg/Charleston units with a census of 57-59 residents. These units have residents that require total care were</p>	F725		

STATEMENT OF DEFICIENCY AND PLAN OF CORRECTION	CXI, FACILITY IDENTIFICATION NUMBER: 215010	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(3) DATE SURVEY COMPLETED C 01/18/2019
NAME OF PROVIDER OR SUBJECT REGENCY CARE OF SILVER SPRING, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 9101 SECOND AVENUE SILVER SPRING, MD 20110	
SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL IDENTIFICATION OR LSC IDENTIFYING INFORMATION TMJ1	TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(111) COW/ITION 111ft
F 725 f Continued From page 27 dependent on staff assistance. i. Additionally, on 08-13-19 at 1:45PM, interview with GNA #3 revealed she/he was assigned care for 18 residents for the shift and was unable to take his/her assigned breaks for the <i>daily</i> due to the need to complete routine care for his/her assigned residents. Further interview, revealed at the time (1:45PM), GNA #3 still needed to provide care to 2 assigned residents. Including getting the residents out of bed. Follow up with the 2 residents revealed resident 171 declined to get out of bed, while the other resident continued to wait for GNA #3 to get the resident out of bed. f. On 06-13-19 and 06-17-19, review of the facility assessment revealed that the intent of the assessment was to determine what resources were necessary to care for residents competently during both day-to-day operations and emergencies. The assessment focused on ensuring that each resident is provided care that allowed the resident to maintain or attain their highest practicable physical, mental, and psychosocial well-being. The assessments are reviewed and updated annually or whenever there is a change that would require a <u>modification</u> in the assessment. j. On 06-13-19 and 06-17-19, review of the May and June 2018 staffing schedules and staffing assignments revealed the following: OS.28-19- 1 GNA on Yorktown unit for census of 19 residents of a ratio of 1:19. 4 GNA for Jamestown/ Charleston/Virfamsburg for 57 residents CBntUS during 7AM-3PM shift		F725	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/CLIA IDENTIFICATION NUMBER: 215080	(X2) MULTIPLE BUILDING CONSTRUCTION I. WING	(X3) DATE SURVEY COMPLETED C 01/12/01
NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 SECOND AVENUE SILVER SPRING, MD 20910	
(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)	ID PREFIX TAG
F 726 Continued From page 29 SSmD CFR(s): 483.35(a)(3)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.30(e). §-183.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(8)(4) Providing care includes but is not limited to assessing , evaluating, planning and implementing resident care plans and responding to residents' needs. (§483.36(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: • Based on review of administrative and clinical records and interviews with facility staff, it was determined that the facility failed to ensure that licensed nurses have the competency to perform suprapubic catheter replacement. This finding	F728	F726 There were no adverse actions due to this finding to any resident. A total house audit will be completed on all residents with suprapubic catheters. All residents with suprapubic catheters have the potential to be effected by this finding. Random auditing will be done to ensure licensed nursing staff do not perform skills of changing these type of catheters. All licensed nurses will be inserviced so they know not to change suprapubic catheters. Random audits will be completed by unit Managers to ensure they are being changed by the appropriate professional per the policy and Standard of Care. Director of Nursing will be responsible for the training and the compliance to this regulation.	I I I I I

8-15-19 and On-Going \

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	CX1) PROVIDER IDENTIFICATION NUMBER: 215080	C(2) MULTIPLE CONSTRUCTION ALUN. MNG _____ II. WING	DCS JDATE SURVY COMPLETED C 01/18/19
NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC		STREET ADDRESS, COY, STATE, ZIP CODE 101 HCOND AVENUE SILVER SPRING MD 20910	
SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRESENT BY FULL REGULATORY OR ICS IDENTIFYING INFORMATION	I TAG	PROVIDER PLAN OF CORRECTION (VACAT CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE N'PROPOSED DEFICIENCY)	DATE
<p>F 728: Continued From page 30</p> <p>was evident for 1 of 3 (#2) residents reviewed for urinary tract infections/catheter use during the survey. The findings included:</p> <p>Asuprapubic catheter is a hollow flexible tube that is inserted into the bladder through the abdominal wall to drain urine from the bladder.</p> <p>On 06-17-19, surveyor review of resident's clinical record revealed a physician's order, written on 04-05-18, for the facility staff to change resident #2's suprapubic catheter every 3 weeks. Review of the treatment administration record (TAR) revealed that the procedure was performed every 3 weeks by the facility's licensed nurses.</p> <p>On 17-19 at 12:17 PM, surveyor interviewed with the facility staff educator revealed that the facility does not allow licensed practical nurses (LPNs) to change suprapubic catheters. The staff educator further stated that there has been no training performed with the facility nurses regarding suprapubic catheter replacement, nor has the facility assessed whether the licensed nurses have the competency to perform the procedure.</p> <p>Further review of resident #2's TAR revealed that 5 of the 10 times resident #2's suprapubic catheter since 04-05-18 were changed by practical nurses. Review of the facility policy regarding suprapubic catheterization revealed that LPNs may be certified for suprapubic catheter insertion at the facility. Review of the facility assessment revealed that part 3 of the assessment listed catheterization insertion as a competency required from the staff to care for the facility's resident population.</p>	F726		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		CX. PROVIDER IDENTIFICATION NUMBER: 215080		ADMINISTRATIVE CONSTRUCTION B. WING		(3) DATE RECEIVED C 08/18/2011	
NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, UC				STREET ADDRESS, CITY, STATE, ZIP CODE 1101 SECOND AVENUE SILVER SPRING, MD 20110			
(X) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY A UIC. REGULATORY OR LICENSING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		OC51 number, MTI
F 726	<p>Continued From page 31</p> <p>On 05-17-19 at 3 PM, interview with staff #6 revealed that he/she had not received any training regarding suprapubic catheter replacement. Review of the TAR revealed that resident #2's suprapubic catheter was changed by staff #8 on 10-11-18.</p> <p>On 06-17-19 at 3:05 PM, interview with staff #7 revealed that they did not remember if they had any training from the facility regarding suprapubic catheter replacement. However, review of the TAR revealed staff #7 changed resident #2 suprapubic catheter on 03-07-19.</p> <p>On 06-17-19 at 3:40 PM, surveyor interview with the Director of Nursing revealed no new information.</p>			F726			
F 730	<p>Nurse Aide Perform Review-12 hr/yr In-Service SS=C CFR(s): 483.35(d)(7)</p> <p>§483.35(d)(7) Regular In-service education.</p> <ul style="list-style-type: none"> The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular In-service education based on the outcome of these reviews. In-service timing must comply with the requirements of §483.95(g). <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on summary review of employee files and interview with facility staff, it was determined that the facility failed to ensure that GNAs (Geriatric Nursing Assistants) had received the required 12 hour per year in-service training based on their performance review. This finding was evident for 4 of 5 GNA employee files reviewed during the</p> <p>MIY-C-1, 12, fl. 14 The "1111" included</p>			F730			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215060	(OC) MULTIPLE CONSTRUCTION A. ITEM DING _____ & WING _____	QUALITY SURVEY & Y COMPLETED C 11/11/01
NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, UC		STREET ADDRESS, CITY, STATE, ZIP CODE 1111 SECOND AVENUE SILVER SPRING, MD 20910	
TAG	ID PREFIX TAG	PRCIDEA'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CORRELATED TO THE APPROXIMATE DEFICIENCY)	ID#
<p>F 730 Continued From page 32</p> <p>1. On 06-17-19 surveyor review of GNA#1's <u>employee</u> file revealed an annual performance review for the period of December 2017 to December 2018.</p> <p>However, further review revealed no documented evidence of the required 12 hour per year inservice training completed for the annual performance review.</p> <p>On 06-17-19 at 4PM, surveyor interview with the facility's staff educator revealed that the facility was unsuccessful in obtaining the documentation of an inservice record for GNA #1 from a previous computer based training no longer in use. Further interview revealed a new computer based training went into operation as of January 2019. No additional information was provided.</p> <p>Interview on 06-17-19 at 4:30PM with the facility administrator and the Director of Nursing revealed no additional information.</p> <p>2. On 17-19, surveyor review of GNA#2's employee file revealed an annual performance review for the period of August 2017 to August 2018.</p> <p>However, further review revealed no documented evidence of the required 12 hour per year inservice training completed for the annual performance review.</p> <p>On 06-17-19 at 4PM, surveyor interview with the facility's staff educator revealed that the facility was unsuccessful in obtaining the documentation of an inservice record for GNA12 from a previous computer based training no longer in use. Further interview revealed that a new computer based</p>	<p>F7301</p>	<p>F730</p> <p>No Residents were affected by this deficient practice. An audit will be completed for all newly hired GNA's to show evidence of the 12- hour training compliance.</p> <p>All residents have the potential to be affected, however, no residents were affected. All GNA files will be reviewed by Aug. 2, 2019.</p> <p>All GNA's hired will have the 12-hour training within 4 months of hire date. All other GNA's will have the required training annually to meet the requirements.</p> <p>The Staff Educator is responsible will report the findings monthly to the QAPI and the Administrator will monitor for compliance.</p>	<p>8-2-19 and On-Going</p>

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

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OMB NO. 09-0000

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER IDENTIFICATION NUMBER: 215080	MULTIPLE CONSTRUCTION BUILDING _____ 1.WJNG	(X) DATE SWIPE COMPLETED C 06/18/2019
NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 9101 SECOND AVENUE! SILVER SPRING, MD 20910	
SUMMARY STATEMENT OF DEFICIENCIES J.: TAO (EACH DEFICIENCY MUST BE PREVIOUSLY IDENTIFIED IN REGULAR OR LSC IDENTIFYING INFORMATION)		ID :Dt (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE HIS, CCMPLTION DATE
<p>F 730 f Continued From page 34</p> <p>On 06-17-19 at 4PM, surveyor Interview with the facility's staff educator revealed that the facility was unsuccessful in obtaining the documentation of an Inservice record for GNA414 from a previous computer based training no longer in use. Further Interview revealed that a new computer based training went into operation as of January 2019. No additional information was provided.</p> <p>Interview, on 06-17-19 at 4:30PM, with the facility administrator and the Director of Nursing revealed no additional information.</p> <p>F 755 Pharmacy Services/Pharmacist/Records 483.45(a)(b)(1)-(3)</p> <p>§483.45 Pharmacy Services The facility must employ routine and emergency drugs and biologics to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, packaging, dispensing, and administering of all drugs and biologics) to meet the needs of each resident.</p> <p>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-</p> <p>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility,</p>	<p>F730</p> <p>F 755</p>		

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

PRINTED: 0711612019
FORM APPROVED
NWA NO 1-93-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	OC1) PROVIDER IDENTIFICATION NUMBER: 215060	OC2) MULTIPLE CONTINUATION A. BUII.DJNG _____ I. WING	(Q) DATE OF REPORT COMPLETION C 08#11/2019
NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 SECOND AVENUE & SILVER SPRING, MD 20110	
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC OPERATING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
<p>F755 Continued From page 35</p> <p>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and</p> <p>§483.45(b)(3) Determine that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by:</p> <p>Based on a surveyor review of the clinical record interview with facility staff, it was determined that the facility failed to provide routine medication to resident #183. This finding was evident in 1 of 25 residents selected for review during the survey. (#183). The findings include:</p> <p>This finding was identified during the investigation of complaint #MD00138454.</p> <p>On 06-18-19 at 08:20 AM, surveyor review of the clinical record revealed a physician order for an antiviral medication used to treat HIV infection. Further review of the medication administration record (MAR) revealed that the antiviral medication was to be administered once a day at 9 AM.</p> <p>Surveyor review of the medication administration record (MAR) revealed physician's order that stated, "resident to provide medication to facility".</p> <p>On 06-18-19 at 10:10 AM, surveyor review of resident #183's admission continued with the facility revealed that, under pharmacy services, resident #183 consented and gave authority to the facility to provide all services provided by a skilled nursing facility.</p>	F755	<p>F755</p> <p>There were no adverse actions due to this finding. The resident #183 was not affected and received the medication at question within 2 days of notification of the supply being depleted.</p> <p>All residents have the potential to be affected by this finding. Random audit of resident profiles will be completed to ensure medications are available as ordered.</p> <p>There will be an established agreement with residents who bring their own medications and for which the facility is not providing by facility pharmacy and how the medication will be provided.</p> <p>The Unit Managers will complete weekly audits to ensure medication is in stock.</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER IDENTIFICATION NUMBER: 2151&0	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ & WING _____	(13) DATE SURVEY COMPLETED C 01/18/2019
NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE & 9161 SECOND AVENUE SILVER SPRING, MD 20910	
(X4) ID PREFIX TAO	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR CFC IDENTIFYING INFORMATION)	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	N
F 158 Continued From page 37 § 483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; § 483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; § 483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is <u>necessary</u> to treat a diagnosed specific condition that is documented in the clinical record; and § 483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in § 483.45(e)(5), if the attending physician or prescribing practitioner believes that it is <u>appropriate</u> for the PRN order to be extended beyond 14 days, he or she should document their rationale in the residents medical record and indicate the duration for the PRN order. § 483.45(e)(5) PRN orders for <u>anti-psychotic</u> drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on surveyor review of clinical records and interviews with facility staff, it was determined that the facility failed to discontinue or <u>reassess</u> the need for the use of a PRN (as needed) psychotropic medication beyond the original 14	F758		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0187

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(C) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 211050	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ 8. WING _____	(CU) DATE SUMMARY REPORTED: C 08/11/2019	
NAME OF PRIMOER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC		STREET ADDRESS, CITY, & STATE, ZIP CODE 1101 SECOND AVENUE SILVER SPRING, MD 20910		
PREFIX TAG I	6. SUMMARY STATEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROW-SRS PUN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETELY REFINANCED TO THE APPROPRIATE DEFICIENCY)	
	<p>F 7581 Continued From page 38</p> <p>days. This finding was evident for 1 of 7 residents selected for the Unnecessary Medication Review (#15). The findings include:</p> <p>A psychotropic drug is any drug that affects the mind, emotions or behavior.</p> <p>On 06/13/2019 at 9:00 AM, surveyor review of resident #15's clinical records revealed a physician's order for anti-anxiety medication to be administered every 6 hours as needed on 04/11/2019.</p> <p>Further review revealed a pharmacist recommendation to discontinue the medication on 05/01/2019. The physician accepted the recommendation on 05/21/2019.</p> <p>Surveyor review of physician's order sheet and medication administration record (MAR) for the months of April, May and June 2019 revealed that the anti-anxiety medication was not discontinued.</p> <p>Further review of the clinical record revealed nursing documentation on 06-12-19 that the anti-anxiety medication was administered to resident #15.</p> <p>There was no evidence in the clinical records that the prescribing physician documented the rationale for the extended use beyond the 14 days as required.</p> <p>On 06/12/2019 at 11:00 AM, surveyor interview with the Director of Nursing revealed no additional information.</p> <p>Following surveyor intervention, the anti-anxiety medication was discontinued on 06/12/2019 at</p>		<p>F758</p> <p>F758</p> <p>There were no adverse actions due to this finding to any resident. A total house audit of all residents on PRN psych medications will be completed by 8-15-19.</p> <p>All residents on PRN psych medications have the potential to be affected by this finding. Random auditing of all patients on Psych medications will be completed to ensure they are all discontinued after 14 days or before of start date.</p> <p>Audits will be done from each unit times 3 months by the Unit manager/supervisor and reported back monthly to QAPI.</p> <p>In-service will be completed with all licensed nurses by the Director of Nursing by 8-15-19</p> <p>8-15-19 and On Going</p>	nm

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16118/2011

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

IDENTIFICATION NUMBER: 216060
PROVIDER'S PLAN IDENTIFICATION NUMBER: I.WING

(X2) MULTIPLE CONSTRUCTION
BUILDING _____

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

REGENCY CARE OF SILVER SPRING, LLC

1101 BECONDAVINUE
SILVER SPRING, MD 20910

CX4) P.III) FIX TAG
SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECISELY IDENTIFIED BY FULLY DESCRIBING THE DEFICIENCY OR IDENTIFYING INFORMATION)

1 10
PROVIDER'S PLAN IDENTIFICATION NUMBER
(EACH COAFFECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

OCSI
COMPLIANCE
M1

F 758 Continued From page 39
4:16 PM.

F758_

F 842: Resident Records - Identifiable Information
SS-c CFR(s): 483.20(f)(5), 483.70(i)(1)(H 5)

F8421 F842

§483.20(f)(5) Resident-Identifiable information.
(I) A facility may not release information that is resident-identifiable to the public.
(II) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

There were no adverse actions due to this citation. Residents #46, #S3, and #19 have been found to have inaccurate documentation on their MOLST forms. All three resident's MOLST forms have been reviewed and corrected on 7-2-19.

§-C83.70(i) Medical records.

§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-

All residents in the facility have the potential to be affected by the same deficient practice. 100% audit of facility MOLST forms has been completed on 7-2-19 and any identified issue has been corrected.

(i) Complete;

(ii) Accurately documented;

(iii) Readily accessible; and

(iv) Systematically organized

The Social Services Director has interviewed attending physicians and nurse practitioners on

§483.70(1)(2) The facility must keep confidential all information contained in the resident's records, regardless of the storage method of the records, except when release is-

(i) To the individual, or their resident representative where permitted by applicable law;

reviewing and accurately

Required by Law;

(6)

45 CFR 164.506;

(ii) For treatment, prevention, or health care

(iv) For public health activities, reporting of abuse,

operations, as permitted by and in compliance

neglect, or demonstrable negligence, health oversight

activities, judicial and administrative proceedings,
law enforcement purposes, organ donation

documenting on the MOLST

forms.

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	UNIT/PRC/MED/SUPA/IER/CLIA IDENTIFICATION NUMBER: 215060	BUILDING/CONSTRUCTION 8.WING	QUALITY IMPROVEMENT PLAN C 01/18/2019
NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 SECOND AVENUE SILVER SPRING, MO 2091G	
(X4) ID P=DC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
F 842	<p>Continued From page 40</p> <p>purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted; by and in compliance with 45 CFR 164.512.</p> <p>§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.</p> <p>§483.70(IX4) Medical records must be retained for-</p> <ul style="list-style-type: none"> (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no equivalent in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. <p>§483.70(1)(5) The medical record must contain-</p> <ul style="list-style-type: none"> (v) Sufficient information to identify the resident; (i) A record of the resident's assessments; (ii) The comprehensive plan of care and services provided; (iii) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (iv) Physician's, nurse's, and other licensed personnel's progress notes; and (v) Laboratory, radiology and other diagnostic services reports as required under §483.50. <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on surveyor review of the clinical record and interview with facility staff, it was determined that the facility failed to ensure accurate documentation on resident's Maryland MOLST. This finding was evident for 3 of 3 residents selected in the Advance Directive review. (#48, #53, #19) The findings include:</p>	F842	<p>Social Services will complete weekly audit on new admissions and readmission's MOLST to ensure accurate documentation. Results of the audit will be reported to the QAPI for a period of 3 months. The QAPI will determine what, if any additional interventions are needed at the end of the three month period.</p> <p style="text-align: right;">8-2-19 and on-going</p>

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

PRINTED: 07/18/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIVE ACTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215080	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ I. WNO	DATE SURVEY COMPLETED C 06/18/2018
NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, U.C		STREET ADDRESS, CITY, STATE, ZIP CODE 9101 SECOND AVENUE	
(Xii) ID PREFIX TAG	IDENTIFICATION OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULLY IDENTIFYING INFORMATION)	SILVER SPRING, MD 20905 CORRECTION CORRECTIVE ACTION SHOULD BE TAKEN TO THE APPROPRIATE DEFICIENCY	CJ DATE
	<p>F 842 Continued From page 41</p> <p>: Maryland MOLST (MOIST) is a portable and enduring medical order form covering options for cardiopulmonary resuscitation and other life-sustaining treatments. The medical orders are based on the resident's wishes about medical treatments.</p> <p>1. On 06-12-19, surveyor review of the clinical record for resident #46 revealed that the 10-31-18 MOLST indicated that the attending nurse practitioner had certified that the medical orders entered were as a result of a discussion with and the informed consent of the resident #46's health care agent as named in the patient's (19) advance directive.</p> <p>However, on 06-13-19 at 12:30PM, surveyor interview with the Director of Social Services revealed that no Advance Directive was in place for Resident #46. Further interview revealed that the medical orders on the Maryland MOLST were the result of a discussion with the attending nurse practitioner and the resident's responsible party, (who was the surrogate as designated in the Health Care Decisions Act).</p> <p>On 06-13-19 at 3PM, interview with the facility administrator revealed no additional information.</p> <p>2. On 06-12-19, surveyor review of the clinical record for resident #53 revealed a hard copy of the Maryland MOLST completed on 02-22-19. The attending physician documented that the medical orders were the result of a discussion with and the informed consent of the resident's health care agent as indicated in the resident's advance directives.</p> <p>However, further review of the electronic record</p>	F842	

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

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FORM APPROVED
OMB NO. 0138-0191

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(C,1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2150&0	(X2) MULTIPLE CONSTRUCTION A. FULLY _____ a. WING	(X5) DATE SURVEY CONDUCTED C 08/18/2019	
NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, UC		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 SECOND AVENUE SILVER SPRING, MD 20110		
(X, O) d) PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	IM1!!
	<p>F 842. Continued From page 42 for resident #53 revealed a copy of the Maryland MOLST was scanned into the record on 02-22-19. However, there was no documentation who the physician discussed the MOLST with.</p> <p>On 06-12-19 at 4:30PM, Interview with the Director of Social Services revealed that the attending physician had failed to check the box on the original 02-22-19 Maryland MOLST form, and it was corrected on the original copy located in the resident's record. However, staff failed to scan the corrected copy into the electronic record.</p> <p>On 06-13-19 8:11AM, interview with the facility administrator revealed no additional information.</p> <p>3. On 06-17-19 at 10:15 AM, surveyor review of resident #19's MOLST, signed on 02-27-19, revealed that the primary physician documented that the MOLST was completed based on a discussion with resident #19.</p> <p>Further record review revealed that physician certification for resident #19's capacity on 02-27-19 and 04-30-19. On both assessments, resident #19 was certified as not being able to make his/her own decisions. Thus resident #19 did not have the capacity to make informed decision regarding the MOLST.</p> <p>On 06-17-19 at 11:10 AM, surveyor interview with the primary care physician and the social worker revealed that resident #19's MOLST was inaccurately documented.</p>	F842		

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER IDENTIFICATION NUMBER: 215060	BUILDING: 8, WING	(X1) DATE SURVEY COMPLETED 08/18/2019
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NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 SECOND AVENUE SILVER SPRING, MD 20910
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PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PFWUC TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
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S000	Initial comments The following deficiencies are the result of the annual survey conducted by the office of Health Care Quality on June 10, 11, 12, 13, 17 and 18, 2019 to determine the facility's compliance with COMAR requirements. Survey activities consisted of a review of 42 residents' records, observation of resident care and staff practices, interviews of residents, residents' family members, the ombudsman, and facility staff. Additionally, administrative and resident care policies were reviewed. In addition to standard survey protocols, complaints #MD0D138454, #MD0D140173, #MO0014128, and #M000141134 and facility reported incidents #MD00138628, #MDD0141556. In addition, an on-site facility reported incident was provided to the survey team and reviewed. The facility is licensed for 92 comprehensive beds. At time of this survey the facility census was 83 beds.	SOAO	
S280	10.07.02.07 G Admin/Res Care Staffing .07 Administration and Resident Care. G. Staffing. (1) The administrator shall employ sufficient and satisfactory personnel as specified in this chapter to give adequate patient care and to do feeding, maintenance, cleaning, and housekeeping. (2) A facility may request a voluntary admissions ceiling by submitting a written request to the Department to authorize a temporary restriction on patient admissions based upon anticipated	S280	

LABORATORY DIRECTOR'S OR PROVIDER SUPPLIER REPRESENTATIVE <i>Michelle York</i>	DATE 4H7011	TITLE <i>Administrator</i>	CX10IITC <i>-di</i>
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Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	ex., IDENTIFICATION NUMBER: 215080	(X2) 14111, TALE CONSTRUCTION ASU. OING: _____ I. WING	DATE SURVEY COMPLETED C 06/18/2018
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NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC	STREET ADDRESS, CITY, & STATE, ZIP CODE 1101 SILVER SPRING AVENUE SILVER SPRING, MD 20910
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W) 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)	DATE
s 510	Continued From page 3 designated by the director of nursing to be in charge of the nursing activities during each tour of duty. The charge nurse or nurses shall have the ability to recognize significant changes in the condition of patients and to take <u>necessary</u> action. This Regulation is not met as evidenced by: Refer to CMS 2567 F684, F694	s 510	SEE F684, F694	
s 512, 10.07.02.12 R Nsg Svcs; Charge Nurse Daily Rounds	10.07.02.12 Nursing Services. 10.07.02.12 R. Charge Nurses' Daily Rounds. The charge nurse or nurses shall make daily rounds to all nursing units for which responsible, performing the following functions as: (1) Visiting each patient; (2) Reviewing clinical records, medication orders, patient care plans, and staff assignments; (3) To the degree possible, accompanying physician and when visiting patients. This Regulation is not met as evidenced by: Refer to CMS 2567 F858	S512	SEE F658	/
S1090; 10.07.02.20 Clinical Records	10.07.02.20 Clinical Records. A. Records for all Patients. Records for all	s1090"		

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STATEMENT OF DEFICIENCIES NFDPLAN OF CORRECTION	OC1J PROVIDER/SUPPLIER IDENTIFICATION NUMBER 215180	CX2J MIA/TIME CONSTRUCTION A. IULDI4G: _____ a. WINO	CIQ/DATISW/MY COMPLETED C 08/18/12 0 1 9	
NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, UC		STREET ADDRESS & QTY, STATE, ZIP CODE 9101 SECOND AVENUE SILVER SPRING, MO 20910		
CIC4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR I.S.C. IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
S10901	Continued From page & ! There shall be sufficient supportive staff to accomplish all medical record functions. D. Consultation. If the medical record supervisor is not a qualified medical record practitioner, the Department may require that the supervisor [REDACTED] Reports. Current medical records and those of discharged patients shall be completed promptly. All clinical information pertaining to a patient's stay shall be centralized in the patient's medical record. F. Retention and Preservation of Records. Medical records shall be retained for a period of not less than 5 years from the date of discharge or, in the case of a minor, 3 years after the patient becomes of age or 5 years, whichever is longer. G. Current Records-Organization and Facilities. The facility shall maintain adequate space and equipment, conveniently located, to provide for efficient processing of medical records (reviewing, indexing, filing, and prompt retrieval). H. Closed or Inactive Records. Closed or inactive records shall be filed and stored in a safe place (free from fire hazards) which provides for confidentiality and, when necessary, retrieval. This Regulation is not met as evidenced by: Refer to CMS 2567 F842	S1090	SEE F842 /	
S1868	10.07.02.34 0 Hskpg; Laundry, existing facilities 34 Housekeeping Services, Pest Control, and Laundry.	S1868		

Office of Health Care ...

STATE IDENTIFICATION OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER IDENTIFICATION NUMBER: 215080	MULTIPLE CONSTRUCTION ABU/DING: _____ B WING	DATE SURVEY COMPLETED C 06/11/2019
NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 9101 SECOND AVENUE SILVER SPRING, MD 20910	
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 APPLICABLE DEFICIENCY)	DATE
S1885 Continued From page 9 documented evidence or notice that explained the ratio of licensed and unlicensed staff to residents. On 08-10-19 at 5:20 PM, surveyor interview with the Director of Nursing revealed no additional information.	S1885	AH nurses will be in-service by 8-2-19. Unit Manager/Director of Nursing are responsible and will monitor for compliance.	
S5CJ95! 10.07.09.08 C (2) Right to receive care in quality environment 10.08 Residents Rights and Services. C. A resident has the right to: (2) Receive treatment, care, and services that are in an environment that promotes maintenance or enhancement of each resident's quality of life; This Regulation is not met as evidenced by: Refer to CMS 2587 F581	65095	SEE f561	8-2-19 and On 10/18
86012 10.07.09.08 C (11) Right to consent/refuse treatment 10.08 Resident's Rights and Services. C. A resident has the right to: (11) Consent to or refuse treatment. Including the right to accept or reject artificially administered medication in accordance with State law; This Regulation is not met as evidenced by: Refer to CMS 2567 F561	88012	SEE F561	

of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER IDENTIFICATION NUMBER 715080	OCCUPANT MULTIPLE OCCUPANCY BUILDING: _____ 8. WING	(X) DATE SURVIVAL COMPLETED C 0111812011
NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 9101 SECOND AVENUE SILVER SPRING, MD 20910	
ICA) 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)	OCCURRENCE DATE
S6285J Continued From page.10 66285: 10.07.09.14 C (1) Phys/Chem Restr, Psycho Orugs, Infection.. .U Physical and Chemical Restraints . C. Use of Psychopharmacologic Drugs. When a physician prescribes <u>psychopharmacologic drugs</u> for a resident, the resident's clinical records shall contain all of the following documentation: (1) A physician's indication that the dosage, duration, indication, and monitoring are clinically appropriate and the reasons why they are clinically appropriate; This Regulation is not met as evidenced by: Refer to CMS 2567 F-758	S9285 S8285	SEE F758	
S8320 10.07.09.15 C (1) (a) Abuse; Report to law enforcement (1) 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: (a) Appropriate law enforcement agency, This Regulation is not met as evidenced by: Refer to CMS 2587 F608	S6320	SEE F608	
S6350 10.07.09.15 D (1) Investigations; thorough .15 Abuse of Residents.	88350		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER IDENTIFICATION NUMBER: 215080	A. BUREAU: 8.WINQ	DATE SURVEY COMPLETED: C 08/11/2011
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NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 SECOND AVENUE SILVER SPRING, MD 20910
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CMI/O M/F/U/C TAG	PRIMARY 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 IDENTIFIED AS APPROPRIATE)	DATE
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88350	Continued From page 11 D. Investigations. A nursing facility shall: (1) Thoroughly investigate all allegations of abuse; and This Regulation is not met as evidenced by: Refer to CMS 2567 F810	68350	SEE F6JO	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER'S NAME: usoeq	MFCION	DATE SURVEY: 3/06/2019
NAME OF PROVIDER: GENESEE		1181 p[Tr,s i: p@DE	
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LABORATORY DIRECTOR'S OR PROVIDER'S/RELIER REPRESENTATIVE'S SIGNATURE: *Michelle M...* TITLE: *Administrator* DATE: *3/20/19*

the institution may be excused from correcting provided it is determined that... Except for nursing homes, the findings stated above are disclosable 90 days after the date of the survey.

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ENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES
CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:
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A. SURVEY DATE
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DEFICIENCY

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§481.21(a)(3) The facility must provide the resident with a summary of the baseline assessment, that includes but is not limited to:
(i) The initial goal of the diet.
(ii) A summary of the resident's medical and dietary instructions.
(iii) Art services and amenities to be provided, including...
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4. The Unit managers and/or OON will monitor for compliance and report audit findings to QAPI and any necessary follow up needed.
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AMbPt.ANQt:	PROVIDER/SUPPLIER/CLIA L1oeii'rw - 1\$AR:	Multiple OOHSTRUCTION awita	C 11
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<p>F 866 Conek, From Ps184t 4 v,sl , -faollty M\I</p> <p>On ..19 1:DPM.tfl,f rb)telV1&W wllh the Director of Nu ng revealed no*fUrtter, information.</p> <p>F684 Quatlfig' C8l'3 \$S=re CFR(i ;:rtf3.26</p> <p>§ 483.2\$Jluaily care ou_my 9,teari inf fW1ct !!!:prir\QJP.IM hat a 1ra1J& Gltreatment erus.(JB,i:-.liofed ta (ia: dOh:ifil',r m• e .lgo</p> <p>llyro8fdantv .Mi- ul+ !r- '1 ffltt 8B6ur8</p> <p>irita: acerls -J-1 dca, reJ'I</p> <p>aCCofialice With p sMialr8ta"14ads... radic the on)rehe" "1!6n-centered 91';P.fat'1 J!ld.Ule'tis .enur" Toicas; Thi\$ REQUIREMENT !& not r'net 88 evidenced i,y:</p> <p>-on\$utY cUn rechrcfae: aiffilr: of cttttrml l l ad tt, fu, ti; o: & .Elatt fatted t6fol9qw a 1 pff W '& ""Ctder, This f(1)d was aylicant lfl1 of a, . dui1ng a coinpW,,t survey.</p> <p>! Thafi & fnt;lu e</p> <p>q5,;0 1 at h;3SA tcur of re* ent #21 1'- .d.that Intra venous fluf4 (IVF) riomiallaune .0.9%-1@S ntnnlMJ thl'Cpg1HI dial How tubing (a of IV l@Ing that allows the userlo eull 181.-tfwt' r. In t!Wt: va4!fa) ott. nti_v (O)\$ Jntg, ft, ;T: P. #t1Nij.: Pmn o,,,,ff Mt to 260 nil</p> <p>itt:.m=i .i,r : ij,at r of ffi:,rii l(tjn(ffi' h!taf-1A re3</p>	<p>F 6615</p> <p>F684</p>	<p>F684</p> <ol style="list-style-type: none"> 1. 'Rasent #2 di;d not haw ahv adverse out(OfueSas related to this citation. 2, Al resld@nts t,aw the ntlal to be affe d bythis d c:Jent pradJ regardlna cian drden; and IV thet'aPV, 3. All licensed staff wil' be reit' ducedet on any N Infusions and physil;2an q,,:c:ffk orifen to ensure the c orrect rat• and volume is being glven and document@d. 	
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Office of Health Care Quality

STATE OF DEFICIENCIES
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NAME: PRQ/MOEA; OR 81.1PrUE1
STREET ADDRESS, CITY, STATE, ZIP CODE

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9101 6EtoPto AVENUE
ftr, VIR SPRING, MO 20910

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QJ1> 1. _____ was ductE'd at this facility by _____ of: l • a e q l i t y to io elec:omplafnts #MD00136787 and IM000137110. Survey activlut\$,iclU(fe fWleW DfMo -nta* rrtedloal rscq r_s'f.;'ln tervl\$wm itd; and of re ent\$lld p. Th.a fulowing dataaehcio. .we the result of tbf vlstt.

S 810 10.07.02..12 Q Nss Svcs;C Nurso

S:510

.12 Nursing Services,

Q. Charge Nurse. M.lea1lo114t'ltcentld nurse shall be on duty ft al til'IM:and ah:all be designated by the director. of:Sm1111iqg to be in- che,ge- of the nursing actv!t'9& duog e8JCh toli" of duty. The charge nurw" O/hu shaU have lha ability to recognize significant change& lit the coodldon of patJ JI and tlfake action.

S"ei)F684

11/11

Thi& egulation. not met ag 8'.lldenoed by:
Refer to CMS 2567
F684

S1730 10.07.02:37 E care Planning; Organimtion of plan

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.37. re.Plal)f)Ing.

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(i) pt(l);lt;rn: akJ fi(1Gaf lhgll b-. tified; bu.ad ,
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OHCA LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

STATE FORM

6X11511

3/20/19
**discussion sheet 1 of 2

OMB NO. 0938-0391

STA... PLAN CW CORREC... ANO PLAN CW CORREC...	P... SUPPLI... IOE:NTIFICATION NUMBER <p style="text-align: center;">216060</p>	Jx : "MULTI... CONSTRUCTION A... L... 8 Wlt<l	(0.3) OATS SUIWIN COMPLmtD <p style="text-align: center;">C 02/02/2019</p>
W.M Of PROVIDER OR S REGENCY CARE, OF SILVER SPRING, LLC		STRI:CT ADDRESS. crvv, STATE. ZIP CODE 9101 SECOND AVENUE SILVER SPRING, MO 20910	
TAI: TW\$UIATORY OR LSC I	PAJUIX T,A,Q	P... f... Of CORRECTION (EACH COAAECTIVE ACTION OI)U, PL. CHQ J J! Alr:IC EO TO THE ANAAQPR:ATE DEF IENCYV)	IITIOU CW'f
<p>F 000 INITIAL COMMENTS</p> <p>bn 2/5119. asurvey\YBs cortd te(f st thtS (e:llrty by tha Qffice of H care Quality to inve t;rgete compJafnt #M000136457. ActMties l ded th8 lnt&NM'N of tl& facit'y\$ business office personnel aild al) audit of the resii:;ients' pe on.al funds records maintained by this ility.</p> <p>The liiP ciflc CQfTiplaint was unsu-bstafillalt!!d. This urvay did not ld ntify noneomplianoe with federal reqrement& IP'lat were reviewed in relationship to the specific complairt.</p> <p>This survey did identify noncompliance with federal reqrememerts that ware revieiHed pertainig to the management of resld&nts- personal funds. (SEE f 567 & F568)</p> <p>F 567 Proteciion/Managell'ent of Persot1al Funds SS=B CFR(s). 4S3.10(f)(10(i){ii)</p> <p>§483.10(f)(10) rhe resident has a rl11ht ta ma e h s or her flnal'l(:lal arrairs This indudes the right to know, In advance, What c:harge5 a facility may impose agalnsc a residenrs p,ersonal funds.</p> <p>(i) The facility must OOT requItl, re&lidents to deposit their personal funds with the facility. If a re\$Jden\ chOOHS to deposit perwriel funds with the facility, upon wrftan aulhori:za on of a res.fdenl the faciltly must act s. a ftduclary of ttie resident's ftJn<ia and tJOld . safeguard, manage, ond account for the personal funda of the residen, deposilecl Wi11 Ul! (i:t<:,llilly, SJJ(rl;rl;lel fn 1111S a ction.</p> <p>(u) Deposit of Funds</p> <p>(A) In 9eneral. Except as set out in paragraph (0(10)(11X8) of lhl's section, the facilty must deposit an residents' personal funds f.n excess of \$1(19 in</p>	<p style="text-align: center;">FOOD</p> <p style="text-align: center;">f 567</p>	<p style="text-align: center;">F.567</p> <p>e. Resident IA Account was reopened on 2/12/1g and \$485A3was redepo5ited into the acco1.1nt. Per National Oatj Care, the Interest amount that should have been pi:litt ii S.22 cents, which the chei::kwas deposited on 3/7/19. Su!JnMS office manager malled a l tte, to the attorney's office informing them of the funds that are avadabl<?. If the letter is not recelv d bl' October 31, 201 . the fundS, w/11 be t1,,lrr'ed over to Unclaimed Property .</p>	

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

Michelle Mahan *Administrator* *3/11/19*

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that, cell,er, E3fagnet ul'ffieier, 1 protection 10th nls. (See f... (r,s.) Exrpt for nu irig il)h les, 11'4 firli((IS emll.d atw-d a d... 90 days fo110... 1'9 thle e or111 y nllrmo,r or not' pron (f ceUon ;:,; p<Ovnlcd. f JI\,llBng h , tit: o lingin&-a- .00plana o(oarroot,Q) are dayii ficllo11111 J . d !'no doamor4A" Aro mAd. a111111llloh' tc, th(' ol\$y. If CK&la'al&0 rci choct. t il opf)N!Wd pla n of gt.lon liJ RO-a to OtInU progra,in po

STATEMENT OF OPERATIONS AND FINANCIAL STATEMENTS OF THE FACILITY	X1) PROVIDE ILLUSTRATION OF THE FACILITY'S FINANCIAL STATEMENTS	X2) TITLES OF THE BUILDING	DATE OF THE STATEMENT
NAME OF PROVIDER REGENCY CARE OF SILVER SPRING, U.		STATE OF MISSOURI, ZIP CODE: 9151 SE D AVENUE SILVER SPRING, MO 20910	
X4) JOINTLY OWNED FACILITY	IO NUMBER	PROVIDER'S PLAN OF CORRECTIVE ACTION	IX#
<p>F 667 Continued From page 1</p> <p>Interest-bearing account (Joint) rate from 5% of the facility - 9 accounts, and that credits made on resident's funds to that account. (In pooled accounts, there must be a separate account for each resident's share.) All must maintain a resident's personal funds that do not exceed \$100 in a non-interest-bearing account. Interest-bearing account, or petty cash fund.</p> <p>(B) Residents whose care is provided by the facility must deposit the facility's personal funds in excess of \$50 in separate interest-bearing account (or accounts) that is separate from any of the facility's operating accounts: that credits are intended for the resident's use and that account, (In pooled accounts; there must be a separate account for each resident's share.) The facility must maintain at least \$50 in interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by</p> <p>Based on the review, on 2/19/19, of the residents' personal funds records, including individual residents account summaries and financial report, this facility failed to deposit a resident's personal funds in excess of \$50.00 into an individual, interest-bearing account. Findings include:</p> <p>1. Resident 1A expired on 1/18 facility closed the resident's interest-bearing account on 4/11/18, without appropriate notification. The facility transferred the resident's 5486.43 closing balance to a non-interest-bearing, pooled, petty cash checking account. The resident's personal funds remained in the non-interest-bearing account until 10/31/18.</p>	F-567	<p>Resident 2A- A check was released and deposited into the resident's account on 2/12/19 in the amount of \$1,412. National Data Care was not able to give an interest amount for the account remains open.</p> <p>An audit will be completed by the Business Manager to ensure there are no other resident's affairs involved.</p> <p>A monthly review will be completed by the Business Manager with review by the Administrator to ensure no further deficiencies occur.</p> <p>Monitoring monthly of the accounts will be completed. Any deficiencies will be addressed at that time.</p>	<p>March 17, 2019, all findings on monitoring.</p>

STA. ID: 11111111 ANO P OF CORR. EC'TION	() PROVW)E)F)W)P)P)I)E)R)I)C)U)A IOE)I)I)T)I)J)C)A)T)I)O)N NUMevt 216060	IX)2)6)U)J)L)T COI SIRI)C)T)I)O)N A t;)L) G ... - -" - - - S WING	ou) DA.re SURVI)Y cm1P)I)D)- C Q) S)I)2)0)1)G
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F 567 Continued from pa;J8 2 O" 1126117, this f.ec;ili1Y withdrew \$1,412.00 from me persooal fund account for tesideftt 2A. The resident's personal ru11d\$. transferred bY the facility to a hatt-inle(etr rf pooled petty cash checking account As ot 2/5/19, tte re t-s pef9onal funct's remamed in the t)O)l)-I)nl)E)l)O)S)t bearing ij,QCQ)\Jnt. F 68B Accounting and Recor<t, of POJsonaf Funds SS-"8 CFR(s)- 483 10(f)(10){iil) . §463.10(f)(10)(lii) Accounting and Racords. (A) The factJlty must establish and maintain a system tnat assures a fJ" atid complete and parate account1119, according to generaly iiocef)tec.f aocounting prlnc•ptu, of &ach rasident'i personai funds entrusted to the facillty on the te\$)Ideor& behaif. (B) The \$)'stem mu=it preclude any comml Dng of i'e&ident funds wif1 racil_ity funds or wifnlf'a funds of any person other t oother resfdeii (C)The lodivdua f,nat' Cial r6COrd m1.19t be , avai ble to the resident througll quarterly statements and upon request This REQUIREMENT Is nol met'\$ evidenced by: B.ased on the reYlew. on 215118, of the testSenta' per5onal funds records, including tndlvktual resident'a acco1Jnt atatemens, banks statements, ttaM&.etlon teP<>rt, transaction receipts, and reooncllatioo reports, this faeallty ralled to maintam a system trnit ensures a full and complete accountmg of the residents' persnal monleiJ en-trusted to th.a faotffty. Findings include. 1. As of 2/5.119. there was no evidence that the re&ideot-spooled. peUy cash cb8r;klf19 account #XXX 6'1 30 tlad been,@mP'&tely a!1d	F 567 F568	FS:68 1. A. A.II monthi. crted were recooc!Gd w th the petty cash checking c.ccounts. Copies have been submitted to the surveyor with l)ls POC, C. All withdrawals of rf'sidenu 1,>ersoMI funds will be recorded with the appropriate transmitted transaction receipts and plac'd lo the appropriate binder. O. All wltl1drawils of rnsklent's personal fund!! will appropriately a: thori:t:ed a(l)or witnessed. All administrative staff will be tn•Sf?Nlc d on th4: ! ne«gs.ary i!!J\hor lzatiun process. £. RerJdent 3A account was	

<p>ST OF OE IEN - AHO PIAN OF COAREctioif</p>	<p>(X) PROVIDIUS1.JPP'USRJCI.A IDENTI TION tliNR-</p> <p style="text-align: center;">215060</p>	<p>IX:Q t.tul,IlfU; cor4STRVJCTION A BIJtLD,,10 _____</p> <p>B'W'ING _____</p>	<p>(in) DATE SURI/EY COMPLETED</p> <p style="text-align: center;">C</p> <p style="text-align: center;">02/0\$12Q19</p>
<p>r-w.1E OF f11 «)VIDER OA SI,JfPU</p> <p>REOENCV CARE Of SILVER \$PRING, LLC</p>		<p>STREET ADDRESS, CITY, STATE, ZIP CODE</p> <p>91013ECOMD. AVIINUI! SfLVER \$PRING, MD 20\$10</p>	
<p>PI'iifIX TA(ti, _____</p>	<p>SUW.11\rf STA'TfMBIT OF 0EFICIEK'ClE6 I,!.ACH PEfICIENCY'4.JSf BE PfIt:ClrOEO 8V FULL REOOt.,\TOR.V OA L 109ITIFINQ INrOIIUATr»J)</p>	<p>PROVIDER'S PLAN(F)C()R £ ICACMCO IiYE>t'T10N. 81-IOUL..O ai; C:R(\Q." £i!!E.HCEDT() THf! ft!A'f!! 01.r.,(llEl'tCY)</p>	<p>. p:1% toM'1 I'I</p>
<p>F 568 Cootltiued Fron, p8!Jtfil 3 appropriately rt1Gonel d f0t the months ending 9118. 10!18 , 11/16, and 12'18. AA of 1/31119, thet• appeared to be d(tpostts with no checks written dating back to 2116.</p> <p>2. All withdrawals of restcf i,nts' pe('aonal funds were 1-o(reoo(i;feQ en epproprijate Iransac:Uon tecalpts.</p> <p>3. AU Wilhdr.QW818 Of residents' personat fUf'ld\$ we.re OOt appropriately authorized andtor wilnessed.</p> <p>4. On 512H18, thie facllrty closed U'i personal fut(f aooounl tor re:liident 3A, wittlout appropriate authorization. A& of 2/5119, there was no eYidel"lCe a6 to the finBf dlspostJon or the resicent's \$120.01 dosing balance.</p>	<p style="text-align: center;"> F 568</p>	<p>reopened en 'i./12/19 and \$120;01 wa5 reclP:Q\$ited into the account. Per NOC, lhe Interest amount should be \$.04, which was d posited into the account on 3/7/19. A k!tte, was mall to the repre\$entative listed Informing them of the funds that re oow available to be claimed aod the process of using. the Letter of Administration. If the tter Is not received by October 31, 2019, the funds. will be turned over to Unclaimed Property.</p>	

Office of Health Care Quality

STATE OF MISSOURI DEPARTMENT OF HEALTH OFFICE OF HEALTH CARE QUALITY 21f060	(1) P E:R UPPUtiRICLIA JOENnfiCAIW.N NUi41tR. 21f060	t(n t.,J,n.,l'PJ,E COJ<STRUCTION A BUIIOING: _____ B V.U4G: _____	(J) O AIE 5 Y COMPtE FEO C 02/0612019
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"1M: Or PROV, OR &VPPLIER STRF.ET CITY, ST/I.TE. 21P CODE
REGENCY CARE OF SILVER SPUNG, I.LC, **9101 SECOND AVENUE**
SILVER SPRING, MO 20910

t IAG SIIIMARV STAr ti, em, Of' PEfICI N:::IES (EACH OFECIENCYMUS1 8.1: P,R f:C: OW SY FUU.. REOUATOYAO ISC IDEITTLF;YING il-FORIMTIOH)	IO PREFIX "WJ	fiOVIDE.F(S Of COAAECTIONf (EiCff CORRECJM ACTION SHOUIO BE CROSS-REFfERENCEf TO TME A?PROPRIAJE 08'10EMCY)	(J)S cam.in DATE
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<p>S 000 iniUal COO"lments</p> <p>, 011 215119, a survey was conducted at this facility by the Office of Health ear; ally tQ IIWt!stl99te complaint #M0001364S7. Activities iflclu<ied the iritervlelv of the facility's busineH office person&l al'd .an 8t1dlt of the residents' pef90nal fuMs records me1ntemed by this! cility.</p> <p>The specific complaint was.unsublitantlat-ed. This survey did not idfintly natieomplat'lee with St t:8 requirements Chat were teVLs:w@d in relationship to the spedftc complaint</p> <p>This SIIIMY did lde11tlfy noncomplianoe with State requirements that were revl ticl IM)rtalng to tle mafagi,ment of re&Jder)'ts' pereoll81 funde. (SEE S8465, -\$&180, \$8520, \$)</p>	<p>S Q00</p>	<p>An au<flt WM be completed bV Uie BOM lo eosure all accounts a.-e f' ctif c:J appropri 1 ltety.</p> <p>A monthly review of the fund a count5 will be completed by the SOM with oversight by the Administrator,</p>	<p>March 29, 2019 and O,,. going.</p>
<p>58466 10.07.09".18 O (1) P10tect res h.Jnds:excess of \$50,int bearing</p> <p>.16 PtotectfO(l of a Re&itlenfs Pen;ooal Fvnos</p> <p>0. PetSonal funds in Exceas of \$50. A nursirtg facility shall:</p> <p>(1) Oep0\$lt a resldi,nrs personal tun<ts In excess or \$5() In an intere&t-ooaring a nt thal ls:</p> <p>(a) E\$tabrls alld maintained by ttie facillty 1.in,der one of the following terms:</p> <p>(i) In the lISme of ttie resi(lent only,</p> <p>(ii) fn the name of the facillty ""in trust for" or as the "tru a" for tt,e indivdue.! re ident, or</p> <p>(iii) 1n a re&idents' pooled account, with a separate. accoonting for each resident's share: and</p> <p>(b) Located in a financial instiwlloo whose accounl& er il\$Uted by the:</p> <p>(1) Federal Deposit Insurance Corporation (FDfC). (ii) Federal Savlnas and Loan InsuraDCe C oon(FSLIC). or</p>	<p>S6465</p>		

OHCO LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Michelle Mah...* TITLE *Administrator* DATE *3/11/19*

STATE FORM *TC0011* If continuation sheet 1 of 3

Office of Health Care Financing

STATE OF MISSOURI DEPARTMENT OF CORRECTIONS PIAFF	(10) P P R I E A I (J U A . W E r , t J I F t C a f N U M B E R . 21\$060	() C , - , _ U I T I P E C O N S I I U C T I O N A B U I L O N O : _____ D. IM	(X3) D A T E S C O M P L E T E O C 1>2/0512019
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Mt. II: OF PROVIDER S REGENCY CARE OF SILVER SPRING, U.C	srR H A O O R E S S , C i r " ! , S f A 1 " E . Z I P C O D E . 9 1 0 1 S . E C O N O A V E N U E S i l . V E R S P R I N G . M O 2 0 9 1 0
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() P R I I R X I P . G (I ! A C t 4 o t , * C Y M U S T B E P R E C P Y F U L L R I G U L A T O R Y O R I 6 C I D E N T I F Y I N Q I N F O A M < ! / O N I	I D F R I F I X T A Q	M O I I I O E F ' 8 P L A N O F C O M E C T I O N (E A C H C O R ; R I ! C T M ! A C T I O R T . S H O I A . D f i e N C F . i) T O T M t t J > , 8 0 P R J 1 . 1 O E F I C E N C Y . ,	I I Q I J c a . t P U : T E I I I \ T E
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S640lj Continued From page 1 (iii) Other insurer epttoved by the Department; and (e) Sepatate from any of the nursing facillty's op«atirtg aceoun end I I " I I S R e g u l a t i o n i s o o t m e t a s e v i d e n c e d - : S E E F 6 6 7	56465	S646S Se FS67	J/ 61
56480 10.07.09.18 F (1) Protact res tunds; earabres acct .18 Protection of e Resident's Personal Funds. F. Establishment of Resident ACCQUnts. When a nurving fsollit, r menagee a reaident's fioaooiel affairs, the nursing faeltity al\ a. t l e - s t a b l l e h a n d m a J o t a l n a s y s t e m t h a t (1) ensures a fud. complete, and separate a « o u n t i n g , a e () () r d l n , g t o n e r a U y p t e d a e o u n t i n g p , l n c f p t e l > . o f e . a c h r e S i d e n r s p e r s o n a l funds entrusted to the nursing facility; and This Regulation is not met as evtdGnced by: SEE F667 & F568	S&480	see S67 and F568	J/1/11
S6620 10.07.09.19 B (1) Recs Pers. Fi.mdt:ReeeiptS ,19 Records of Resident Personal Funds. 8. Rsc.afpts of Transactions. (1) tf a transaction Involves a transfer of fun.d.& tietween a resident and a second party, or between the n u l ' \$ l n Q f a e i f l t y a n d t h e i n s t i t u t i o t \ i n which the residenrc account l o c a t e d , t h e nursing facility o t f i r l B r i c : i a l I n s t i M i o n s h a l l : (a) Provide a p \ o r c o p y o f s r e c e i p t t o t h e residenl or retain the resident's copy of the	56520	56S20 See FS68	'rJ i

Qualification of Hearing Care

STATEMENT OF DEFICIENCIES At Pr. AN OF CORRECTION	Q(t) PAOV!omlSIIM.t tA IDF,NTIFICATION.NVIIU1EA* 218060	!X2)Ml.1ffltl;COMSTRUCTION A 6UTT.OI.NO B. WING	<X!) OAT; SU CO\ifil.f:tf0 C 02/0512019	
NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVERSPRING , LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 8t01 \$EC0'1DAVENUe SILVER'S,PI'ONG. MD 2.0910		
(X4) ti !-H,UI) 1NJ	stIMWRV &TATQil:N'f Of! otfJ CItS tH QEFIGIENHCY 1U T PRUCB! QD;(fUI1, NCOUL.Arur- uu;; IUI:'OI'YING INrOR%fflI0H)	10 PRIJ11X 'LAC.f	PR reACtl CORR! ACtION SHOOLD Ge cttoSS-REffRe'NCI!bto tH!APPf(O?RIATF. OS'ICIENCY)	rn OATf;
<p>56520 Continued From page <i>i</i></p> <p>receipt as part of the resident's individual financial record; and</p> <p>(b) Maintain the original receipt and make it available for audit.</p> <p>This Regulation is not met as evidenced by: SEE 568</p> <p>see 10.01.oe.19 B(4) Recs Pets Funds:faal withdrawal authority</p> <p>.19 Records Of RestQent Personal Funds.</p> <p>B. Receipts of Transactions</p> <p>(4) Except as set forth in Regulation .18H(2) of this chapter, a nursing facility may withdraw money from a resident's account without written authorization of the resident or, when applicable, the resident's agent. If the:</p> <p>(a) Nursing facility document that the resident is incapable of understanding the resident's rights and responsibilities regarding finances;</p> <p>(b) Resident's agent is unavailable; and</p> <p>(c) Withdrawal of funds for an item or service needed for the resident's direct and immediate benefit and the facility maintains documentation that the withdrawal was for that purpose</p> <p>This Regulation is not met as noted SEE F568</p>	<p>86620</p> <p>\$6535</p>	<p>SG53S</p> <p>See FS68</p>	<p>ir</p>	

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

PRINTED: 08/08/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2110BG	OC2) MULTIPLE CONSTRUCTION ABUJIDING _____ LWINO	CIQJ DATE SURVEY COMPLETED R-C 08/04/2018
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NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 B&COND AVENUE SILVER SPRING, MD 20110
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(X4) PREFIX TAG	INITIAL STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	IMTE
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(F 000)	INITIAL COMMENTS On June 4, 2018 a revisit survey was conducted to determine the facility's compliance with the plan of correction submitted for the deficiencies cited during a federal monitoring survey that concluded on April 16, 2018. Survey activities included the review of the clinical records for 18 residents, observations of resident care and staff practices. Interview of residents and facility staff, and review of facility policies, credible evidence of compliance, and other pertinent documentation. The following deficiencies were cited as a result of the on-site survey.	(FOOO)		
(F 580) SS,.,.o	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(1HIV)(1) §483.10(9)(14) Notification of Changes. (i) A facility must immediately inform the resident's physician; and notify, in consultation with his or her authority, the resident representative(1) 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 social 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)(v) of this section, the facility must ensure that	(F 580)	FSBO Resident #55 did not have any adverse outcomes as related to this citation. POA was notified of the change in condition with the initiation of the new medication. Any resident that resides in the facility has the potential to be affected by this citation. No other residents were affected by this citation.	

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JUN 26 '18
OFFICE OF HEALTH CARE QUALITY

DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Michelle Mahan* TITLE: *Administrator* DATE: *6/21/18*

any statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the institution has met the requirements of the regulation. (See instructions.) Except for injuries, the findings stated above are disclosable 90 days after the date of the survey. For nursing homes, the findings stated above are disclosable 14 days after the date of the survey. If a facility is cited, an approved plan of correction must be submitted to the state within 30 days of the date of the survey.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	CX1 PROVIDER/CLIA IDENTIFICATION NUMBER: 215010	(JC) MULTIPLE CONSTRUCTION A. BUILDING _____ 8, 11/18	(X3) DATE SURVEY COMPLETED R-C 08/08/2018	
NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 9101 SECOND AVENUE SILVER SPRING, MD 20910		
041D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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)	DATE
(F 580)	<p>Continued From page 1</p> <p>all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.</p> <p>(IB) The facility must also promptly notify the resident and the resident representative, if any, when there is a:</p> <p>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or</p> <p>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.</p> <p>(IV) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(a).</p> <p>§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 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).</p> <p>This REQUIREMENT is not met as evidenced by the surveyor review of the clinical record and interview with facility staff. It was determined that the facility staff failed to notify resident #55 of medical Power of Attorney of a change in condition timely. This finding was evident for 1 of 3 residents affected for a change in condition interview. The finding includes:</p> <p>On 06-04-18, surveyor review of the clinical record for resident #55 revealed that, on 05-29-18, the attending facility's psychiatrist assessed resident #55 for agitated behavior after</p>	(F 580)	<p>Licensed nurses and professional staff will be in-serviced on the proper notification of the correct family members and/or POA's when there is a change in condition by the Administrator, Social Service Director and the Director of Nursing,</p> <p>DON and Unit Manager(s) will review changes in condition to ensure proper notification is made. The result of the audits will be reviewed during QAPI and followed up as needed.</p>	By 6/25/18 and on-going

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	C,C1) PROVIDER IDENTIFICATION NUMBER: 215080	CX) MULTIPLE CONSTRUCTION A. BUILDING _____ I. WING	X) SURVEY COMPLETED R.C 08/14/2011	
NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 HCONDAVENUE SILVER SPRING, MD 20910		
CXA) ID PREFIX TAO	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	OIG COMPLETION DATE
{F 580}	Continued From page 2 staff reported the resident was exhibiting verbal and physical agitation during the evening. Further review of the psychiatric documentation revealed an order for staff to administer the medication, <u>Gabapentin</u> 300 mg at 5PM daily to the resident for agitation. However, review of staff documentation revealed no evidence that resident #558 medical POA (Power of Attorney) was notified of the change in condition with the initiation of the new medication on 05-11-18. On 08-04-18 at 5PM, surveyor interviewed with the Interim Director of Nursing revealed no additional information. {F 656} SSaD 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 person-centered care plan 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 outcomes 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 <u>practicable</u> physical, mental and psychosocial well-being as 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	{F 580}	F656 Residents #1, #48, and #172 did not have any adverse outcomes as related to this violation. Resident #1 no longer resides at the facility. Residents #48 and #72 care plans were revised to reflect their current care the MDS nurse on <u>8/11/18</u> . Residents in the facility have the potential to be affected by this violation. No other residents were identified to be affected.	

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(JC1) PROVIDER IDENTIFICATION NUMBER: 215080	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ a. WING	(3) DATE SURVEY COMPLETED R-C G& / 04/2018
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NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 8101 SECOND AVENUE SILVER SPRING, MD 20910
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CMI) PREFERRED 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)	DATE
{F 656}	<p>Continued From page 3 treatment under §483.10(c)(8). (iii) My 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 desires 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 11K1 movement set forth in paragraph (c) of this action plan. This REQUIREMENT is not met as evidenced by: Based on surveyor review of the clinical record, and resident and staff interview, it was determined that facility staff failed to develop care plans to address the needs of residents. This finding was evident for 3 of 4 residents reviewed for care plans. (#1, #48, 172) The findings include: 1. On 08-04-18 surveyor review of the dated clinical record for resident #1 revealed a "Discharge Planning Review" that was completed on 03-04-18. The review revealed that the resident was to return home, but the family was open to other options. However, further review of the clinical record</p>	{F 656}	<p>The IDT team will be reeducated by the Director of Nursing on ensuring Residents plan of care are comprehensive and person centered. Chart audits will be conducted twice per week for four weeks for ensuring residents who have changes in condition or new orders have their plan of care updated according to the changes by the Unit Managers and MDS coordinator. The results of the audits will be reviewed during QAPI and followed up as needed.</p>	By 6-25-18 and 01 golna

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	p(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21508D	(JC2) MULTI-CONSTRUCTION ADDRESS: 8 WING	(3) SURVEY COMPLETION DATE: R.C --M.018	
NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 SECOND AVENUE SILVER SPRING, MD 20910		
04) ID PREFIX TAB	STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY REGIATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAB	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(3) COMPLETION DATE
{F 656}	<p>Continued From page 4</p> <p>revealed no evidence that a care plan was developed to address the discharge planning needs for resident #1.</p> <p>On 08-04-18 at 6:30 PM, surveyor interviewed with the Director of Social Services provided no additional information.</p> <p>2. On 06-04-18, surveyor review of the Clinical record for resident 148 revealed a comprehensive assessment, completed on 05-21-18, that indicated that the resident had an anxiety disorder.</p> <p>However, further review of the clinical record revealed no evidence that a care plan was developed to address resident #48's anxiety.</p> <p>On 08-04-18 at 5:45 PM, surveyor interviewed the Inform Director of Nursing provided no additional information.</p> <p>3. On 08-04-18 at 11 AM, interview of resident #72 19V881 revealed the resident was alert and oriented, but only able to answer simple questions. The resident was observed wearing a right hand resting splint</p> <p>On 06-04-18, review of the clinical record revealed an order, documented on 05-08-18, to apply a right hand resting splint 4 hours on and 4 hours off, and on an night for resident #72. Further review of the May and June 2018 Treatment Administration Record (TAR) revealed the nursing staff documented that the splint was applied as ordered in May & June 2018.</p> <p>However, there was no evidence of a care plan related to resident #72's right hemiparesis (right sided paralysis) or limited range of motion in the</p>	{f 656}		

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 SERVICES FOR MEDICARE & MEDICAID SERVICES

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 OMB NO. MAE-0A1

TITLE OF DEFICIENCY AND PLAN OF CORRECTION	(JC1) PROVIDER IDENTIFICATION NUMBER: 211050	(2) MULTIPLE CONSTRUCTION A. IIC, DINB _____ II. IICNC3	(X3) DATE SURVEY COMPLETED R-C 01/G417018
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NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF 8LYER SPRING, UC	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 SECOND AVENUE SILVER SPRING, MD 20910
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(OC4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
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(F 656) F 658 SS=B	<p>Continued From page 5 clinical record.</p> <p>On 06-04-18 at 7:20 PM, Interview of the Interim Director of Nursing revealed no additional information.</p> <p>Services Provided Meet Professional Standards CFR(a): 483.21(b)(3)(1)</p> <p>§483.21(b)(3) Comprehensive care Plans The seMCH provided or arranged by the facility, as outlined by the comprehensive care plan, must:</p> <p>(i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by:</p> <p>Based on surveyor review of the clinical record and interview of the facility staff and attending physician, it was determined that the facility staff failed to meet the standards of nursing practice for verifying physician's orders for resident #32. This finding was evident for 1(#32) of 8 residents selected for review. The findings include:</p> <p>a. On 06-04-18, review of a clarification order for resident 132, which was documented on 03-03-18 by the facility's Medical Director, revealed the nursing staff was instructed to administer 4 mg every 8 hours Pain > 5/10. (Pain rated as over 5 on a scale of 1-10) Hydromorphone is a controlled II drug for pain relief.</p> <p>HO'S review of the May and June 2018 Medication Administration Record (MAR) between 05-2-18 and 08-02-18 revealed that the nursing staff documented that the Hydromorphone was administered to resident #32 every 4 hours when</p>	(F856) F858	<p>F658</p> <p>Resident 132 did not have any adverse outcome as related to this citation. Residents medication was clarified on 6-4-18 with the attending Physician. Resident #32 Attending physician clarified on 6-11-18, that the suprapubic catheter should be changed on an as needed basis.</p> <p>Residents in the facility have the potential to be affected by this citation. No other residents were identified to be affected.</p>	
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STATEMENT OF DEFICIENCIES MIO PREFIX OF CORRECTION	CJ(1) PROVIDER IDENTIFICATION NUMBER: 21SOIO	(X) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	CXI) DATE SURVEY COMPLETED R-C 0810412018
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NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 SECOND AVENUE SILVER SPRING, MD 20910
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CM) 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)	DATE
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F 658	<p>Continued From page 6</p> <p>pain was reconfirmed as equal to 5, which was inconsistent with the clarification order. There was no evidence that the nursing staff clarified with the attending physician as to whether to administer the Dilaudid every 8 hours, or based on the pain scale.</p> <p>On 08-04-18 at 4 PM, interview of resident #321 attending physician revealed the resident should have received Hydromorphone 4 mg every 8 hours routinely for pain.</p> <p>On 08-04-18 at 7:10 PM, interview of the interim Director of Nursing revealed no additional information.</p> <p>b. Additionally, on 08-04-18, review of resident #321's clinical record revealed a physician's order, on 03-22-18, to change the suprapubic catheter every 3 weeks. A suprapubic catheter is a flexible tube used to drain urine from the bladder through an incision in the abdomen. According to the nursing progress note and May 2018 Treatment Administration Record (TAR), the resident's suprapubic catheter was changed on 05-27-18. The suprapubic catheter was then scheduled to be changed on 06-07-18 and 06-21-18 per the June 2018 TAR.</p> <p>Further review revealed on 05-27-19, another physician order was written to change resident #321's suprapubic catheter "one time only until (08-23-18 23:59 Resident for suprapubic catheter change week of 08-11-18)". Per June 2018 TAR, the suprapubic catheter was scheduled to be changed once between 08-17-18 and 08-23-18.</p> <p>Review of the May and June 2018 TAR, revealed resident #321's suprapubic catheter was changed</p>	F858	<p>Licensed nurses will be educated on the 24 hour Chart Checks by the Director of Nursing and the Unit Managers to ensure the Physician Orders are accurate and to contact the Attending Physician if clarification of orders is needed.</p> <p>Weekly audits will be conducted by the Unit Managers to ensure Residents with new orders have clear accurate orders that affect their plan of care. The results of the audits will be reviewed during QAPI and followed up as needed.</p>	By 08-25-18
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMA NO. 093M391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER IDENTIFICATION NUMBER: 215010	CROSS-REFERENCED TO APPROPRIATE DEFICIENCY		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. IMNG	(X3) DATE SUMMARY COMPLETED R-C 08/04/2018
NAME OF PROVIDER OR SUPERVISOR REGENCY CARE OF SILVER SPRING, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 SECOND AVENUE SILVER SPRING, MD 20910			
(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)		CROSS-REFERENCED TO APPROPRIATE DEFICIENCY	
F 658	Continued From page 7 on 05-27-18. It was then scheduled to be changed on 08-07-18, then once during the week of 06-17-18 and 08-23-18, and 08-28-18, which was 10 days apart from each catheter change. However, there was no evidence that the nursing staff obtained clarification from the attending physician about the schedule and frequency of the resident's suprapubic catheter change. On 06-04-18 at 4 PM, Interview of resident #32's attending physician revealed the suprapubic catheter should only be changed on an as needed basis. On 06-04-18 at 7:10 PM. Interview of the Interim Director of Nursing revealed no additional information. As Code of Maryland Regulations 10.27.10.03 D (3), Collection of data and reporting of problems that arise in the carrying out of the nursing plan. (F 680) Discharge Planning Process SS=D CFR(s): 483.21(c)(1)(1)(ix)	F658				
(F 680) SS=D	§483.21(c)(1)(j) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals , the preparation of residents to be active partners and effectively transition them to post-discharge care , and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at § 83.15(b) applicable and: (1) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident	{F660}				

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

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OMB NO. 1511-0047

IDENTIFICATION NUMBER AND PLAN, CORRECTIVE ACTION	(C) PROVIDER IDENTIFICATION NUMBER: 218080	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ 8. WING	C, DATE SURVEY COMPLETE R-C 0810412D18
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NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 9101 SECOND AVENUE SILVER SPRING, MD 20910
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(X) ID PREFIX TAO	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)	IMT!!
{F 680}	Continued From page 8 (I) Include regular monitoring of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (II) Involve the interdisciplinary team, as defined by §483.21(b)(2)(0), in the ongoing process of developing the discharge plan. (Y) Consider caregiver/support person availability and the resident's or caregiver/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vi) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH. Bill residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not	(F 660)	F660 Resident 11 discharge was placed on hold due to the availability of a suitable discharge location. Resident #1 not on 1st floor at this facility. All residents in the facility have the potential to be affected by this citation. No other residents were affected by this citation. Social Services Department will conduct an audit to ensure residents have a discharge plan that	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	&1(1) IDENTIFICATION NUMBER: 215080	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(CQ) DATE SURVEY COMPLETED R-C 081041Z011
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NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1161 SECOND AVENUE SILVER SPRING, MD 20910
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(M) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(O) COMPLIANCE DATE
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(F 660)	<p>Continued From page 9</p> <p>limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the residents goals of care and treatment preferences.</p> <p>(b) Document, complete on a timely basis based on the residents needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the residents discharge or transfer.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on surveyor review of the clinical record and staff interview, it was determined that facility staff failed to ensure that the discharge needs of resident #1 were identified and incorporated into the discharge plan to avoid unnecessary delays in the resident's discharge. This finding was evident for 1 of 2 residents selected for the discharge planning review. The findings include:</p> <p>On 08-04-18, surveyor review of the closed clinical record for resident #1 revealed a "Discharge Planning Review" that was completed on 03-04-18. The review revealed that the resident was <u>upped</u> to return home but the famt/ was "open to other options".</p> <p>Further review of the clinical record revealed a social service note documented on 05-10-18 that</p>	{F 860}	<p>Identifies their needs and modifications due to any needs that are changed.</p> <p>Chart audits will be completed by Social Service Director once a week for four weeks to ensure residents have a discharge plan that identifies their needs and modifications to their needs. The results of the audits will be reviewed during QAPI and followed up on as needed.</p>	<p>6/25/18</p> <p>and On-soma</p>
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
 CENTERS FOR MEDICARE & MEDICAID SERVICES

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 FORM APPROVED
 NMA Nn 0938-0391

STATEMENT OF DEFICIENCY ANOTHER PLAN OF CORRECTION	(X) PROVIDER IDENTIFICATION NUMBER: 215010	(a) MULTIPLE CONSTRUCTION A BUILDING _____ 8. WING	(X) DATE SURVEY COMPLETED R-C G110412018
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NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 SECOND AVENUE SILVER SPRING, MD 20910
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TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION (EACH CORRECTIVE ACTION SHOULD BE CORRELATED & REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
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{F 660}	<p>Continued From page 10</p> <p>a referral for resident #1 was sent to... Care Placement on 1 a and that the social worker would follow up. However, there was no evidence of further follow up of placement or other discharge planning completed by social workers.</p> <p>In addition, there was no evidence that a care plan addressing resident #1's discharge planning was developed during the resident's stay at the facility. (Refer to F856 for additional information)</p> <p>Surveyor review of the nursing notes revealed a note documented on 05-25-18 that resident #1's discharge was on hold due to availability of available discharge location". The family members told the nurse that the resident would be unable to be discharged home on 05-26-18 due to the home having too many stairs that may be unsafe for the resident. The family stated that they would look at an assisted living facility to transfer the resident.</p> <p>Surveyor review of the "Discharge Transition Plan" for resident #1, dated . . . revealed instructions for the resident to contact the home health service provider listed. If the resident did not hear from the provider in 24 hours. However, the name and contact number for the home health care agency was not listed. Despite a physician's order written on 05-29-18 that revealed resident #1 was to be discharged to home with home health services on</p> <p>In addition, there was no information documented regarding upcoming follow up appointments despite a nurse's note written on 05-29-18 that revealed resident #1 had a follow up neurology</p>	{F680}		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 081081201B
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	CX1J PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215080	(JC2) MULTIPLE CONSTRUCTION BUILDING _____ B. VITING	CXS) & URVEV COMPLETED R-C aammole
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NAME OF PROVIDER OR JURISDICTION REGENCY CARE OF SILVER SPRING, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 9101 SECOND AVENUE SILVER SPRING, MO 20910
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QW) ID PRIORITY TAG	81.MMR) 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)	MT) i
{F 680}	Continued From page 11 appointment on 08-08-18.	{f 860}		
{F 681} SS-D	<p>On 06-16-04-18 at 5:45 PM, surveyor Interview with the interim Director of Nursing provided no additional information.</p> <p>On 08-04-18 at 8:30 PM, surveyor Interview With the Director of Social Work provided no additional information.</p> <p>Discharge Summary CFR(s): 483.21(c)(2)(i)(ii)(y)</p> <p>§483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge shall be <u>available for release</u> to authorized persons and <u>aged 18 & over</u>, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medication with the resident's post-discharge medication (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up</p>	{F 681}	<p>F661</p> <p>Resident #1 and #2 did not have any adverse outcomes as related to this citation. Resident #1 and #2 no longer resides at the facility,</p> <p>Any resident at the facility has the potential to be affected by this citation. No other residents were affected by this citation.</p> <p>The facility has begun utilizing two discharge assessments that are in our electronic medical record system which will help ensure that every member of the IDT provides a summary</p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/08/2018
FORM APPROVED
OMB NO. 1838-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(C1) PROVIDER/WORKER IDENTIFICATION NUMBER: 215080	(C2) MULTIPLE CONSTRUCTION A. BUILDING _____ 8. WING	(Q) DATE SURVEY COMPLETED R-C 08/04/2018
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NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 SECOND AVE SILVER SPRING, MD 20910
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(JW) ID PREFIX TAO	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
{F 681}	<p>Continued From page 12</p> <p>category and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by:</p> <p>Based on a review of the Closed clinical records and Interview with facility staff, it was determined that the facility staff failed to ensure a complete and thorough discharge summary for residents at the time of discharge. This finding was evident for 2 of 2 residents selected for the discharge summary review. (#2, #1) The findings include:</p> <p>1. On 06-04-18, closed recon review revealed that resident 1112... discharged from the facility to home on 06-04-18 after a short term rehabilitation stay. Further review revealed a copy of "Discharge Transition Plan" which included the following completed information: recommendations addressed by physical, occupational and speech therapy services and copies of the medication prescriptions (written out by the attending physician on 05-29-18). In addition, a copy of a prescription script by the attending physician with the order for PT (physical therapy) /OT (occupational therapy) 8x81 (evaluation) and treat home care Human Touch " (area home health agency). Review of the social service note on 05-31-18 at 7:38AM, by the facility's social worker assistant, revealed documentation that the resident was discharged home on 06-04-18 and received a Discharge Transitional Plan with discharge instructions that included the resident will receive Home Health Services.</p> <p>However, further review of the discharge Transition Plan revealed no information indicated by the facility's social services regarding the</p>	(F 681)	<p>of the resident's discharge.</p> <p>reconciliation of all medical orders, follow up appointments, Social Service related resources/referrals and a discharge plan of care that is developed with the participation of the resident and/or the resident representative.</p> <p>Social Services Director will audit discharge assessments on a weekly basis to ensure proper discharges are being completed. The results of the audits will be reviewed during QAPI and followed up as needed.</p>	6/25/18 and On-site

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	CX1) PROVIDER IDENTIFICATION NUMBER: 2t&G80	CX2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	CX3) DATE SURVEY COMPLETED R-C DI/04/2018
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NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 SECOND AVENUE SILVER SPRING, MD 20910
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CX4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR UC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
(F 661)	<p>Continued From page 13</p> <p>designated Home Health agency, nor the agency's contact information that was to provide therapy services to resident #2 when discharged home.</p> <p>On 08-04-18 at 6PM, surveyor interviewed with the Director of Social Services revealed a log book kept in the social services office that indicated resident #2 was to receive Adventist Home Health Services, and not the Home Health agency on the physician script sent home with the resident. However, the Director of Social Services was uncertain whether this information was given to the resident since the "Discharge Transition Plan" was left blank of this contact information. No additional information was provided.</p> <p>2. On 08-04-18, surveyor review of the closed clinical record for resident #1 revealed that the resident <u>was</u> discharged from the facility on</p> <p>Review of the "Discharge Transition Plan", provided to resident #1 at the time of discharge, revealed staff had not documented the following information; "you were treated for", "discharge date from rehabilitation", "special care instructions", "flu vaccine", "pneumonia vaccine", and "steroids".</p> <p>Further review revealed that the name and contact number information for the home health care agency was not listed despite a physician's order documented on 06-29-18 that resident #1 <u>was to be discharged</u> with home health services.</p> <p>0</p> <p>In addition, there was no information documented regarding upcoming follow up appointment, despite a nurse's note documented on 05-2-18</p>	(F 681)		

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	C,C1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215060	OC2) MULTI-UNIT CONSTRUCTION A. BUILDING _____ B. WING _____	(X) DATE SURVEY COMPLETED R-C 08/04/2018	
NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, UC		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 811 ST COND AVENUE SILVER SPRING, MD 20910		
CM/ID PRU1X TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
{F 681}	Continued From page 14 that resident 11 had a follow up neurology appointment on 08-06-18. On 08-04-18 at 5:45 PM, surveyor interview with the Interim Director of Nursing provided no additional information. On 06-04-18 at 8:30 PM, surveyor interview with the Director of Social Work provided no additional information. (F 684) Quality of Care SS=E CFR(s): 483.25 § 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 and is evidenced by: Based on surveyor review of clinical records and interview of residents, facility staff and attending physician, it was determined that the facility staff failed to administer medications as ordered. This finding was evident for 3 of 4 residents selected for the quality of care review (#32, #4, #230). The findings include: 1. On 08-04-18, review of resident #32's May 2018 Medication Administration Record (MAR) revealed that the nursing staff documented that a controlled drug, Hydromorphone 4 mg, was given to the resident on 05-31-18 at 2 PM.	(F681)	F&84 Residents #32, #4, and #230 were not adversely affected by this citation. All residents that receive PRN medications have the potential to be affected by this citation. No other residents were identified as being affected by this citation.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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FORM APPROVED
OMB NO. 0938-0381

STATEMENT OF DEFICIENCY AND PLAN OF CORRECTION	C(1) PROVIDER IDENTIFICATION NUMBER: 211060	C(2) MULTIPLE CONSTRUCTION A. BUILDING _____ I. WING	(X1) DATE SURVEY COMPLETE R-C 0810412018
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NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, UC	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 SECOND AVENUE SILVER SPRING, MD 20910
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CM/JD 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)
{ f 684)	<p>Continued From page 16 .</p> <p>However, review of the controlled drug back revealed no evidence that the Hydromorphone 4 mg was removed on 05-31-18 at 2 PM for resident #32.</p> <p>On 08-04-18 at 7:15 PM, Interview of the Interim Director of Nursing revealed no additional information.</p> <p>2. On 06-04-18 at 4:45 PM, Interview of resident #4 revealed that the resident reported having pain last week on the left foot. After taking the prescribed medication, the pain was resolved.</p> <p>a. Review of the physician's order, dated 06-29-18, revealed an anti-inflammatory medication, Colchicine 0.6 mg, was ordered three times a day for 3 days, then daily for resident #4. Further review of the May 2018 Medication Administration Record (MAR) revealed that the final dose of Colchicine 0.6 mg was administered on 05-28-18 at 5 PM.</p> <p>However, further review of the May and June 2018 MAR revealed no evidence Colchicine was given to resident #4 on 05-30-18. Then, the nursing staff documented that Colchicine was administered three times a day on 05-31-18 and 08-01-18, which was Inconsistent with the physician's order.</p> <p>Further review of the June 2018 MAR revealed that the nursing staff documented that resident #4 received Colchicine daily starting on 08-02-18.</p> <p>on 08-05-18 at 3 PM, surveyor telephone interview of the Interim Director of Nursing and review of the pharmacy admission detail, revealed that a total of 45 tablets of Colchicine 0.8 mg</p>	{ F 684)	<p>All licensed nursing staff will be educated by the DON and Unit Managers to ensure Residents who receive PRN pain medications and scheduled pain medications have them available in a timely manner and the medications are ordered before the last dose. Part of the education will address the licensed nurse responsibility for notifying the Physician and the Pharmacy and requesting to either set the medication from</p>

STATEMENT OF DEFICIENCIES AND PIM OF CORRECTION	CX1) PROVIDER IDENTIFICATION NUMBER: 21108D	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	CX3) DATE REVISION COMPLETED R-C 08/04/2018
NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 9101 SECOND UE SILVER SPRING, MD 20910	
CICA) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PUA REGULATORY OR LSC INFORMATION)	PREFUC TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION (EACH CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DEFICIENCY)
{F884}	<p>Continued From page 16.</p> <p>were delivered to the facility on 05-31-18 and 05-31-18. There were 35 tablets available in the medication cart of 06-05-19. Therefore, the nursing staff only administered 10 doses between 05-29-18 and 08-05-18 and not the required 45 as ordered by the physician.</p> <p>On 08-04-18 at 7:25 PM and 08-05-18 at 3 PM, interview of the Interim Director of Nursing revealed no additional information.</p> <p>3. On 08-04-18 at 2:45 PM, Interview of resident #230 revealed the resident had left shoulder pain intermittently. The attending physician ruled out a heart attack and believed the pain was related to a displaced disc. Surgery was scheduled for 06-08-19 at the hospital.</p> <p>On 06-04-18, a review of the physician's order, dated 06-21-18, revealed that the attending physician discontinued a pain patch, Lidoderm, for resident #230's left shoulder. An order was given to start the application of a topical analgesic gel, BioFreeze, on the resident's right shoulder three times a day. There was no clinical rationale to explain why the attending physician started BioFreeze on resident #30's right shoulder on 05-21-18.</p> <p>However, further review of the May and June 2018 Medication Administration Record (MAR) revealed that the nursing staff documented that the BioFreeze was applied to the resident's left shoulder three times a day, which was not as ordered on 05-21-18, except on the following dates when it was applied to the right shoulder: 9 AM on 05-31-18, 08-01-18, 08-04-18 2 PM 05-31-18, 08-01-18, 06-04-18 5 PM on 05-24-18, 05-25-18, 05-28-18, 05-30-18.</p>	(f 684).	<p>the emergency supply or obtain an order for an alternative pain medication.</p> <p>Random Resident Interviews and Resident record reviews will be conducted three times per week for four weeks on ensurina. Residents have pain medications available upon request by the Unit Managers. The results of the audits will be reviewed during QAPI and follow up as needed.</p> <p style="text-align: right;">By 6-25-18</p>

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

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FORM APPROVED
OMA NO. 0938

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER IDENTIFICATION NUMBER: 215080	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ & WING _____	CROSS-CHECK SURVEY COMPLETED R-C 08/04#2018
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NAI IOP PROVIDER OR SUPPORT REGENCY CARE OF SILVER SPRING, LLC	FACILITY ADDRESS, QTY. & TATE, ZIP CODE 9101 SECOND AVENUE SILVER SPRING, MD 20910
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TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR CFC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
(F 884)	Continued From page 17 It was unclear why some nursing staff applied the Biofreeze to the resident's right shoulder and other nursing staff applied the Biofreeze to the left shoulder. On Q6.04.18 at 4 PM, interview of the attending physician revealed that an error was made on the physician's order and that the Biofreeze should be used for resident #230's left shoulder. A clarification order was written. On 08-04w1B at 7:30 PM, Interview of the Interim Director of Nursing revealed no additional information.	(F884)		
(F 745) SS=E	Provision of Medically Related Social Services CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Sued on surveyor review of the clinical records and interview with resident and facility staff, it was determined that the facility failed to ensure medically-related social services to maintain the highest practicable physical, mental and psychosocial well-being of residents. This finding was evident for 2 of 3 residents selected for the social services review. (#1, #155) The findings include: 1. Based on surveyor review of the closed clinical records and facility staff interview, it was determined that the facility failed to provide medically related social services to meet the	(F 745)	F745 Resident #'s discharge was placed on hold due to the availability of suitable discharge location. Resident #1 no longer resides in this facility. Resident #55 did not have any adverse outcomes due to this citation. Social Services Director will make contact with the Medical POA to have a discussion with him in regards to becoming POA for financial and	

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	CX1) PROW>ERISUPPUERICUA 110N NUMBER: 215080	(1) MULTIPLE CONSTRUCTION A. BUILDING _____ L.WING	(X1) DATE SURVY COMPUTED R-C 08/04/2018
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NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 SECOND AVENUE SILVER SPRING, MD 20910
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&M)ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR IDENTIFYING INFORMATION)	ID MEFOC TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	C15) COMPLETION DATE
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(F 745)	<p>Continued From page 18 transition of care needs for resident #1.</p> <p>On 08-04-18, a review of the clinical record for resident #1 revealed a "Discharge Planning Review" that was completed on 03-14-18. This review revealed that the resident was expected to return home, but the family was "open to other options".</p> <p>Further review of the clinical record revealed a social service note, documented on 05-10-18, that a referral for resident #1 was sent to "... care Placement on 05-09-18" and that the social worker would follow up. However, there was no evidence of further follow up for placement, or of other discharge planning completed by social services.</p> <p>In addition, there was no evidence that a care plan addressing resident #1's discharge planning was developed during the resident's stay at the facility. (refer to F656 for additional information)</p> <p>Surveyor review of the nursing notes revealed a note documented on 05-25-18 that resident #1's discharge was on hold "due to availability of suitable discharge location". The family members informed the nurse that the resident would be unable to be discharged home on 05-28-18 due to the home having too many stairs that may be unsafe for the resident. The family revealed that they would look at an assisted living facility to transfer the resident.</p> <p>Surveyor review of the "Transition Plan" for resident #1, dated 08-04-18, revealed instructions for the resident to contact the home health service provider. However, the resident did not hear from the provider within 24 hours.</p>	(F 745)	<p>legal matters for resident #55.</p> <p>Any resident in the facility has the potential to be affected by this citation. No other residents were affected by this citation.</p> <p>The facility has begun utilizing two discharge assessments that are in the electronic medical record system which will help ensure that every member of the IDT provides a summary of the resident's discharge, reconciliation of the medications, follow up appointments, Social Service related resources/referrals and a discharge plan of care that is developed with the participation of the resident and/or resident representative.</p>	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(J) PROGRAM IDENTIFICATION NUMBER: 21&a80	(C) MULTIPLE CONSTRUCTION BUILDING _____ B.WING	(C) SITE SURVEY COMPLETED R.C 0111W2011
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NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE! 11D1 SECOND AVENUE SILVER SPRING, MD 20910
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TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR UC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
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(F 745)	<p>Continued From page 19</p> <p>However, the name and contact number information for the home health care agency was not Dated. despite a physician's order documented on OS.29-18 that resident #1 was to be discharged with home health services on</p> <p>In addition, there was no information documented regarding upcoming follow up appointments despite a nurse's note documented on 05a23-18 that resident #1 had a follow up neurology appointment on 06-08-18.</p> <p>On 06-04-18 at 6:30 PM, surveyor Interview with the Director of Social work provided no additional information.</p> <p>2. On 06-04-18, SUN/01' review of the clinical record revealed that, In Mardi 2017. two physicians certifications were in place that resident #55 lacked adequate decision making capacity (Including decisions about life sustaining treatments). Further interview revealed that, In May 2016. resident #55 identified 2 friends on the health care decision worksheet for making health care decisions for the resident if the resident lacked or lost the capacity for decision making . Resident #55 also had a legal guardian of property in place for decisions. but this was terminated In August 2017.</p> <p>However, surveyor review revealed no documented evidence that the facility's social worker provided any assistance or arrangement of referrals to pursue resident #55's needs for financial and legal matters since the termination of the resident's guardian of property In August 2017.</p>	(F 745)	<p>Social Services Director will audit discharge assessments on a weekly basis to ensure proper discharges are being completed and complete documentation is provided to the resident/resident representative prior to discharge. The results of the audits will be reviewed during QAPI and followed up as needed.</p>	6-25/18 and on-going
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	C1. PROVIDER IDENTIFICATION NUMBER: 211010	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(XJ) DATE SURVEY COMPLETED R-C 08/04/2018
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NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, U.C	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 SECOND AVENUE SILVER SPRING, MD 20910
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(X4) ID PREFIX TAG	SIMILAR STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LIC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE OF COMPLETION
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(F 745)	<p>Continued From page 20</p> <p>Additionally, record review revealed that the facility's social worker became aware in August 2017 that the primary medical POA (Power of Attorney) had passed away. Further review revealed 2 attempted <u>unsuccessful</u> telephone contacts in May 2018 by facility staff to the surviving medical POA, but at each attempt, the POA's voice mail was full.</p> <p>However, record review on 08-04-18 revealed no documented evidence that the facility's social worker had provided any assistance or arrangement either with resident #55 or with the surviving medical POA regarding the continuation of the POA role.</p> <p>On 06-04-18 at 1:30PM, surveyor interview with resident #55 revealed there has been no current contact with the surviving medical POA since the loss of the primary POA. Further interview revealed other friends have visited the resident and could possibly be considered to take over the POA role if they were approached.</p> <p>On 06-04-18 at 1:30PM, surveyor interview with the Director of Social Services revealed that the resident's information was updated in the electronic record to identify only the surviving medical POA as the primary contact. No additional information was provided.</p> <p>On 06-04-18 at 3PM, surveyor interview with the Assistant Social Worker revealed that the surviving medical POA provided updated <u>information</u> on funeral arrangements for resident #55 recently, that there had been difficulty in contacting the POA via phone. When questioned whether any referrals for the financial guardian of property had been developed since the</p>	(F 745)		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	C) (1) PRO10EMUPPUEIUCLIA IDENTIFICATION NUMBER: 2150&0	CXZ) MULTIPLE CONSTRUCTION ABUOING _____ 8.WING	XJd) TEIURWY COMPLETED R-C 0&10412018	
NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 9111 SECOND AVENUE SILVER SPRING, MD 20910		
OW) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCE8 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)	CICS) CAUTION: WE
{F 745}	Continued From page 21 termination of the initial guardian In August 2017. no additional information was provided. On 08-04-18 at 1PM and 4PM, Interview with the Interim Director of Nursing and the facility administrator revealed no additional information.	{f 745}		

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215060	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 06/04/2018
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NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 9101 SECOND AVENUE SILVER SPRING, MD 20910
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(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}	<p>Initial comments</p> <p>On June 4, 2018 a revisit survey was conducted to determine the facility's compliance with the plan of correction submitted for the deficiencies cited during a federal monitoring survey that concluded on April 16, 2018. Survey activities included the review of the clinical records for 18 residents, observations of resident care and staff practices, interviews of residents and facility staff, and review of facility policies, credible evidence of compliance, and other pertinent documentation. The following deficiencies were cited as a result of the revisit survey.</p> <p>{S 506} 10.07.02.12 O Nsg Svcs;Care 24 Hrs per Day .12 Nursing Services.</p> <p>O. Nursing Care—24 Hours a Day. There shall be sufficient licensed and supportive nursing service personnel on duty 24 hours a day to provide appropriate bedside care to assure that each patient:</p> <ul style="list-style-type: none"> (1) Receives treatments, medications, and diet as prescribed; (2) Receives rehabilitative nursing care as needed; (3) Receives proper care to prevent decubitus ulcers and deformities; (4) Is kept comfortable, clean, and well-groomed; (5) Is protected from accident, injury, and infection; (6) Is encouraged, assisted, and trained in self-care and group activities. <p>This Regulation is not met as evidenced by: Refer to CMS 2567 F 684</p>	{S 000}	<p>SEE F 684</p>	6/26/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Michelle Naha* TITLE: Administrator DATE: 6-21-18

STATE FORM 6888 OE9E12 If continuation sheet 1 of 8

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215080	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 06/04/2018
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NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 9101 SECOND AVENUE SILVER SPRING, MD 20910
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{S 510}	<p>10.07.02.12 Q Nsg Svcs; Charge Nurse</p> <p>.12 Nursing Services:</p> <p>Q. Charge Nurse. At least one licensed nurse shall be on duty at all times and shall be designated by the director of nursing to be in charge of the nursing activities during each tour of duty. The charge nurse or nurses shall have the ability to recognize significant changes in the condition of patients and to take necessary action.</p> <p>This Regulation is not met as evidenced by: Refer to CMS 2567 F580</p>	{S 510}	SEE F580	6/25/18
{S 512}	<p>10.07.02.12 R Nsg Svcs; Charge Nurse Daily Rounds</p> <p>.12 Nursing Services.</p> <p>R. Charge Nurses' Daily Rounds. The charge nurse or nurses shall make daily rounds to all nursing units for which responsible, performing such functions as:</p> <p>(1) Visiting each patient; (2) Reviewing clinical records, medication orders, patient care plans, and staff assignments; (3) To the degree possible, accompanying physicians when visiting patients.</p> <p>This Regulation is not met as evidenced by: Refer to CMS 2567 F 658</p>	{S 512}	SEE F658	6/25/18

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<p>{S 535}</p> <p>{S 535}</p>	<p>Continued From page 2</p> <p>10.07.02.13 B Dietetic Svcs;Supervision</p> <p>.13 Dietetic Services.</p> <p>B. Supervision.</p> <p>(1) In facilities exceeding 50 beds, overall supervisory responsibilities for the dietetic service shall be assigned to a full-time qualified dietetic service supervisor. It shall be the responsibility of the supervisor to delegate relief duties to a person qualified to serve as relief. (See Supportive Personnel, Regulation .07J, above.)</p> <p>(2) In facilities with 26–50 beds, exceptions may be made by the Department to allow the supervisor to share cooking responsibilities with the full-time cook.</p> <p>(3) In facilities with 25 beds or fewer, responsibility may be assigned to the full-time cook.</p> <p>(4) If a facility can demonstrate that because of the experience and training of its personnel and the physical layout and equipment, less supervisory personnel is required, the Department may modify the above requirements for supervision.</p> <p>This Regulation is not met as evidenced by: Based on surveyor interview of the facility staff, it was determined that the facility failed to ensure that the overall supervisory responsibilities for the dietetic service be assigned to a full-time qualified dietetic service supervisor. This finding was evident during the certified food service manager review. The findings include:</p> <p>As stated in COMAR 10.07.02.13 B(1), facilities exceeding 50 beds, overall supervisory responsibilities for the dietetic service shall be assigned to a full-time (40 hours per week)</p>	<p>{S 535}</p> <p>{S 535}</p>	<p>S535</p> <p>Residents at this facility did not have any adverse outcomes due to this citation.</p> <p>All residents have the potential to be affected by this citation.</p> <p>A Certified Dietary Manager has been hired and begins employment 6-25-18.</p> <p>Facility Administrator will monitor to ensure deficient practice does not reoccur should there be a change in status of the CDM.</p>	<p>4/25/18</p> <p>6-25-18 and On-going as needed.</p>

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY CARE OF SILVER SPRING, LLC	9101 SECOND AVENUE SILVER SPRING, MD 20910

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{S 535}	<p>Continued From page 3</p> <p>qualified dietetic service supervisor. The dietetics service supervisor is defined as a person who is a qualified dietitian or a certified dietary manager who has successfully completed the certification requirements for a qualified dietetic service supervisor.</p> <p>On 06-04-18, surveyor review of the May 2018 Consultant Dietician Reports revealed documentation of 3 times a week both kitchen/food observations and review of nutrition services provided by the consultant dietician.</p> <p>However, on 06-04-18 at 5PM surveyor interview with the facility's consultant dietician revealed that the report is developed as a summary after the end of each week when the 3 times a week visits are completed. The documented activities are a compilation of the week and each visit does not consist of everything listed. Further interview revealed other duties by the dietician included during the 3 times a week visits to the facility, include new admission assessments of residents, follow up and consult assessments of residents. In addition, the food service dietary manager continues not to be certified</p> <p>On 06-04-18 at 7PM surveyor interview with the facility administrator revealed no additional information.</p>	{S 535}		
{S1050}	<p>10.07.02.18 Social Work Svcs</p> <p>.18 Social Work Services.</p> <p>A. Services Provided. The facility shall provide or make arrangements for services to identify and meet the patient's medically related social and emotional needs.</p>	{S1050}		

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{S1050}	<p>Continued From page 4</p> <p>B. Designated Staff Responsibility. A member of the facility's staff shall be assigned responsibility for social services. If the designee is not a certified social worker, the facility shall effect an agreement with a qualified social work consultant. The agreement shall provide for sufficient hours of consultation to assure that the staff's services meet the medically related social and emotional needs of the patients.</p> <p>C. Social History. The written social history shall be initiated within 7 days after admission. The history shall be as complete as possible and shall include:</p> <p>(1) Social data about personal and family background to provide understanding of the patient and how he functions; and</p> <p>(2) Information regarding current personal and family circumstances and attitudes as they relate to patient's illness and care.</p> <p>D. Records. Records shall include:</p> <p>(1) Social history; and</p> <p>(2) Recommendations made by the social work consultant, if applicable.</p> <p>E. Space. Facilities shall provide:</p> <p>(1) Space for social work personnel, accessible to patients, medical, and other staff;</p> <p>(2) Privacy for interviews.</p> <p>This Regulation is not met as evidenced by: Refer to CMS 2567 F660, F661, F745</p>	{S1050}	SEE F660, F661, F745	6/25/18
{S1090}	<p>10.07.02.20 Clinical Records</p> <p>.20 Clinical Records.</p> <p>A. Records for all Patients. Records for all</p>	{S1090}		

Office of Health Care Quality

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{S1090}	<p>Continued From page 5</p> <p>patients shall be maintained in accordance with accepted professional standards and practices.</p> <p>B. Contents of Record. Contents of record shall be:</p> <p>(1) Identification and summary sheet or sheets including patient's name, social security number, armed forces status, citizenship, marital status, age, sex, home address, and religion;</p> <p>(2) Names, addresses, and telephone numbers of referral agencies (including hospital from which admitted), personal physician, dentist, parents' names or next of kin, or authorized representative;</p> <p>(3) Documented evidence of assessment of the needs of the patient, of establishment of an appropriate plan of initial and ongoing treatment, and of the care and services provided;</p> <p>(4) Authentication of hospital diagnoses (discharge summary, report from patient's attending physician, or transfer form);</p> <p>(5) Consent forms when required (such as consent for administering investigational drugs, for burial arrangements made in advance, for release of medical record information, for handling of finances);</p> <p>(6) Medical and social history of patient;</p> <p>(7) Report of physical examination;</p> <p>(8) Diagnostic and therapeutic orders;</p> <p>(9) Consultation reports;</p> <p>(10) Observations and progress notes;</p> <p>(11) Reports of medication administration, treatments, and clinical findings;</p> <p>(12) Discharge summary including final diagnosis and prognosis;</p> <p>(13) Discipline assessment; and</p> <p>(14) Interdisciplinary care plan.</p> <p>C. Staffing. An employee of the facility shall be designated as the person responsible for the overall supervision of the medical record service.</p>	{S1090}		

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NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 9101 SECOND AVENUE SILVER SPRING, MD 20910		
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{S1090}	Continued From page 6 There shall be sufficient supportive staff to accomplish all medical record functions. D. Consultation. If the medical record supervisor is not a qualified medical record practitioner, the Department may require that the supervisor receive consultation from a person so qualified. E. Completion of Records and Centralization of Reports. Current medical records and those of discharged patients shall be completed promptly. All clinical information pertaining to a patient's stay shall be centralized in the patient's medical record. F. Retention and Preservation of Records. Medical records shall be retained for a period of not less than 5 years from the date of discharge or, in the case of a minor, 3 years after the patient becomes of age or 5 years, whichever is longer. G. Current Records—Location and Facilities. The facility shall maintain adequate space and equipment, conveniently located, to provide for efficient processing of medical records (reviewing, indexing, filing, and prompt retrieval). H. Closed or Inactive Records. Closed or inactive records shall be filed and stored in a safe place (free from fire hazards) which provides for confidentiality and, when necessary, retrieval. This Regulation is not met as evidenced by: Refer to CMS 2567 F661	{S1090}		
S1730	10.07.02.37 E Care Planning; Organization of plan .37 Care Planning.	S1730	SEE F661	6/25/18

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NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 9101 SECOND AVENUE SILVER SPRING, MD 20910		
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S1730	Continued From page 7 E. Organization of Care Plan. (1) Problems and needs shall 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. The goal shall be realistic, practical, and tailored to the resident's needs. Goal outcome shall be measurable in time or degree, or both. (3) Approaches to accomplishing each goal shall be established. Approaches shall communicate the work to be done, by whom it is to be done, and how frequently it is to be performed. This Regulation is not met as evidenced by: Refer to CMS 2567 F656	S1730	SEE F656	6/25/18

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

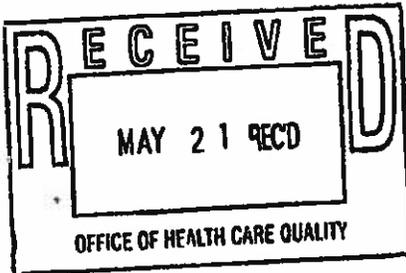
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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215060	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/16/2018
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NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 9101 SECOND AVENUE SILVER SPRING, MD 20910
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F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies are the result of an annual survey conducted on April 9, 10, 11, 12, 13 and 16, 2018 to determine the facility's compliance with Medicare/Medicaid requirements. Survey activities consisted of the review of 29 residents' record, observation of resident care and staff practices, interviews of residents, residents' family members, the Ombudsman and facility staff. Additionally, administrative records and resident care policies were reviewed.</p> <p>On April 11, 2018 at 2PM, an Immediate Jeopardy for health and safety was called after the facility failed to ensure that residents were free from increased risk for serious harm from fire. This deficient practice had the potential for serious injury to affect residents currently residing within the facility.</p> <p>After the determination of immediate jeopardy concerns, an extended survey was conducted.</p> <p>The Immediate Jeopardy was abated on April 11, 2018 at 10:15PM following the facility's implementation of corrective actions to ensure the health and safety of all residents who were at risk for serious harm from fire.</p> <p>In addition to standard survey protocols, complaints MD 00123611, and facility reported incidents MD 00123780 and MD 00122728 were investigated and this survey identified noncompliance with Federal requirements.</p> <p>Additionally, facility reported incidents MD</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Michelle Mah</i>	TITLE Administrator	(X6) DATE 5-11-18
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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.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215050	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/18/2018
NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 SECOND AVENUE SILVER SPRING, MD 20910		
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F 000	Continued From page 1 00122940 was investigated and this survey did not identify noncompliance with Federal requirements. The facility's licensed bed capacity is 92 beds. The census at the time of the survey was 81 residents.	F 000			
F 558 SS-D	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 observations, review of the clinical record, and interview with facility staff, it was determined that the facility failed to ensure reasonable accommodation of resident #6's needs. This finding was evident for 1 of 29 residents selected for the survey. The findings include: On 04-09-18, surveyor review of the clinical record revealed that resident #6 had contractures (a permanent shortening of a muscle or joint) of the bilateral (both) upper extremities, secondary to a stroke. Further review revealed the resident was dependent on facility staff for all of his/her needs, including turning and positioning. Surveyor observations, on 04-09-18 at 11AM, and 04-13-18 at 11AM and 12:50PM, revealed resident #6 lying in bed, alert only to tactile and verbal stimuli, with a call light push button system	F 558	F558 Resident #6 was affected by this citation. All residents with hand contractures have the potential to be affected. The IDT team reviewed all residents with hand contractures to ensure they are able to use their call lights. No other residents were affected by this citation. The Director of Nurses obtained a flat, style call light device for resident #6. Nursing and therapy staff will be informed of this type of call light device if other residents should be identified. Facility staff will be re-educated by the facility administrator by 5-11-18 to ensure residents who need alternative call lights receive them in a timely manner.		

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F 558	Continued From page 2 located across the resident's chest. Further observation revealed the resident had a left upper extremity splint in place, while the resident's right hand had contractures in the fingers. Resident #6 was also non verbal and incapable of pushing the button type call light due to weakness and the contractures. On 04-13-18 at 12:50PM, surveyor interview with LPN (Licensed Practical Nurse) # 12 revealed resident #6 displayed slight body movement at times and responded to verbal stimuli. However, further interview revealed that the current button call light would be difficult for the resident to use. On 04-13-18 at 1PM, surveyor interview with the Director of Nursing revealed, after surveyor intervention, an appropriate flat style pad call light device, that activates with resident's movement, will be provided to resident #6.	F 558	Nursing leadership staff will ensure all residents in need of an alternate call light device receive it through daily rounds. Audits will be conducted by the administrator and DON twice per week for 4 weeks on ensuring residents have the ability to use their call light device appropriately. The results of the audits will be reviewed during QAPI and followed up as needed. Completed 4/14/18 and On-going		
F 559 SS-B	Choose/Be Notified of Room/Roommate Change CFR(s): 483.10(e)(4)-(6) §483.10(e)(4) The right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement. §483.10(e)(5) The right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement. §483.10(e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced	F 559	F559 Resident #32 and #231 were not adversely affected by this citation. Any resident that resides in a semi-private room would have the potential to be affected by this citation. As of facility audit of 5-7-18 no other residents were affected by this citation.		

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NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 SECOND AVENUE SILVER SPRING, MD 20910		
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F 559	<p>Continued From page 3</p> <p>by: Based on surveyor review of clinical records and staff and resident interviews, it was determined that the facility staff failed to provide written notice to residents prior to the admission of new roommates. This finding was evident for 2 of 29 residents selected for the survey (#32, #231). The findings include:</p> <p>1. On 04-10-18 at 9 AM, during surveyor interview with resident #32, he/she stated "they never tell me in advance of a new roommate, they just bring them in."</p> <p>On 04-11-18 at 12 PM, during an interview with the SW (social worker) #2, he/she stated that staff didn't inform resident #32 of roommate changes. Staff inform residents, verbally, when the new roommate is transferring from another room within the facility. Furthermore, he/she stated that staff don't inform residents if the new roommate was newly admitted to the facility. In that particular case, the facility's admission director would be responsible to inform the resident.</p> <p>On 04-12-19 at 1 PM, surveyor review of resident #32's clinical record revealed no documented evidence that he/she was ever informed in advance when roommates were admitted to his/her room.</p> <p>On 04-16-18 at 4 PM, during surveyor interview with the facility's admissions director, he/she stated that they informed resident #32 about the new roommate, however, there was no documented evidence of the notification.</p> <p>2. On 04-09-18 at 3 PM, during surveyor</p>	F 559	<p>All necessary staff who will be responsible to inform any resident of an impending roommate change will be trained on the electronic form in order to document this action by the facility administrator before 5-11-18.</p> <p>Audits will be completed twice per week for 4 weeks by the administrator and DON on residents who receive roommates to ensure they have been informed ahead of time they will be receiving a new roommate by the facility administrator. A monthly review of the activity will be completed and reported to the QAPI team.</p> <p>A monthly review of the activity will be completed and reported to the QAPI team.</p> <p style="text-align: right;">By May 24, 2018 and On-going as necessary</p>		

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F 559	Continued From page 4 interview with resident #231, he/she stated that the facility staff did not provide any advance notice when a new roommate was admitted to the resident's room. On 04-09-18 at 4 PM, surveyor review of resident #231's clinical record revealed no documented evidence that the facility staff had given written notice to the resident prior to admitting a new roommate. On 04-16-18 at 4 PM, during surveyor interview with the admissions director, he/she revealed they informed resident #231 about the new roommate, however, there was no documented evidence of the notification.	F 559			
F 580 SS=D	Notify of Changes (Injury/Degrade/Room, etc.) CFR(s): 483.10(g)(14)(i)-(v)(15)	F 580	F580		
	§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 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		Resident #33 was not adversely affected by this citation. Any resident that resides in the facility has the potential to be affected by this citation. No other residents were affected by this citation. All licensed nurses and professional staff will be in-serviced on the proper notification of the correct family members and/or POA's when there is a		

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F 580	Continued From page 5 §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).	F 580	change in condition with a resident by the administrator and social worker by 5/15/18. DON and Unit Manager will review all incidents and/or changes in condition to ensure proper notification is made. The results of the audits will be reviewed during QAPI and followed up as needed.	5-24-18 On-going	
	§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 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 surveyor review of the clinical record and interview with resident #33's Power of Attorney (POA) and the facility staff, it was determined that staff failed to notify the resident #33's POA timely of a change in condition. This finding was evident for 1 of 29 residents selected for the survey. The findings include: On 04-11-18, surveyor review of the clinical				

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F 580	<p>Continued From page 6</p> <p>record and interview of staff and resident #33's POA revealed that the facility staff failed to notify the POA timely with a change in condition. This finding was identified during the investigation of the facility reported incident MD 0000122728 .</p> <p>On 04-10-18 at 9:30AM, surveyor interview with resident #33's POA revealed, that while visiting with resident #33 on 02-04-18, the resident alleged that a staff member "threw" the resident down while transferring the resident to the bed from the wheelchair on 02-03-18, and became upset with the resident. The resident grabbed the staff member's shirt and ripped the shirt. Further interview revealed the POA noted that, after the resident complained about his/her thumb, it appeared slightly swollen. The next day, on 02-05-18, the POA sent a letter regarding the incident to the facility's social worker via fax. The administrator notified the POA that an investigation would be initiated, however, there was no follow up contact until the POA initiated the contact to the facility staff.</p> <p>On 04-11-18, surveyor review of the clinical record revealed that, on 02-05-18, an X-ray of resident #33's right thumb was ordered by the attending nurse practitioner with pain medication. However, further review revealed that staff did not notify the resident #33's POA, but another family member was informed of the X-ray orders and results.</p> <p>In addition, further record review revealed facility staff documentation, on 02-20-18, of an attempted notification to another family member of the status of the resident's right thumb fracture and the facility's investigation of the allegation. However, not until 02-21-18, which was 16 days</p>	F 580			

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F 580	Continued From page 7 after the reported allegation, was there any documented evidence of staff notification to the resident's POA of the investigation, and/or a follow up visit with the resident regarding the investigation. On 04-12-18 at 11:30AM, surveyor interview with the facility administrator revealed no additional information.	F 580			
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §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 surveyor review of the clinical records, review of the facility's policy and procedures, interviews with resident's Power of Attorney (POA) and the facility staff, it was determined that the facility failed to ensure a thorough investigation of alleged staff to resident abuse.	F 610 F610	Resident #33 and #26 were not adversely affected by this citation. All residents have the potential to be affected by this citation. There have been no allegations of abuse since the date of exit on 4-16-18 Training will be conducted with all nurse supervisors and leadership staff on the specific requirements of responding and investigating all alleged violations of abuse, neglect, exploitation or mistreatment by the facility administrator and DON by 5-15-18.		

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F 610	<p>Continued From page 8</p> <p>This finding was evident for 2 of 29 residents selected for the survey. (#33, #26) The findings include:</p> <p>1. On 04-11-18, surveyor review of the clinical record, review of the facility's policy and procedures, and interview of resident #33's POA and staff revealed that the facility staff failed to complete a thorough investigation of an alleged staff to resident abuse. This finding was identified during the investigation of the facility reported incident MD 0000122728.</p> <p>On 04-10-18 at 9:30AM, surveyor interview with resident #33's POA revealed, that while visiting with resident #33 on 02-04-18, the resident alleged that a staff member "threw" the resident down while transferring the resident to the bed from the wheelchair on 02-03-18, and became upset with the resident. The resident grabbed the staff member's shirt and ripped the shirt. Further interview revealed the POA noted that, after the resident complained about his/her thumb, it appeared slightly swollen. The next day on, 02-05-18, the POA sent a letter regarding the incident to the facility's social worker via fax. The administrator contacted the POA and stated that an investigation would be initiated, however, there was no follow up contact until the POA initiated contact with the facility staff. (Refer to F 580 for additional information)</p> <p>On 04-11-18, surveyor review of the facility's investigation of the allegation revealed that an investigation was initiated on 02-05-18 by the facility, after being contacted by the resident's POA. The resident was interviewed, as well as facility staff who were assigned to the resident, on both 02-03 and 02-04-18 for all shifts. After being</p>	F 610	<p>Audits will be completed by the administrator of all allegations of abuse. The abuse investigations will then be reviewed by the Company Director of Clinical Services to ensure a thorough investigation has been completed for 4 weeks. The results of the audits will be reviewed during QAPI and followed up as needed.</p> <p>Administrator and DON will be responsible to ensure a thorough investigation of alleged staff to resident abuse is completed.</p>	5-24-18 and On-going as Needed.	

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F 610	<p>Continued From page 9</p> <p>Informed of the resident complaint of the right thumb, the facility staff notified the attending nurse practitioner on 02-05-18 who ordered an X-ray of the thumb and pain management. Further review revealed X-ray results which confirmed a fracture of the right thumb. An orthopedic consult was completed and a splint for the right thumb was ordered and in place.</p> <p>Review of the facility's policy and procedure in regards to abuse, neglect, and exploitation revealed indicators for possible abuse, neglect and/or exploitation of residents included, but were not limited to, the resident, staff or family reports of abuse, physical injury of a resident of unknown source, and physical marks i.e. bruises or patterned appearances. Further review of the policy revealed that components of the facility's investigation included interviews of the involved resident, if possible and documentation of all responses. In addition, if the resident was cognitively impaired, an interview of the resident several times for a comparison of the responses is necessary.</p> <p>Additionally, the policy references for the resident's protection after an alleged abuse, neglect and exploitation, the facility will make efforts to protect all residents including the reassignment of nursing staff duties, increase supervision of staff and/or residents.</p> <p>However, review of the facility's investigation revealed facility staff interviewed the resident in regards to the allegation, on 02-05-18 and not again until 02-21-18 which was after the completion of the investigation. In addition, further review revealed GNA (Geriatric Nursing Assistant) # 11 and LPN (Licensed Practical</p>	F 610			

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F 610	<p>Continued From page 10</p> <p>Nurse) # 16, who both were assigned to the resident during the 7-3 shift on 02-03 and 02-04-18, remained assigned to either the resident's room directly or on the same hall as the resident during the investigation. Additionally, there was no evidence of other residents and/or visitors during the identified time frame of the allegation had been interviewed by the facility staff during the facility's investigation.</p> <p>On 04-12-18 at 11:30AM, surveyor interview with the facility administrator revealed no additional information.</p> <p>2. On 04-11-18, surveyor review of the clinical record for resident #26 revealed the facility failed to thoroughly investigate an allegation of employee to resident abuse. This findings was identified during the investigation of a facility reported incident #MD00123780.</p> <p>On 04-11-18 at 1:30PM, surveyor review of the clinical record for resident #26 revealed the resident reported an allegation of employee to resident abuse to the facility staff. Review of the facility's investigation of the incident included the resident's assessment, and suspension of the alleged perpetrator pending the outcome of the investigation.</p> <p>However, further review revealed no evidence that the facility interviewed the alleged perpetrator (staff #9) or any other staff members. Additionally, the facility staff failed to expand the investigation to include other residents assigned to staff #9 to corroborate the allegation of abuse or to determine if any other residents were potentially subjected to abuse.</p>	F 610			

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F 610	Continued From page 11 On 04-11-18 at 2PM, surveyor interview with the facility administrator revealed no interviews were conducted with other staff members or residents. No additional information was provided.	F 610			
F 625 SS-B	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on surveyor review of the clinical record	F 625	F625 Residents #47, #44, #66 and #231 were not adversely affected by this citation. All residents have the potential to be affected by this citation. Residents who were discharged after the date of exit 4-16-18 were reviewed to ensure they were given a copy of the bed hold notice. Training was conducted with all nursing staff regarding the notice of Bed Hold Policy upon transfer to the hospital. Upon transferring a resident out to hospitals, a copy of the signed notice will be attached to the transfer paperwork which accompanies the patient to the ED and/or hospital. This was completed by the administrator by 5-15-18. This was completed by the DON on 4-15-18 and on-going.		

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F 625	<p>Continued From page 12</p> <p>and interviews with residents/responsible party and the facility staff, it was determined that the facility staff failed to provide written information about the bed-hold policy to the resident and/or the resident's representative at the time of a hospital transfer. This finding was evident for 4 of 29 residents selected for the survey. (#47, #44, #66, #231). The findings include:</p> <p>1. On 04-11-18 surveyor review of the clinical record revealed resident #47 was transferred to the hospital from the facility on [redacted] at 6:50AM secondary to a change in condition and seizure activity.</p> <p>Further clinical record review revealed staff documentation of the [redacted] transfer summary of the resident's change in condition and contact with the attending nurse practitioner for the order to transfer the resident via 911 and the notification to the resident's responsible party of the hospital transfer.</p> <p>However, there was no documented evidence that the facility staff provided the resident's responsible party information of the bed hold policy in writing at the time of the transfer to the hospital.</p> <p>On 04-12-18 review of the facility policy and procedure of Bed Hold Prior to Transfer, located in the admission packet, revealed "prior to transferring a resident to the hospital or the resident goes on therapeutic leave, the facility will provide written information to the resident and/or the resident representative regarding bed hold".</p> <p>On 04-12-18 at 1PM surveyor interview with LPN (Licensed Practical Nurse) # 13 revealed at the</p>	F 625	<p>Audits will be conducted of all hospital discharges from the facility for 4 weeks by the IDT team to ensure they were given a copy of the bed hold policy prior to being sent to the hospital. The results of the audits will be reviewed during QAPI and follow up as needed.</p> <p>DON and/or QA coordinator will monitor monthly for compliance and review in the QAPI forum.</p>	<p>5-24-18</p> <p>On-going</p>	

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NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 9101 SECOND AVENUE SILVER SPRING, MD 20910		
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F 625	<p>Continued From page 13</p> <p>time of a hospital transfer the following documents will accompany the resident: a physician order for the transfer, recent/pertinent lab results, face sheet, transfer summary and medication list.</p> <p>On 04-13-18 at 10:30AM surveyor interview with the Director of Nursing revealed no additional information.</p> <p>2. On 04-13-18 at 12 PM, surveyor interview with resident #44's two children revealed that the resident had recently been transferred to the hospital and they didn't receive written notice of the bed-hold policy.</p> <p>On 04-11-18 at 10 AM, surveyor review of resident #44's clinical record revealed that he/she was transferred to a hospital on [redacted] for emergency treatment. However, there was no documented evidence that the transferring nurse provided written notice of the bed-hold policy at the time of the transfer.</p> <p>On 04-16-18 11:30 AM, surveyor interview with the Yorktown unit manager revealed that nurses don't provide the written notice of bed-hold policy when transferring residents to the hospital.</p> <p>3. On 04-10-18 at 12:30 PM, surveyor interview with resident #66 revealed that they had been transferred to the hospital a few weeks ago for a medical evaluation. Further interview revealed that staff hadn't informed the resident of the bed-hold policy at the time of transfer.</p> <p>On 04-10-18 at 2 PM, surveyor review of resident #66's clinical record revealed no evidence that the notice of bed hold was provided to the</p>	F 625		

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F 625	Continued From page 14 resident upon transfer to the hospital. On 04-16-18 11:30 AM, surveyor interview with the Yorktown unit manager revealed that nurses don't provide the written notice of bed-hold policy when transferring residents to the hospital. 4. On 04-10-18 at 9 AM, surveyor review of resident #231's clinical record revealed that on [REDACTED] at 4 PM, the resident had been transferred to the hospital, per his/her request. However, there was no evidence that the resident was given the written notice of the bed-hold policy upon transfer to the hospital. On 04-10-18 at 11 AM, during surveyor interview with the admission director, they stated that the nurses don't provide written notice of the facility's bed-hold policy to residents when transferring them to the hospital because it is included in the admission contract.	F 625			
F 641 SS-B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on surveyor review of the clinical record and interview with facility staff, it was determined that the facility failed to ensure accurate MDS (Minimum Data Set) assessments for residents.	F 641			

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F 641	<p>Continued From page 15</p> <p>This finding was evident for 2 of 29 residents selected for the survey. (#56, #14) The findings include:</p> <p>The MDS is a mandated process for clinical assessment of all residents in Medicare or Medicaid certified nursing homes. This process provides a comprehensive and accurate assessment of each resident's functional capacity and health status to assist nursing home staff in identifying health problems. MDS assessments are required for residents on admission to the nursing facility and then periodically, within specific guidelines and time frames.</p> <p>1. On 04-13-18 surveyor review of the clinical record for resident #56 revealed at the time of admission to the facility, LPN (Licensed Practical Nurse) #12 documented on the nursing assessment that resident #56 had a stage 1 pressure ulcer on the resident's right heel with a measurement of 2 cm x 1.5 cm. A Stage 1 pressure ulcer is not an open wound. The skin may be painful, but it has no breaks or tears. The skin appears reddened and does not blanch (lose color briefly when you press your finger on it then remove your finger).</p> <p>However, review of the admission MDS section M (Skin Conditions) revealed no evidence of staff documentation of resident #56's Stage 1 pressure ulcer during the 7 day look back ARD (Assessment Reference Date) of [REDACTED]</p> <p>On 04-16-18 at 4:30PM surveyor interview with the MDS coordinator revealed no additional information.</p> <p>2. On 04-16-18 at 3 PM, surveyor review of</p>	F 641	<p>F641</p> <p>Resident #56 MDS section M was modified on 3/13/18 by the facility MDS to match the status at the time of the assessment.</p> <p>All residents with pressure ulcers have the potential to be affected by this citation. No other residents were identified to be affected by this citation.</p> <p>The facility MDS nurse was re-educated by the Company MDS specialist on completing section M appropriately on 5-10-18.</p> <p>The DON will complete record review audits of section M to ensure residents with pressure ulcers were coded correctly two times per week for 3 weeks. The results of the audit will be</p>		

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F 641	Continued From page 16 resident #14's clinical record revealed the following inaccuracies of the most recent MDS, Section N-Medication. The assessment review date was 01-03-18. Question N0300 (number of days that resident received injections) was answered 1. Question N0350 (number of days that insulin injection were received) was answered 1. Question 0410 Medications Received (number of days the resident received during the last 7 days, option E. Anticoagulant) was coded 7. On 04-16-18 at 3 PM, surveyor review of the clinical record for resident #14 revealed that the resident did not receive insulin or anticoagulant medication in the specified timeframe. On 04-16-18 at 3:30 PM, surveyor interview with the MDS coordinator revealed that the 01-03-18 MDS was coded incorrectly and he/she made the correction. On 04-16-18 at 4 PM surveyor interview with the Director of Nursing revealed no further information.	F 641	reviewed during QAPI and followed up as needed. Residents #14 MDS assessment for 1/3/18 was modified to reflect an accurate assessment according to the medical record. The facility MDS nurse was re-educated by the company MDS specialist on completing section N of the MDS accurately on 5-10-18. The DON will complete record review audits of section N to ensure residents with medications were coded correctly two times per week for 3 weeks. The results of the audit will be reviewed during QAPI and followed up as needed.		
F 656 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 person-centered care plan 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 timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must	F 656	On-going	5-24-18	

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F 656	Continued From page 17 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 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 observations, review of the clinical records, and interviews with residents and facility staff, it was determined that the facility staff failed to develop a comprehensive person-centered care plan for residents. This finding was evident for 4 of 29 residents selected for the survey (#9, #48, #80, #72). The findings	F 656	F656 Residents #9, 48, 60, 72 did not have any adverse outcomes as related to this citation. Residents #9, 48, 60, and 72 care plans were revised to reflect their current care by the MDS nurse on 5/8/18. All residents in the facility have the potential to be affected by this citation. No other residents were identified to be affected. The IDT team will be re-educated by the Director of Clinical Services on ensuring residents plan of cares are comprehensive and person-centered by 5-11-18. Chart audits will be conducted twice per week for four weeks on ensuring residents who have changes in condition or new orders have their plan of cares updated according to the changes needed by the DON and MDS coordinator. The results of the audits will be reviewed during QAPI and followed up as needed.	5-24-18 On going	

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F 656	<p>Continued From page 18 include:</p> <p>1. On 04-10-18 at 10AM, surveyor observation revealed resident #9 smoking in the facility's designated smoking area.</p> <p>On 04-10-18, surveyor review of the clinical record for resident #9 revealed smoking assessments completed on the following dates: 03-14-17, 06-14-17, 12-14-17 and 03-31-18. The smoking assessments determined that the resident was unsafe to smoke independently, and required supervision with smoking.</p> <p>However, there was no evidence of a care plan nor interventions regarding smoking or safe smoking practices for resident #9.</p> <p>On 04-10-18 at 1PM, surveyor interview with the Director of Nursing (DON) revealed resident #9 was a smoker, and there should be a care plan specifically addressing safety interventions for smoking per facility policy.</p> <p>Following surveyor intervention, a care plan for risk for injury related to smoking was initiated by the facility.</p> <p>2. On 04-10-18 at 2PM, surveyor review of resident #48's clinical record revealed multiple medications including but not limited to Lovenox solution 40 mg/4ml daily x 30 days (a blood thinner medication to prevent blood clots), diazepam 5 mg daily at bedtime (antianxiety) and bupropion 100mg daily (antidepressant).</p> <p>However, there was no evidence in the clinical record of care plans addressing resident #48's depression, anxiety, or the blood clot prevention</p>	F 656			

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F 656	Continued From page 19 medications. On 04-10-18 at 2PM, surveyor interview with the Director of Nursing revealed no additional information. 3. On 04-09-18 at 4 PM, during surveyor interview with resident #60 the resident stated that he/she had a malignant brain tumor (cancer) and was homeless prior to being hospitalized. On 04-10-18 at 9 AM, surveyor review of the clinical record revealed a diagnosis of a malignant brain tumor. However, review of the comprehensive plans of care revealed no evidence of monitoring for complications of resident #60's brain tumor and possible issues with homelessness identified as problems and care planned.	F 656			
	On 04-13-18 at 12 PM, surveyor interview with the Director of Nursing revealed no additional information. 4. On 04-09-18 at 11 AM, surveyor observation of resident #72 revealed that the resident has right arm hemiparesis (paralysis of one side), with decreased movement of the right fingers. On 04-10-18 at 10 AM, surveyor review of the clinical record for resident #72 revealed that the right arm hemiparesis was related to a recent stroke. On 04-16-18 at 10 AM, surveyor interview with the occupational therapist revealed that the resident had increased tone and decreased range of motion in two fingers of the right hand. In addition, there was the risk that resident #72				

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F 656	Continued From page 20 could develop worsening of the decreased tone and therefore would benefit from stretching throughout the day. However, review of the comprehensive plans of care revealed that the right hemiparesis with limited movement of the fingers was not identified as a problem nor was a plan in place. On 04-16-18 at 4 PM surveyor interview with the director of nursing revealed no additional information.	F 656			
F 657 SS-E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §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.	F 657			

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F 657	<p>Continued From page 21</p> <p>(ii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on surveyor review of the clinical records and interviews with residents and facility staff, it was determined that the facility staff failed to ensure that comprehensive plans of care are reviewed and revised by an interdisciplinary team and care plan meetings are held in a timely manner. This finding was identified for 2 of 29 residents selected during the survey. (#47, #32) The findings include:</p> <p>1. On 04-12-18 surveyor review of the clinical record for resident #47 revealed that the quarterly MDS (Minimum Data Set) with an Assessment Reference Date of 11-27-17 was completed on 11-29-17. The care plan conference was scheduled for 11-30-17, but resident #47's responsible party requested a reschedule of the 11-30-17 meeting.</p> <p>The MDS is a mandated process for clinical assessment of all residents in Medicare or Medicaid certified nursing homes. This process provides a comprehensive and accurate assessment of each resident's functional capacity and health status to assist nursing home staff in identifying health problems. MDS assessments are required for residents on admission to the nursing facility and then periodically, within specific guidelines and time frames</p> <p>However, further record review revealed no documented evidence of of an interdisciplinary care plan meeting held after the quarterly</p>	F 657	<p>F657</p> <p>Residents #47 and #32 did not have any adverse outcomes related to this citation.</p> <p>All residents in the facility have the potential to be affected by this citation. The social services department completed an audit of all residents to ensure their responsible parties and themselves have been invited to their previous care conference. Any residents who were not invited to their plan of care meetings will be offered another meeting. This audit will be completed by 5/11/18.</p> <p>The Social Services department will be re-educated by the Director of Clinical Services on the process for inviting residents and responsible parties and</p>		

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F 657	<p>Continued From page 22</p> <p>November 2017 MDS assessment for resident #47. In addition, there was no documented evidence of the resident's responsible party involvement for a requested rescheduled 11-30-17 meeting.</p> <p>On 04-12-18 at 1PM surveyor interview with SW (Social Worker) #2 revealed that the quarterly care plan meetings are arranged via the social worker with a letter sent to the resident's responsible party as well as posted in the resident's room in advance of the scheduled meeting. In addition, the meeting attendance sheet is a record for the meeting. However, there was no evidence of an attendance sheet for the November 2017 meeting regarding resident #47.</p> <p>On 04-13-18 at 10AM interview with the Director of Nursing revealed no additional information.</p> <p>2. On 04-10-18 at 8 AM, surveyor interview with resident #32 revealed that he/she has not had a care plan meeting "in a long time".</p> <p>On 04-10-18 at 11 AM, surveyor review of resident #32's clinical record revealed that the last interdisciplinary care plan meeting was held in October 2017.</p> <p>On 4-10-18 at 11:45 AM, surveyor interview SW (social worker) #2 revealed that meetings were not held consistently by the previous social worker.</p> <p>On 04-13-18 at 12 PM surveyor interview with the Director of Nursing revealed no additional information.</p>	F 657	<p>keeping documentation of their invitations by 5/10/18.</p> <p>Audits will be completed by the facility Administrator and social worker twice weekly for four weeks of residents who are scheduled for Quarterly care plan meetings to ensure all parties have been invited to the meeting. The results of the audits will be reviewed during QAPI and followed up as needed.</p>	5-24-18	

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F 660 F 660 SS=D	Continued From page 23 Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and: (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.	F 660 F 660			

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F 660	<p>Continued From page 24</p> <p>(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.</p> <p>(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.</p> <p>(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.</p> <p>(vii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.</p> <p>(ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.</p> <p>This REQUIREMENT is not met as evidenced by: Based on surveyor review of the clinical record</p>	F 660	<p>F660</p> <p>Resident #35 has been discharged from the facility.</p> <p>All residents who are going to be discharged from the facility have the potential to be affected by this citation. No other residents that have requested or been discharged have been affected by this citation from the date of survey exit 4-16-18.</p> <p>Social Services department was reeducated by the facility administrator on ensuring residents that are to be discharged from the facility have a plan of care in place and the discharge is completed in a timely manner by 5-11-18.</p> <p>The facility administrator will audit planned facility discharges weekly for 4 weeks to ensure proper discharge planning was completed. The results of the audits will be reviewed during QAPI and followed up as needed.</p>	5-24-18 On-going	

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F 660	<p>Continued From page 25</p> <p>and interview with facility staff, it was determined that the facility staff failed to ensure the discharge needs of resident #35 were identified in a timely manner. This finding was evident for 1 of 29 residents selected for the survey. The findings include:</p> <p>On 04-09-18 surveyor review of the clinical record revealed resident #35 was readmitted to the facility in December 2017. Resident #35 is non ambulatory and totally dependent on staff for Activities of Daily Living (ADLs). In addition, the resident lacks the capacity for making both health and financial decisions.</p> <p>Record review revealed a 11-02-17 social service note regarding resident #35's Power of Attorney (POA) for health care decisions who notified the facility's social worker on possible facilities within the community with an availability for potential placement options. On 11-07-17 documentation by the facility's social worker revealed an attempted contact with the POA but was unsuccessful and a message was left instead with the financial POA regarding discharge plans.</p> <p>Further record review revealed social service documentation on 12-18-17, 12-20-17, 12-21-17, 12-28-17, and 01-02-18 of unsuccessful attempts to contact the POA for health care regarding discharge assessments/planning.</p> <p>However, there was no further documented evidence of any further discharge planning in place after 01-02-18 until [REDACTED] at 13:07 when SW (social worker) #2 documented that resident #35 was discharged to an assisted living facility (ALF) on this day. In addition, further review of the [REDACTED] documentation revealed that SW</p>	F 660			

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F 660	Continued From page 26 #3 "relayed all discharge information to the family of the resident". On 04-10-18 at 12PM surveyor interview with SW # 2 revealed an unawareness of the ALF status including if it is licensed and capable of meeting the resident's needs. SW #2 revealed that resident #35's POA had identified the ALF and the SW assumed the ALF could accommodate the resident's dependent needs including tube feeding, contracture management and other ADL needs since the representative had made a visit to the facility on 04-09-18 and accepted the resident. Further record review revealed no evidence of a comprehensive plan addressing resident #35's discharge planning needs since the resident's readmission to the facility in December 2017 until the resident's discharge to the ALF on [REDACTED]	F 660			
F 661 SS-D	On 04-12-18 at 3PM surveyor interview with the Director of Nursing revealed no additional information. Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recaptulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at	F 661			

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F 661	Continued From page 27 the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. <u>This REQUIREMENT is not met as evidenced by:</u> Based on surveyor review of the clinical record and interview with facility staff, it was determined that the facility staff failed to ensure a complete and thorough discharge summary for resident #35 at the time of discharge. This finding was evident for 1 of 29 residents selected for the survey. The findings include: On 04-09-18 at 1PM, RN (Registered Nurse) # 13 revealed that resident #35 was to be discharged on [redacted] to an assisted living facility (ALF). However, there was no evidence of any details regarding the ALF, such as the facility's name and/or its location, in the clinical record. Record review on 04-09-18 revealed no documented evidence of a discharge plan including the facility's location in the clinical record. (Refer to F660 for additional information)	F 661	F661 Resident #35 was discharged from the facility on [redacted] All residents who are discharged from the facility have the potential to be affected by this citation. No other residents were identified as being affected. Staff involved in the discharge process will be re-educated by the administrator on ensuring discharge paperwork is complete for all residents who are going to be discharged from the facility by 5-11-18. Record reviews will be completed by the DON on all facility discharges for 4 months to ensure the discharge information is complete. The results of the audits will be reviewed during QAPI and followed up as needed.	5-24-18	

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F 661	Continued From page 28 Further record review on [REDACTED] revealed that resident #35 was discharged from the facility and transferred to an ALF on this day. Record review then revealed a copy of the "Discharge Transition Plan" that included the following information completed: contact information of the ordered equipment, list of discharge medications including feeding tube orders via the gastrostomy tube (tube inserted into the stomach for feeding, fluid, medications) and copies of the medication prescriptions (written out by the attending physician on 04-08-18). However, further review of the "Discharge Transition Plan" revealed incomplete or blank information regarding any medical follow up necessary or recommendations regarding contracture management and the use of a splint as was indicated while still in the facility.	F 661			
F 684 SS-D	On 04-16-18 at 3PM, surveyor interview with the Director of Nursing revealed no additional information. Quality of Care CFR(s): 483.25 § 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 surveyor observations, clinical record	F 684			

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F 684	<p>Continued From page 29</p> <p>review, and interviews with residents and facility staff, it was determined that the facility staff failed to follow physician's orders. This finding was evident for 3 of 29 residents (#60, #230, #28) selected for the survey. The findings include:</p> <p>1. On 04-09-18 at 9 AM, surveyor interview with resident #60 revealed that he/she suffered with pain and had an order for the oral pain medication, Dilaudid 4 mg, on an as-needed (PRN) basis. The medication could be administered every 4 hours, as needed, for pain when requested by the resident. Further resident interview revealed that the resident received a dose of the Dilaudid on the previous day at 10 AM. Dilaudid is a controlled substance for which a licensed nurse is required to get a refill prescription from the physician, and then electronically send it to the pharmacy, and can only be dispensed 30 tablets at a time.</p> <p>However, the medication was requested by resident #60 later that same evening /night for pain, but the medication wasn't available until it was delivered on the next day at 6 AM.</p> <p>On 04-09-18 at 11 AM, further surveyor interview with resident #60, revealed that the resident was able to fall asleep without the need for the Dilaudid, but was unhappy that staff had not ordered the refill in advance.</p> <p>On 04-09-18 at 2 PM, surveyor review of the facility's list of stock/available medications revealed that Dilaudid 2 mg was on hand in the facility for use.</p> <p>On 04-09-18 at 2 PM, surveyor interview with the LPN (Licensed Practical Nurse) #15 revealed that</p>	F 684	<p>F684</p> <p>Resident #60 was not adversely affected by this citation.</p> <p>All residents that receive PRN have the potential to be affected by this citation. No other residents were identified as being affected by this citation.</p> <p>All licensed nursing staff will be educated by the DON on ensuring residents who receive PRN pain medications have them available in a timely manner and they are ordered before the residents last dose. Part of the education will address the licensed nurse responsibility for notifying the physician and the pharmacy and requesting to either get the medication from the emergency supply or obtain an order for other pain medications</p> <p style="text-align: right;">By 5/8/18</p>		

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F 684	<p>Continued From page 30</p> <p>the medication would have been available from the stock supply. No additional information was provided.</p> <p>On 04-13-18 at 12 PM, surveyor interview with the Director of Nursing revealed no additional information.</p> <p>2. a. On 04-09-18 at 8 AM, surveyor review of resident #230's clinical record revealed an order, written on 04-08-18, for "medrol dosepak 4 mg oral tablet, see instructions by mouth x (for) 6 days as directed on package labeling, "stat". "Stat" is a common medical abbreviation for urgent or rush. Further review of the medical record revealed the hospital discharge summary listed a prescription for the medrol dosepak. However, the medication wasn't administered by facility staff until 04-10-18.</p>	F 684	<p>Random resident interviews and resident record review will be conducted three times per week for four weeks on ensuring residents have pain medications available upon request by the DON. The results of the audits will be reviewed during QAPI and follow up as needed.</p> <p>Resident #230 was not adversely affected by this citation and received all of their prescribed medications.</p>		
	<p>On 04-10-18 at 9 AM, surveyor interview with LPN (Licensed Practical Nurse) #14 revealed that the medication was delivered to the unit on 04-09-18, with the first dose to be administered on 04-09-18 in the AM as documented on the Medication Administration Record (MAR).</p> <p>However, surveyor review on 04-10-18 at 9:30 AM, of the April 2018 MAR revealed staff documentation entered into the electronic medical record that the initial Medrol dosepak medication was to begin on 04-10-18, and not as the physician ordered as "stat." Further review of the pharmacy requisition form revealed that the medications had been delivered the morning of 04-09-18.</p> <p>On 04-10-18 at 10 AM, surveyor interview with the Yorktown unit manager revealed no further</p>				

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F 684	<p>Continued From page 31</p> <p>Information to account for the delay in administration.</p> <p>b. Additionally, record review revealed resident #230's admission medication orders scheduled to be administered on 04-09-18 included: 2 eye drops for the treatment of glaucoma: latanoprost ophthalmic 0.005%, one drop every evening and timolol ophthalmic 0.5% solution, one drop to both eyes daily, as well as the medication, Lidoderm patch 5%, apply to lower back topically one time a day for pain.</p> <p>On 04-10-18 at 11 AM, surveyor review of resident #230's April 2018 Medication Administration Record (MAR) revealed that the timolol maleate solution, that was scheduled for at 9 AM, wasn't administered on 04-09-18. Staff documentation on the MAR revealed a code "O," which is defined as other, see progress notes. The progress note indicated that the medication was "on order." However, review of the pharmacy requisition form revealed that the medication had been delivered to the facility the morning of 04-09-18.</p> <p>Further review of the April 2018 MAR revealed that the latanoprost eye drop solution, which was ordered to be administered on 04-09-18 at bedtime, had not been administered. Staff documentation on the MAR revealed an "NA" which is defined as not available. The progress note indicated that the "Pharmacy called, will supply overnight." However, review of the pharmacy requisition form revealed that the medication had been delivered to the facility the morning of 04-09-18.</p> <p>In addition, the April 2018 MAR revealed that</p>	F 684	<p>Resident #26 was not adversely affected by this citation.</p> <p>All residents who have physician orders for foam boots have the potential to be affected by this citation. No other residents were identified during the survey as being affected.</p> <p>Nursing staff was reeducated by the administrator and Director of Clinical services beginning 5-8-18.</p> <p>Audits will be completed by the Director of Nursing and unit managers on ensuring residents with orders for foam boots have them on according to the physician orders three times per week for 4 weeks and the results will be reviewed during QAPI and follow up as needed.</p> <p>All residents in the facility that receive medications have the potential to be affected by this citation. No other residents were identified as being affected by this citation.</p>	5-24-18	

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F 684	<p>Continued From page 32</p> <p>resident #230's Lidoderm patch was ordered to be administered on 04-09-18 and was not. Staff documentation for 04-09-18 on the MAR revealed an "O". The progress note indicated that the medication was "on order." However, review of the pharmacy requisition form revealed that the medication had been delivered to the facility the morning of 04-09-18.</p> <p>On 04-10-18 at 12 PM, surveyor interview with the Director of Nursing revealed no additional information.</p> <p>3. On 04-09-18 at 9:30AM, 11:15AM, 3:30PM and 04-10-18 at 08:05AM, surveyor observations revealed resident #26 was lying in bed with no devices applied to his/her heels. Further observation revealed a pair of foam boots in the chair by the resident's bed.</p>	F 684			
F 685 SS=D	<p>On 04-09-18 at 10AM, surveyor review of the clinical record for resident #26 revealed a physician's order written on 03-23-18 to apply foam boots to both heels at all times while in bed for prevention of skin impalment.</p> <p>On 04-10-18 at 08:10AM, interview with the Director of Nursing revealed the foam boots should have been applied to resident #26's heels as ordered by the physician.</p> <p>Following surveyor intervention, facility staff applied the foam boots to resident #26's bilateral heels as ordered.</p> <p>Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2)</p> <p>§483.25(a) Vision and hearing</p>	F 685			

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F 685	<p>Continued From page 33</p> <p>To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident-</p> <p>§483.25(a)(1) In making appointments, and</p> <p>§483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by:</p> <p>Based on surveyor observation, review of the clinical record and interviews with resident #32 and staff, it was determined that the facility staff failed to ensure that resident #32 receive a new pair of eye glasses as prescribed. This finding was evident for 1(#32) of 29 residents selected for the survey. The findings include:</p> <p>On 04-10-18 at 9 AM, surveyor interview with resident #32 revealed that the resident's eyeglass frame was broken and held together with tape. Further interview revealed that resident #32 had a recent eye exam and glasses were prescribed, but the resident had not received them.</p> <p>On 04-10-18 at 3 PM, surveyor review of the clinical record for resident #32 revealed that, on 02-26-18, an eye exam was done outside of the facility. The optical prescription was found in the clinical record with a handwritten note "seen by Dr. NNO (no new order) 02-26-18" and was signed by a nurse. There was no corresponding note in the progress notes to provide details.</p> <p>On 04-11-18 at 1 PM, interview with resident #32</p>	F 685	<p>F685</p> <p>Resident #32 received their new pair of glasses on 4-25-18.</p> <p>All residents in the facility who have broken glasses have the potential to be affected by this citation. No other residents in the facility currently have broken glasses as of 5-7-18. The facility will inform the residents during the next scheduled resident council to notify the facility when their glasses are broken so that we can have them repaired properly for the residents.</p> <p>The facility Administrator re-educated the Social Services department on ensuring residents who need glasses to be fixed so that they are repaired in a timely manner.</p> <p>The administrator and social worker will audit the facility concern log to ensure there are no residents who have broken glasses have not been addressed weekly x 4 weeks. The results of the audits will be reviewed during QAPI and followed up as needed.</p>	5-24-18	On-going

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F 685	<p>Continued From page 34</p> <p>revealed that the glasses didn't fit right and scraped his/her nose, causing discomfort.</p> <p>On 04-12-18 at 4 PM, surveyor interview with the social worker revealed that assistance was provided in scheduling the consultation, but the social worker was unaware of the prescription for the eye glasses. In addition, the social worker was aware that resident #32's glasses were broken and held together with tape, and would make arrangements to obtain the eye glasses.</p> <p>On 04-13-18 at 10 AM, surveyor interview with the Yorktown unit manager revealed no additional information.</p> <p>On 04-13-18 at 12 PM, surveyor interview with the Director of Nursing revealed no additional information.</p>	F 685			
F 689 SS-J	<p>Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)</p> <p>§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</p> <p>§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 surveyor observations, review of the clinical records, review of facility policy and procedure and interviews with facility staff and residents, it was determined that the facility failed to ensure that residents were free from accident hazards when a resident was observed smoking</p>	F 689			

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NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 SECOND AVENUE SILVER SPRING, MD 20910		
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F 689	<p>Continued From page 35</p> <p>In their room, and residents assessed as requiring supervision with smoking were left unsupervised. This deficient practice put all residents at increased risk for serious harm from fire. This finding was identified for 2 out of 3 residents who smoke in the facility. (#9, #34). On April 11, 2018 at 2 PM, an Immediate Jeopardy for health and safety was determined by the State Office of Health Care Quality.</p> <p>The Immediate Jeopardy was abated on April 11, 2018 at 10:15 PM, following the facility's implementation of corrective actions to ensure the health and safety of all residents who were at risk for serious harm from fire. The following is the facility's abatement plan developed on 04-11-18:</p> <p>a. Residents #9, #17 and #34 have had their care plans and assessments updated to address the dangers of unsafe smoking. Additionally, these residents have all been counseled on the requirements for smoking and received reinforcement of the facility's smoking policy as well as the requirement of facility staff supervision for resident #9 when smoking. Smoking assessments will be conducted with residents during the admission process, and during each quarterly or MDS (Minimum Data Set) assessment process.</p> <p>b. The facility has posted a smoking schedule at nursing stations to ensure that supervision is present in the smoking area for resident #9 who requires staff supervision when smoking. Additionally, the facility provided a smoking apron to resident #9, with spare aprons also located inside the smoking area at a common known location. Additional fire extinguishers were</p>	F 689	<p>F689</p> <p>No residents were adversely affected by this citation.</p> <p>All Residents have the potential to be affected by this citation.</p> <p>The facility began an Abatement plan which begun at 3:30pm with the Administrator, DON and Social Services Director meeting with resident #17 to reinforce the smoking policy. [redacted] plan of care was revised and updated on 4/11/18 as stated in the Abatement plan.</p> <p>Resident #34 met with the Administrator, DON, and Social Services Director to reiterate the smoking policy in which [redacted] refused to acknowledge or take a copy of the policy. A copy of an involuntary discharge notice was served to resident #34 approx. 4:15pm. This resident was put on Q15 minute checks until the time of [redacted] discharge. This resident discharged from this facility on</p>		

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F 689	Continued From page 38 obtained on 04-12-18, and mounted in the designated smoking area. c. All smoking materials of residents who smoke were secured in the facility's medication carts. Both residents, as well as their family members, were notified to have all smoking articles to be secured with the nursing staff and not in their rooms. The Action Plan also included immediate staff education, including ancillary departments, regarding the facility's current and the revised smoking policy and procedures. d. All Nursing Leadership will monitor for compliance daily throughout daily rounds to ensure compliance by residents who smoke. The Administrator and/or Director of Nursing are responsible for ensuring compliance. All smoking activities will be reviewed at the Facility Safety Committee level and/QA&A (Quality Assurance) committees on monthly basis and interventions will be reviewed as deemed necessary. The findings include: 1. On 04-10-18 at 2:30 PM, surveyor observation of resident #9 revealed the resident smoking in the designated smoking area. There was no evidence that resident #9 was supervised by staff and no evidence of a smoking apron ((flame retardant apron for smokers) in use. The resident is a quadriplegic (unable to use all four limbs). Further observation revealed that resident #9 dropped the filter of the cigarette on the ground while it was lit. Further observation at 3:30 PM, revealed resident #9 smoking again in the designated smoking area with resident #34. Surveyor observed resident #34 putting a cigarette in	F 689	Administrator, DON and Social Services director met with Resident #9 to review the smoking policy. This resident was involved in the writing of a Smoking Schedule to be followed by the staff and this resident. All nursing staff were advised of the schedule and copies placed on the unit and Medication cart. Additional fire protection equipment was installed in the smoking area as well as monitoring the area on rounds. Abatement plan was approved and accepted approx.. 10:15pm on 4-11-18. Administrator and DON will monitor for compliance.	4-11-18 On-going	

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F 689	<p>Continued From page 37</p> <p>resident #9's mouth and lighting the cigarette for him/her. There was no evidence of staff supervision and no use of a smoking apron by resident #9. A bath towel instead was observed wrapped around resident #9's chest directly underneath the lit cigarette, while the cigarette was secured only by the resident's lips</p> <p>On 04-10-18, surveyor review of the 03-01-17 facility's smoking policy and procedures revealed that smoking materials of residents requiring supervision while smoking will be maintained by nursing staff in the medication cart. In addition, supervised smokers will require supervision by staff, and a smoking apron will be provided.</p> <p>Surveyor review of the clinical record revealed that resident #9 was a quadriplegic and unable to light or hold a cigarette while smoking. The resident was grandfathered in as a smoker when the facility became smoke free (on grounds of facility) on 03-01-17. Further review revealed a smoking assessment on 03-31-18, which revealed that resident #9 was assessed with a score of 8 on a scale of 1-10. The score determined that the resident was at high risk for injury and required supervision with smoking. Based on the smoking policy, staff should maintain all smoking materials for the resident, provide supervision and use of a smoking apron.</p> <p>In addition, surveyor review of the comprehensive plans of care for resident #9 revealed no evidence of a care plan with interventions addressing smoking practices that reflected the individualized smoking needs of resident #9. (Refer to F656 for additional information)</p> <p>On 04-10-18 at 10:30 AM, surveyor interview with</p>	F 689			

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F 689	<p>Continued From page 38</p> <p>resident #9 revealed that his/her mother brings the resident's smoking materials, which are kept within the resident's room. Further interview revealed the resident goes to the designated smoking area outside and "usually smokes with another resident who helps me smoke by lighting my cigarette and we smoke with no staff supervision".</p> <p>On 04-10-18 at 12:12 PM, surveyor interview with LPN (Licensed Practical Nurse) #9 revealed that all residents who smoke keep their own cigarettes and lighters. In addition, there is no designated time to smoke and residents can go out to the outside patio, (designated smoking area) and smoke without staff supervision.</p> <p>On 04-10-18 at 3:35 PM, surveyor interview with GNA (Geriatric Nursing Assistant) #10 revealed "I do not supervise or assist residents to smoke, because I am not a smoker and do not want to inhale the second-hand smoke."</p> <p>On 04-10-18, surveyor interview at 1:30PM with the facility administrator revealed that residents assessed as requiring supervision for smoking are not to be left unsupervised while smoking. Other residents are not to provide supervision for residents deemed as requiring supervision by staff. In addition, the administrator revealed "I think the facility has at least 2 smoking aprons, but I don't remember where they are kept", when asked about smoking aprons.</p> <p>On 04-10-18 at 4:15 PM, surveyor interview of the Director of Nursing provided no additional information.</p> <p>2. On 04-10-18 at 2:30 and 3:30 PM, surveyor</p>	F 689			

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F 689	<p>Continued From page 39</p> <p>observations revealed resident #34 assisting resident #9 to smoke a cigarette in the designated smoking area. There was no evidence of facility staff supervision..</p> <p>On 04-10-18, surveyor review of the clinical record revealed that resident #34 was admitted after the implementation of the no smoking policy last year, with multiple medical conditions including, but not limited to, paraplegia (complete paralysis of the lower half of the body including both legs) and acquired absence of unspecified fingers.</p> <p>In addition, further record review revealed 03-11-18 nursing documentation that resident #34 was caught smoking a cigarette in his/her room. There was a pack of cigarettes and a lighter found on the resident's bedside table. On 03-12-18, documentation by SW (social worker) #2 revealed that both SW #2 and the facility's administrator met with the resident to discuss concerns about smoking in the facility.</p> <p>On 03-26-18, SW #2's documentation revealed that resident #34 was observed burning receipts in his/her room. However, the resident denied burning receipts in the room but admitted to doing so in the designated smoking area. There was a meeting with the resident, as well as the resident's mother, regarding a warning for the second time and the mother agreed to take away the resident's smoking materials.</p> <p>On 03-28-18, SW #2's documentation revealed an observation of #34 smoking a cigarette in the designated smoking area. Further review revealed that the resident admitted to smoking due to being stressed. At this time, SW #2</p>	F 689			

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F 689	<p>Continued From page 40</p> <p>reiterated the facility's No Smoking Policy, and provided an update of the progress on finding the resident another facility, per the resident's request. On 03-30-18, a smoking care plan was initiated for resident #34 that included interventions to instruct the resident about smoking risks and hazards of smoking in the room.</p> <p>On 04-09-18 at 11:35 AM, surveyor interview of resident #34 revealed "I go outside to use my vaporizer (electronic cigarette). While outside, I help another resident to smoke by putting the cigarette in his/her mouth and lighting it since the resident is paralyzed from the neck down". Further interview revealed that there are only 3 smokers in the facility and they usually go to the designated area to smoke without staff supervision, and no designated smoking schedule. In addition, the resident's electronic cigarettes are kept in the resident's room, while the other smokers keep their materials in their rooms.</p> <p>On 04-10-18 at 12:12 PM, surveyor interview with LPN (Licensed Practical Nurse) #9 revealed that all residents who smoke keep their own cigarettes and lighters. In addition, there is no designated times to smoke and residents can go out to the outside patio, (designated smoking area) and smoke without staff supervision.</p> <p>On 04-10-18 at 4:30 PM, surveyor interview with the facility administrator revealed that resident #34 was aware of the facility's no smoking policy prior to admission. The resident agreed to stop smoking prior to admission. The resident was warned three times about smoking in the building and a meeting was held with the resident's</p>	F 689			

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F 689	Continued From page 41 mother, who agreed to remove all smoking materials from the resident.	F 689			
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 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	F 690	F690 Resident #34 was not adversely affected by this citation. All residents who have Foley catheters have the potential to be affected by this citation. The facility DON and Unit Manager completed a review of all residents who currently have Foley catheters on May 7, 2018, to ensure they were receiving care for the catheters according to physician orders. No other residents were affected by this citation. Nursing staff will be re-educated by the DON and Unit manager on ensuring residents with foley catheters receive catheter care every shift and as needed and the medication record is completed after the services are given to the residents. If residents are able to provide their own catheter care the residents plan of care will be updated and the facility will ensure the resident is able to appropriately care for the catheter by 5-15-18.		

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F 690	<p>Continued From page 42 possible. This REQUIREMENT is not met as evidenced by: Based on surveyor review of the clinical record, surveyor observations and interviews of resident #34 and facility staff, it was determined that the facility staff failed to provide treatment and services of a Foley catheter (a flexible tube which a clinician passes through the urethra and into the bladder to drain urine) for resident #34. This finding was evident for 1 of 29 residents selected for the survey. The findings include:</p> <p>This finding was identified during the investigation of complaint MD00123611.</p> <p>On 04-09-18 at 11:30 AM, surveyor observation revealed resident #34 in bed with a Foley catheter drainage bag on the floor, with no strap attached to the catheter tubing to prevent it from pulling from the resident, which could cause trauma to the urethra.</p> <p>On 04-09-18 at 11:40AM, surveyor interview with resident #34 revealed the resident was admitted to the facility with the Foley catheter due to a medical condition. Further interview revealed "staff does not take care of the Foley. I empty the bag myself when it's full".</p> <p>On 04-10-18, surveyor review of the clinical record revealed a physician's order on 01-27-18 for staff to monitor the Foley catheter every shift. However, review of the February 2018 Treatment Administration Record (TAR) revealed blanks on the following days: 7 AM-3 PM shift on 02-22-18, 02-24-18, and 02-27-18. Additionally, there was no evidence that the Foley catheter was being monitored by staff on all shifts for the entire</p>	F 690	<p>The DON and Unit manager will complete audits of all residents with Foley Catheters twice per week for 4 weeks to ensure they are receiving the appropriate catheter care according to the physician orders. The results of the audits will be reviewed during QAPI and followed up as needed.</p>	5-24-18 On-going	

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F 690	Continued From page 43 month of March 2018 per the March 2018 TAR. .	F 690			
F 732 SS-B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.	F 732 F732	No residents were adversely affected by this citation. All residents have the potential to be affected by this citation. All licensed nurses/supervisors will be in-serviced on the proper method of posting nurse staffing data per the regulation F732 by the facility Administrator by 5/15/18. Nursing leaders and DON will monitor daily for compliance. They will audit the posted nursing staffing sheets twice per week for 4 weeks to ensure they are in compliance with regulation.	5-24-18 On going	

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F 732	<p>Continued From page 44</p> <p>§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by:</p> <p>Based on surveyor observation, review of the facility's staffing documentation and staff interviews, it was determined that the facility staff failed to post accurate licensed nursing staffing information. This finding was evident for 1 of 3 nursing units within the facility. The findings include:</p> <p>On 04-13-18 at 8:45 AM, surveyor observation of the Yorktown unit nurse staffing board revealed that the posted nurse staffing information was the information for the day before (04-12-18). Further observation of the staffing board revealed that the posted 04-12-18 information didn't accurately show which GNAs (Geriatric Nursing Assistant) was assigned to each group of residents. On the board, it was documented that one GNA had Team 1 (rooms 202-207A + 209) and one GNA had Team 3 (rooms 213-218), however, Team 2 (which had rooms 207 B-212 B) had no GNA assigned, indicating that the rooms were unassigned.</p> <p>Review of the handwritten paper copy of the nurse staffing information inaccurately showed that 3 GNAs had worked the shift on 04-12-18. In addition, the posted nurse staffing board and the paper copy in the staffing book revealed no evidence of the staff to resident ratios, as required. After surveyor intervention, the charge nurse corrected the information on the staffing</p>	F 732			

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F 732	Continued From page 45 board and in the staffing book. On 04-13-18 at 8:50 AM, surveyor interview with the Yorktown unit manager revealed no additional information. On 04-13-18 at 10:30 AM, surveyor interview with the DON revealed no additional information.	F 732			
F 745	Provision of Medically Related Social Service SS=D CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on surveyor review of the clinical record and interview with facility staff, it was determined that the facility failed to ensure medically-related social services to maintain the highest practicable physical, mental and psychosocial well being of resident #55. This finding was evident for 1 of 29 residents selected for the survey. The findings include: On 04-12-18, surveyor review of the clinical record revealed that, in March 2017, two physician certifications were in place that resident #55 lacked adequate decision making capacity (including decisions about life sustaining treatments). Further review revealed that, in May 2016, resident #55 identified 2 friends on the health care decision worksheet for making health care decisions for the resident if the resident lacked or lost the capacity for decision making. Resident #55 had a legal guardian of property in place for decisions.	F 745	F745 Resident #55 was not adversely affected by this citation. All residents have the potential to be affected by this citation. Social Services will update the living POA for continuation of serving as the residents designated medical decision maker. An audit will be completed by 5/15/18 for all designated POS's and accuracy of contact information. This will be reported to QAPI monthly x 3 months.	5-24-18 On-going	

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NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 SECOND AVENUE SILVER SPRING, MD 20910		
(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 745	Continued From page 46 Further record review revealed that, on 08-01-17, the local area circuit court terminated the guardianship of property, with a copy of the termination provided both to the facility, as well as the Social Security Administration and the resident's employee pension department. However, surveyor review revealed no documented evidence that the facility's social worker provided any assistance or arrangement of referrals to pursue resident #55's needs for financial and legal matters since the termination of the resident's guardian of property on 08-01-17. Additionally, further record review revealed a 08-24-17 social service note that, when the social worker contacted resident #55's identified POA (Power of Attorney) for medical decisions, the social worker was informed at that time that the primary of the two designated medical decision makers had passed away, while the other designated decision maker was in mourning. Further review revealed that, on 11-20-17, there was an unsuccessful attempt in making contact with the surviving designated medical decision maker. However, there was no documented evidence that the facility's social worker provided any assistance or arrangement of services for the resident after the loss of one of the resident's designated medical decision maker. In addition, there was no evidence of further follow up with the designated medical decision maker on the continuation of the POA role for resident #55. On 04-16-18 at 1PM and 3PM, surveyor interview	F 745			

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NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 SECOND AVENUE SILVER SPRING, MD 20910		
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F 745	Continued From page 47 with the Director of Nursing and the facility administrator revealed no additional information.	F 745			
F 755 SS=D	Pharmacy Svcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 755	F755 Residents #60 was not adversely affected by this citation. All residents in the facility that receive PRN medications have the potential to be affected by this citation. No other residents were adversely affected by this citation or identified during survey. Licensed nurses will be re-educated by the DON on ensuring the appropriate documentation is being completed after administering PRN medications by May 11, 2018.		
	§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by:		Audits will be completed by the DON two times per week for 4 weeks on ensuring residents who receive PRN medications have the correct documentation in place. The results of the audits will be reviewed during QAPI.	5-24-18 On-going	

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NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 SECOND AVENUE SILVER SPRING, MD 20910		
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F 755	<p>Continued From page 48</p> <p>Based on surveyor review of the clinical record and interview with the facility staff, it was determined that the facility failed to ensure accurate reconciliation of controlled drugs in the residents' clinical record. This finding was evident for 1 of 29 residents selected for the survey. (#60) The findings include:</p> <p>On 04-09-18 at 9 AM, surveyor interview with resident #60 revealed the resident had pain and was administered the pain medication, Dilaudid 4 mg, on an as-needed basis. Further interview revealed the last dose the resident had received was at 6AM on 4/9/18. Dilaudid is a controlled substance for which a licensed nurse must sign out each time a dose is removed from the inventory, as well as document the administration to the resident on the MAR (Medication Administration Record).</p>	F 755			
	<p>a. On 04-09-18 at 1 PM, surveyor review of the April 2018 MAR for resident #60 revealed no documented evidence that the resident #60 had received Dilaudid that morning at 6 AM. Surveyor review of the Schedule 2 Original Prescription Inventory for the 4 mg Dilaudid revealed that a dose had been signed out by a nurse at 6 AM. However, the dose was not documented as being administered on the MAR to the resident.</p> <p>b. Additionally, further review on 04-13-18 at 11 AM of the April 2018 MAR and the Schedule 2 Original Prescription Inventory for the 4 mg Dilaudid for resident #60 revealed no staff documentation on the April 2018 MAR for the following time/dates: 04-01-18 at 11 AM, 04-01-18 at 5 PM, 04-02-18 at 9 PM, 04-03-18 at 4 AM, 04-03-18 at 2 PM, 04-03-18 at</p>				

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F 755	Continued From page 49 10:30 PM, 04-04-18 at 5 AM, 04-04-18 at 2:30 PM, 04-05-18 at 6 AM, 04-06-18 at 1:30 AM, 04-06-18 at 6:30 AM, 04-06-18 at 9:15 AM, 04-06-18 at 4:30 PM, 04-07-18 at 10 PM, 04-08-18 at 3:30 AM, 04-08-18 at 9 AM, 04-09-18 at 4 PM, 04-10-18 at 6 AM, 04-11-18 at 8:15 PM, 04-12-18 at 5 AM, 04-12-18 at 11 AM, 04-13-18 at 4 AM. On 04-13-18 at 11 AM, surveyor interview with the Yorktown unit manager revealed no additional information. On 04-13-18 at 12 PM, surveyor interview with the director of nursing revealed no additional information.	F 755			
F 800 SS-C	Provided Diet Meets Needs of Each Resident CFR(s): 483.60 §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is not met as evidenced by: Based on surveyor observation and interview with facility staff, it was determined that the facility staff failed to keep all food items covered during transportation to the units and delivery to residents. This finding was evident for 4 of the 4 unit halls within the facility. The findings include:	F 800			

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F 800	Continued From page 50 On 04-09-18 at 11:45 AM, surveyor's kitchen observation of the tray line revealed that the blueberry cobbler dessert was uncovered and placed onto the lunch trays. On 04-09-18 from 12:15 PM until 12:45 PM, surveyor observation of the Yorktown Unit hall revealed staff carrying trays with uncovered cobbler through the hallway. Further observation revealed staff carrying lunch trays to rooms with uncovered cobbler dessert on the Charleston, Williamsburg and Jamestown halls. On 04-09-18 at 4 PM, surveyor interview with the facility's kitchen manager revealed that staff didn't cover the cobbler because they didn't want to have the wrap pressing on the dessert's whipped topping.	F 800	F800 Residents were not adversely affected by this citation. All residents will have the potential to be affected by this citation. No residents adversely affected by this citation. An in-service of all dietary staff was completed to ensure the error does not occur again by the facility Administrator and RD by 5/11/18. The trayline will be monitored by Food Service Manage and/or RD and/or Cook Supervisor with a tray line audit completely at least weekly. Results will be reported to the QAPI monthly x 3 months or until the issue is corrected.		
F 835 SS-F	On 4-11-18 at 11 AM, surveyor interview with the administrator revealed no additional information. Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on surveyor observation, review of the clinical records, review of facility policies and procedures and interview of facility staff, it was determined that facility administration failed to implement a safe smoking policy for residents that violated their guidelines, which compromised	F 835		5-24-18 and On-going	

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F 835 Continued From page 51
the health and safety of all residents within the facility. The findings include:

1. On 04-10-18, surveyor review of the facility's smoking policy and procedure revealed that, on 03-01-17, the facility initiated a facility-wide "Smoke-Free Facility Policy". This policy did not affect residents who were smokers as of 03-01-17. Further review of the policy revealed that smoking materials (i.e. cigarettes and lighters) for residents who are assessed requiring supervision with smoking, will be maintained by nursing staff in the medication cart. In addition, unsafe smokers will require supervision by appropriate facility staff and the use of a smoking apron (flame retardant) will be provided.

Further review revealed that resident #9 was assessed by facility staff as a high risk smoker who required staff supervision. However, the resident was allowed access to the smoking area without staff supervision, was able to keep his/her own cigarettes and lighter, and was assisted to smoke by other residents.

On 04-10-18 at 2:30PM, surveyor observation revealed resident #9, who was a quadriplegic (unable to use upper and lower extremities), smoking in the designated smoking area unsupervised by facility staff, without a smoking apron. Further observation at 3:30PM revealed resident #9 was again in the designated smoking area with resident #34 putting a cigarette in resident #9's mouth and lighting the cigarette. There was no evidence that the "safe smoking policy" that included facility staff supervision and the use of a smoking apron was followed by staff for the resident who required supervision. (Refer to F689 for additional information)

F 835

All residents in the facility were affected by this citation.

The facility will maintain ongoing audits for F689 to ensure the facility maintain compliance with F835 and F689. Please see the plan of correction with the completed on going audits that have been completed by the facility staff in an effort to maintain the highest practicable physical, mental and psychosocial well-being of each resident. The results of all the audits will be reviewed during facilities monthly and quarterly QAPI and followed up as needed. This plan of correction was reviewed with the medical director for their specific input on the different areas that are being addressed.

5-11-18

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F 835

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On 04-10-18 at 4:30PM and 04-11-18 at 2PM, surveyor interview with the facility administrator and the Director of Nursing revealed no additional information.

2. In addition, the facility failed to ensure the safety of other residents in the facility when resident #34 was caught smoking cigarettes in his/her room.

Review of the facility's policy and procedure, implemented on 03-01-17, revealed that, if a resident or family does not abide by the smoking policy or care plan, the plan of care may be revised to include additional measures such as room searches, prohibited smoking or even discharge. The resident was admitted after the policy was said to have been put into effect.

F 835

On 04-10-18, surveyor review of the clinical record for resident #34 revealed that, on 02-01-18, resident #34 signed the facility's no smoking policy. Further review revealed staff documentation on 03-11-18 that resident #34 was caught smoking a cigarette in their room, and a pack of cigarettes and a lighter was found on the resident's bedside table.

However, there was no evidence of any administrative actions after 03-11-18, that included a room search or other measures, including a plan of care for safe smoking.

On 03-26-18, staff documented that resident #34 was observed burning receipts in his/her room. At the time, the resident was warned and reminded of the no smoking policy. The resident's mother agreed to take away all smoking materials from

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F 835	Continued From page 53 the resident. On 03-28-18, resident #34 was observed by staff smoking a cigarette in the designated smoking area. At that time, the social worker documented that the facility's No Smoking Policy was reiterated to the resident. On 03-30-18, a smoking plan of care was initiated for the resident. However, there was no evidence that the facility administration proceeded with consequences after the smoking violations were observed, until surveyor intervention on 04-10-18. (Refer to F889 for additional information) On 04-10-18 at 4:30PM, and 04-11-18 at 2PM, surveyor interview with the facility administrator and the Director of Nursing revealed no additional information.	F 835			
F 842 SS-B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are: (i) Complete; (ii) Accurately documented;	F 842			

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NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 SECOND AVENUE SILVER SPRING, MD 20910		
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F 842	<p>Continued From page 54</p> <p>(iii) Readily accessible; and</p> <p>(iv) Systematically organized</p> <p>§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-</p> <p>(i) To the individual, or their resident representative where permitted by applicable law;</p> <p>(ii) Required by Law;</p> <p>(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;</p> <p>(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.</p> <p>§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.</p> <p>§483.70(i)(4) Medical records must be retained for-</p> <p>(i) The period of time required by State law; or</p> <p>(ii) Five years from the date of discharge when there is no requirement in State law; or</p> <p>(iii) For a minor, 3 years after a resident reaches legal age under State law.</p> <p>§483.70(i)(5) The medical record must contain-</p> <p>(i) Sufficient information to identify the resident;</p> <p>(ii) A record of the resident's assessments;</p> <p>(iii) The comprehensive plan of care and services</p>	F 842	<p>F842</p> <p>Resident #476 was not adversely affected by this citation.</p> <p>All residents with pressure wounds have the potential to be affected by this citation. No other residents were identified during the survey to be affected by this citation.</p> <p>License nursing staff will be re-educated by the DON and other wound specialists on ensuring assessments are completed accurately and they reflect the current status of the resident by May 11, 2018.</p> <p>Record review and resident observation audits will be conducted to ensure residents are being assessed appropriately and the documentation reflects the residents' current wound status by the DON and Unit Manager twice per week for four weeks. The results of the audits will be reviewed during QAPI and follow up as needed.</p>	5/24/18 On-going	

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F 842	Continued From page 55 provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on surveyor review of the clinical record and interview with the facility staff, it was determined that the facility failed to ensure accurate documentation in the residents' clinical records. This finding was evident for 1 of 29 residents selected for the survey. (#47) The findings include: On 04-11-18, surveyor review of the clinical record revealed that, on 03-05-18, resident # 47 had developed a facility acquired open wound area on the right gluteal area. Staff obtained daily wound treatment orders for the open wound area. Review of the 03-25-18 Skin Observation Tool revealed staff documentation that the area was an unstageable pressure ulcer with measurement of 9.5 x 9 cm. Unstageable pressure ulcer can be defined as, full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Further review revealed staff documentation on 04-03-18 that the right gluteal wound was measured at 8 x 2 cm with moderate amount (30%) of slough (dead tissue) noted in the wound, and for the continuation of the current treatment plan. However, review of the 04-08-18 Skin Observation Tool revealed staff	F 842			

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F 842	Continued From page 56 documentation that resident #47's "skin was intact and warm", even though the resident continued to have an unstageable right gluteal wound with the continuation of wound treatment. On 04-12-18 at 11:17 AM, surveyor interview with LPN (Licensed Practical Nurse) # 12 revealed that resident #47 was transferred to the hospital on [redacted] and at the time of the hospital transfer, continued to have a wound on the right gluteal area. On 04-13-18 at 10AM, surveyor interview with the Director of Nursing revealed the 04-08-18 Skin Observation Tool documentation was inaccurate and resident #47 still had an unstageable pressure wound. No additional information was provided.	F 842			
F 867	QAPI/QAA 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 assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on surveyor interview with facility staff, review of the facility policies and procedures, review of resident records and review of the facility Quality Assurance and Assessment, (QAA) it was determined that the QAA committee failed to adequately implement and monitor comprehensive plans of action to correct identified smoking issues. The findings include:	F 867			

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F 867	<p>Continued From page 57</p> <p>On 04-16-18 at 5:10 PM, surveyor review of QAA minutes with the facility administrator revealed that smoking was identified in January 2017 as an issue during the January 2017 meeting. The facility at that time was to become smoke free on 03-01-17. Further review revealed a safe smoking or tobacco use policy and procedure would include the following:</p> <ol style="list-style-type: none"> 1. Smoking is prohibited in all areas except the designated smoking area. 2. Safety measures for the designated smoking area will include <ol style="list-style-type: none"> A. accessible fire extinguisher B. provision of ashtrays made of noncombustible material 3. Electronic cigarettes will be treated the same as any other smoking product. 4. Smoking materials of residents requiring supervision with smoking will be maintained by nursing staff. 5. Residents identified as unsafe smokers will wear protective gear such as smoking aprons when smoking. 6. Unsafe smokers will be supervised while smoking. <p>On 04-10-18, surveyor review of the 03-01-17 facility's smoking policy and procedure revealed that smoking materials of residents requiring supervision with smoking would be maintained by nursing staff in the medication cart. In addition, unsafe smokers will require supervision by facility staff and a smoking apron will be provided.</p> <p>On 04-10-18 at 10:30 AM, surveyor interview with Resident #9, who is required to be a supervised smoker, revealed that his/her mother brings the resident's smoking materials and they are kept in</p>	F 867	<p>F867</p> <p>F867</p> <p>The facility works to maintain a functioning Quality Assurance and Assessment committee. The facility is dedicated to ensuring the residents receive the highest quality of care.</p> <p>Residents #9 and 34 were not adversely affected by this citation.</p> <p>All residents in the facility not were affected by this citation.</p> <p>The facility currently has two residents that smoke. Both residents were reassessed by the licensed nurses and one was determined to be able to smoke independently and the other one needs supervision. The resident who requires supervision has agree to scheduled smoking times with the facility and has agreed to follow the smoking policy that was provided to [redacted] on 4-11-18.</p>	5-24-18 And on-going	

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F 867	Continued From page 58 the resident's room. Further interview revealed resident #9 goes to the designated smoking area to smoke by choice without any designated times. The resident stated he/she "usually smoke with another resident who help me smoke by lighting my cigarette and we smoke with no staff supervision". (Refer to F889 for additional information) Additionally, record review of resident #34 revealed staff documentation of the resident smoking cigarettes in his/her room as well as caught burning receipts. Further review revealed staff documentation of three (3) incidents when the resident violated the facility's smoking policy. (Refer to F889 for additional information) However, the facility only issued warnings to resident #34 with no evidence that of other corrective measures put into place as indicated in the smoking policy.	F 867	The facility will audit the residents smoking times and observe for violations in the smoking policy that was reviewed with the resident on 4-11-18. All issues regarding smoking will be brought to morning meeting and will be reviewed monthly during the facility QAPI. If needed the facility will work to develop or modify the current smoking program to ensure the safety of the residents and staff of the facility.	-5-24-18	And on-going
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the	F 880			

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F 880	<p>Continued From page 59 development and transmission of communicable diseases and infections.</p> <p>§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident, including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p>	F 880	<p>F880</p> <p>Residents #14, 58, and 72 did not have any adverse reactions to this citation. Their oxygen tubing was immediately changed.</p> <p>All residents in the facility have the potential to be affected by this citation. The facility IDT team completed an audit of all residents in the facility who received oxygen, aerosols to ensure their tubing, masks are stored and dated properly by 5-10-18.</p> <p>Facility staff will be re-educated by the facility administrator on ensuring residents who receive oxygen or aerosols have their tubing dated and stored appropriately by 5-11-18.</p> <p>Random observation audits will be completed by the Administrator and Central Supply Nurse twice per week for 4 weeks on ensuring oxygen tubing, aerosol masks are dated and stored appropriately. The results of the audits will be reviewed during QAPI and followed up as needed.</p>	5-24-18 and On-going	

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F 880	Continued From page 60 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on surveyor review of the clinical records, surveyor observation and interviews with the facility staff, it was determined that the facility staff failed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection. This finding was evident for 3 of 29 residents selected for the survey. (#14, #56, #72). The findings include: 1. On 04-09-18 at 08:30 AM, surveyor tour revealed oxygen tubing connected to a concentrator (a medical device used to deliver oxygen) tank in resident #14's room. The tubing was observed on the floor with the nostril section (the tip that goes into the resident's nose) under the resident's bed. Further observation revealed	F 880			

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F 880	<p>Continued From page 61 that the tubing had no date indicated.</p> <p>Surveyor review of the clinical record for resident #14 revealed a physician order "Change and date oxygen tubing every week and as needed."</p> <p>On 04-11-18 at 09:12 AM, surveyor interview with the Director of Nursing (DON) revealed that the oxygen tubing was to be stored in a plastic bag when not in use.</p> <p>There was no evidence that the facility staff had stored the oxygen tubing in a plastic bag, nor that the tubing was changed.</p> <p>2. On 04-12-18 at 12 PM, surveyor observation of resident #72's room revealed an oxygen concentrator with a humidifier bottle attached and a nasal cannula used to deliver the oxygen to the resident. The nasal cannula was found hanging on the feeding pump near the resident's bed. The humidifier water bottle and the oxygen tubing were not dated nor initialed. In addition, resident #72 has a nebulizer at the bedside to deliver inhaled medication via a tubing and a mask. Both the tubing and mask were found in the dresser drawer, with the mask dirty and not dated on its initial use.</p> <p>On 04-12-18 at 1:30 PM, surveyor interview with the Yorktown unit manager revealed that the tubing should have been dated and initialed when it was put into the resident's room.</p> <p>On 04-13-18 at 12 PM, surveyor interview with the Director of Nursing revealed no additional information.</p> <p>3. On 04-12-13 at 1 PM, surveyor observation of</p>	F 880			

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F 880	Continued From page 62 resident #58 revealed the resident's oxygen tubing, which was not dated, with the nasal cannula was hanging on the tube feeding pump near the resident's bed. On 04-12-18 at 1:30 PM, surveyor interview with the Yorktown unit manager revealed that the tubing should have been dated and initialed when it was put into the resident's room. On 04-13-18 at 12 PM, surveyor interview with the Director of Nursing revealed no additional information.	F 880			
F 922 SS-C	Procedures to Ensure Water Availability CFR(s): 483.90(i)(1) The facility must— §483.90(i)(1) Establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply; This REQUIREMENT is not met as evidenced by: Based on surveyor observation and staff interviews, it was determined that the facility failed to follow procedures to ensure water availability to essential areas in the event of the loss of normal water supply. This finding was evident during the surveyor's initial tour of the kitchen. The findings include: On 04-09-18 at 9:30 AM, surveyor observation of the facility's emergency water supply revealed 72 gallons of bottled water available for resident use during an emergency. On this day, the facility's census was 81 with the maximum bed capacity at 92. On 04-09-18 at 9:30 AM, surveyor interview with	F 922			

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F 922	Continued From page 63 the facility's maintenance director revealed that the facility has an agreement with a food service supplier that guarantees automatic delivery of water during an emergency. On 04-13-18 at 3 PM, further interview with the maintenance director revealed that an order was made for the correct amount of water necessary following surveyor intervention. The amount required would be 276 gallons. On 04-13-18 at 3:30 PM, interview with the facility administrator revealed that the necessary emergency water had been ordered.	F 922	No residents were adversely affected by this citation. All residents have the potential to be affected by this citation in the event of an emergency. The additional required water was delivered on April 18, 2018. The food service manager was re-educated by the facility administrator on ensuring the facility has the water available to essential areas when there is a loss of normal water supply by 5-11-18. The Food Service Manager and RD will track the freshness and/or inventory of the emergency water supply and replenish as necessary. The status of this tracking will be reported monthly and reported to the QAPI on the department report.	4-18-18 and On-going	

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S 000	<p>Initial comments</p> <p>The following deficiencies are the result of an annual survey conducted on April 9, 10, 11, 12, 13 and 16, 2018 to determine the facility's compliance with State COMAR requirements. Survey activities consisted of the review of 29 residents' record, observation of resident care and staff practices, interviews of residents, residents' family members, the Ombudsman and facility staff. Additionally, administrative records and resident care policies were reviewed.</p> <p>On April 11, 2018 at 2PM, an Immediate Jeopardy for health and safety was called after the facility failed to ensure that residents were free from increased risk for serious harm from fire. This deficient practice had the potential for serious injury to affect residents currently residing within the facility.</p>	S 000		
	<p>After the determination of immediate jeopardy concerns, an extended survey was conducted.</p> <p>The Immediate Jeopardy was abated on April 11, 2018 at 10:15PM following the facility's implementation of corrective actions to ensure the health and safety of all residents who were at risk for serious harm from fire.</p> <p>In addition to standard survey protocols, complaints MD 00123611, and facility reported incidents MD 00123780 and MD 00122728 were investigated and this survey identified noncompliance with State requirements.</p> <p>Additionally, facility reported incidents MD 00122940 was investigated and this survey did not identify noncompliance with State requirements.</p>			

DHCD
LABORATORY DIVISION'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Michele Mab...

ADMINISTRATOR

5/11/18

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S 000	Continued From page 1 The facility's licensed bed capacity is 82 beds. The census at the time of the survey was 81 residents.	S 000		
S 230	10.07.02.07 A Administration and Resident Care .07 Administration and Resident Care. A. Responsibility. (1) The licensee shall be responsible for the overall conduct of the comprehensive care facility or extended care facility and for compliance with applicable laws and regulations. (2) The administrator shall be responsible for the implementation and enforcement of all provisions of the Patient's Bill of Rights Regulations under COMAR 10.07.09.	S 230		
			SEE F835	5-11-18
S 285	This Regulation is not met as evidenced by: Refer to CMS 2567 F835 10.07.02.07 H Admin/Res care educ pgm .07 Administration and Resident Care H. Educational Program. An ongoing educational program shall be planned and conducted for the development and improvement of skills of all the facility's personnel, including training related to problems and needs of the aged, ill, and disabled. Records shall be maintained reflecting attendance, by	S 285		on-going

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S 265	Continued From page 2 name and title, and training content. In-service training shall include at least: (1) Prevention and control of infections; (2) Fire prevention programs and patient related safety procedures in emergency situations or conditions; (3) Accident prevention; (4) Confidentiality of patient information; (5) Preservation of patient dignity, including protection of the patient's privacy and personal and property rights; (6) Psychophysical and psychosocial needs of the aged ill; (7) Receipt by each employee of appropriate orientation to the facility and its policies, and to the employee's position and duties; (8) Approval by the Department of the orientation and training programs.	S 265	S265 No Residents were adversely affected by this citation. All Staff members can be affected by this citation. An audit will be completed to verify training per regulation has been conducted for all new staff, licensed and non-licensed. Any staff member who has not received the required training will do so per regulation by May 24, 2018.	
	This Regulation is not met as evidenced by: Based on surveyor review of selected personnel files and interview with staff, it was determined that the facility staff failed to provide cognitive training to newly hired employees. This finding was evident for 2 of 8 staff members selected for review. (#1, #3) The findings include: 1. On 04-16-18, review of the personnel record for Staff #1 revealed their initial date of hire as 06-12-17. However, there was no evidence of the required 8 hours of cognitive training within the first 90 days of employment. 2. On 04-16-18, review of personnel record for Staff #3 revealed an initial date of hire as 09-05-17. However, there was no evidence of the		File review will be completed Administrator will be for all new hires and reported monthly to QAPI.	5-24-18 On-going

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S 265	Continued From page 3 required 2 hours of cognitive training within the first 90 days of employment: On 04-16-18 at 1:07 PM, interview with the administrator revealed no further information.	S 265			
S 292	10.07.02.07-1D(1) Emp Train on Cog Impairment and Mental Illnes .07-1 Employee Training on Cognitive Impairment and Mental Illness. D. Ongoing training in cognitive impairment and mental illness shall be provided annually and consist of, at a minimum: (1) 2 hours for employees who are licensed, certified, or registered under the Health Occupations Article, Annotated Code of Maryland, or who assist residents with activities of daily living; an This Regulation is not met as evidenced by: Based on surveyor review of selected personnel files and interview with staff, it was determined that the facility staff failed to provide ongoing annual cognitive training to staff #4. This finding was evident for 1 of 8 staff members selected for review. The findings include: On 04-16-18, review of the personnel record for staff #4 a GNA (geriatric nursing assistant) revealed the initial hire date of 12-05-16. However, there was no evidence of the required 2 hours of ongoing annual cognitive training was provided to staff #4. On 04-16-18 at 1:07PM interview with the administrator revealed no further information.	S 292	S292 No residents were adversely affected by this citation. All staff members can be affected by this citation. An audit will be completed by HR Coordinator to verify annual training has been conducted for all staff, licensed and non-licensed. The Annual cognitive behavior training will be conducted accordingly to ensure all employees receive the two hours required training.	S-24-18 On-going	

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S 508	<p>10.07.02.12 O Neg Svcs; Care 24 Hrs per Day</p> <p>.12 Nursing Services.</p> <p>O. Nursing Care—24 Hours a Day. There shall be sufficient licensed and supportive nursing service personnel on duty 24 hours a day to provide appropriate bedside care to assure that each patient:</p> <ul style="list-style-type: none"> (1) Receives treatments, medications, and diet as prescribed; (2) Receives rehabilitative nursing care as needed; (3) Receives proper care to prevent decubitus ulcers and deformities; (4) Is kept comfortable, clean, and well-groomed; (5) Is protected from accident, injury, and infection; (6) Is encouraged, assisted, and trained in self-care and group activities. 	S 508		
S 510	<p>This Regulation is not met as evidenced by: Refer to CMS 2567 F684, F689, F690</p> <p>10.07.02.12 Q Nsg Svcs; Charge Nurse</p> <p>.12 Nursing Services.</p> <p>Q. Charge Nurse. At least one licensed nurse shall be on duty at all times and shall be designated by the director of nursing to be in charge of the nursing activities during each tour of duty. The charge nurse or nurses shall have the ability to recognize significant changes in the condition of patients and to take necessary action.</p>	S 510	SEE F684, F689, F690	5-1-18 on going

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NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 9101 SECOND AVENUE SILVER SPRING, MD 20910		
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S 510	Continued From page 5 This Regulation is not met as evidenced by: Refer to CMS 2567 F684, F685	S 510	SEE F684, F685	5-11-18 on-going
S 512	10.07.02.12 R Nsg Svcs; Charge Nurse Daily Rounds .12 Nursing Services. R. Charge Nurses' Daily Rounds. The charge nurse or nurses shall make daily rounds to all nursing units for which responsible, performing such functions as: (1) Visiting each patient; (2) Reviewing clinical records, medication orders, patient care plans, and staff assignments; (3) To the degree possible, accompanying physicians when visiting patients.	S 512		
S 535	This Regulation is not met as evidenced by: Refer to CMS 2567 F689 10.07.02.13 B Dietetic Svcs; Supervision .13 Dietetic Services. B. Supervision. (1) In facilities exceeding 50 beds, overall supervisory responsibilities for the dietetic service shall be assigned to a full-time qualified dietetic service supervisor. It shall be the responsibility of the supervisor to delegate relief duties to a person qualified to serve as relief. (See Supportive Personnel, Regulation .07J, above.) (2) In facilities with 26-50 beds, exceptions may	S 535	SEE F689	4-11-18 on-going

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S 535	<p>Continued From page 6</p> <p>be made by the Department to allow the supervisor to share cooking responsibilities with the full-time cook.</p> <p>(3) In facilities with 25 beds or fewer, responsibility may be assigned to the full-time cook.</p> <p>(4) If a facility can demonstrate that because of the experience and training of its personnel and the physical layout and equipment, less supervisory personnel is required, the Department may modify the above requirements for supervision.</p> <p>This Regulation is not met as evidenced by: Based on surveyor interview of the facility staff, it was determined that the facility failed to ensure that the overall supervisory responsibilities for the dietetic service be assigned to a full-time qualified dietetic service supervisor. This finding was evident during the surveyor's kitchen observation. The findings include:</p> <p>As stated in COMAR 10.07.02.13 B(1), facilities exceeding 50 beds, overall supervisory responsibilities for the dietetic service shall be assigned to a full-time (40 hours per week) qualified dietetic service supervisor. The dietetics service supervisor is defined as a person who is a qualified dietitian or a certified dietary manager who has successfully completed the certification requirements for a qualified dietetic service supervisor.</p> <p>On 04-09-18 at 9 AM, surveyor interview with the facility's dietary manager revealed that he/she had completed the required education to take the certified dietary manager exam. However, as of 4/9/18, the dietary manager was not certified.</p>	S 535	<p>S535</p> <p>No residents were adversely affected by this citation.</p> <p>All residents have the potential to be affected by this citation.</p> <p>The facility will provide the necessary scheduled consultation of a n RD per COMAR 10.07.02.13B until there is a Food Service Manager that is Certified.</p> <p>This coverage began the week of May 7, 2018.</p>	<p>5-7-18</p> <p>On-going</p>

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S 535	Continued From page 7 On 04-13-18 at 3 PM, during surveyor interview with the administrator and the dietary manager revealed no additional information.	S 535			
S 932	10.07.02 C(1)(i) Pharm Svcs; Sched II Drug Record .15 Pharmaceutical Services. C. Duties of Pharmaceutical Services Committee. Unless the Department decides that semiannual meetings are appropriate, the committee shall meet at least quarterly to: (1) Establish policies and procedures which shall include, at least, statements which assure that: (i) Facilities which administer Schedule II Drugs shall maintain a drug record in which is recorded: (i) The name of the patient, the date, time, kind, dosage, and method of administration of all Schedule II Drugs; (ii) The name of the physician who prescribed the medication; (iii) The name of the nurse or medicine aide who administered the medication. This Regulation is not met as evidenced by: Refer to CMS 2587 F755	S 932			
S1050	10.07.02.18 Social Work Svcs .18 Social Work Services. A. Services Provided. The facility shall provide or make arrangements for services to identify and meet the patient's medically related social and	S1050	SEE F755	5-11-18 on going	

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S1050	<p>Continued From page 8</p> <p>emotional needs.</p> <p>B. Designated Staff Responsibility. A member of the facility's staff shall be assigned responsibility for social services. If the designee is not a certified social worker, the facility shall effect an agreement with a qualified social work consultant. The agreement shall provide for sufficient hours of consultation to assure that the staff's services meet the medically related social and emotional needs of the patients.</p> <p>C. Social History. The written social history shall be initiated within 7 days after admission. The history shall be as complete as possible and shall include:</p> <p>(1) Social data about personal and family background to provide understanding of the patient and how he functions; and</p> <p>(2) Information regarding current personal and family circumstances and attitudes as they relate to patient's illness and care.</p>	S1050		
S1090	<p>D. Records. Records shall include:</p> <p>(1) Social history; and</p> <p>(2) Recommendations made by the social work consultant, if applicable.</p> <p>E. Space. Facilities shall provide:</p> <p>(1) Space for social work personnel, accessible to patients, medical, and other staff;</p> <p>(2) Privacy for interviews.</p> <p>This Regulation is not met as evidenced by: Refer to CMS 2567 F660, F 685, 745</p> <p>10.07.02.20 Clinical Records</p> <p>20 Clinical Records.</p>	S1090	SEE F660, F685, F745	5/11/18 on-going

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S1090	<p>Continued From page 9</p> <p>A. Records for all Patients. Records for all patients shall be maintained in accordance with accepted professional standards and practices.</p> <p>B. Contents of Record. Contents of record shall be:</p> <p>(1) Identification and summary sheet or sheets including patient's name, social security number, armed forces status, citizenship, marital status, age, sex, home address, and religion;</p> <p>(2) Names, addresses, and telephone numbers of referral agencies (including hospital from which admitted), personal physician, dentist, parents' names or next of kin, or authorized representative;</p> <p>(3) Documented evidence of assessment of the needs of the patient, of establishment of an appropriate plan of initial and ongoing treatment, and of the care and services provided;</p> <p>(4) Authentication of hospital diagnoses (discharge summary, report from patient's attending physician, or transfer form);</p> <p>(5) Consent forms when required (such as consent for administering investigational drugs, for burial arrangements made in advance, for release of medical record information, for handling of finances);</p> <p>(6) Medical and social history of patient;</p> <p>(7) Report of physical examination;</p> <p>(8) Diagnostic and therapeutic orders;</p> <p>(9) Consultation reports;</p> <p>(10) Observations and progress notes;</p> <p>(11) Reports of medication administration, treatments, and clinical findings;</p> <p>(12) Discharge summary including final diagnosis and prognosis;</p> <p>(13) Discipline assessment; and</p> <p>(14) Interdisciplinary care plan.</p> <p>C. Staffing. An employee of the facility shall be designated as the person responsible for the</p>	S1090		

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S1090	Continued From page 10 overall supervision of the medical record service. There shall be sufficient supportive staff to accomplish all medical record functions. D. Consultation. If the medical record supervisor is not a qualified medical record practitioner, the Department may require that the supervisor receive consultation from a person so qualified. E. Completion of Records and Centralization of Reports. Current medical records and those of discharged patients shall be completed promptly. All clinical information pertaining to a patient's stay shall be centralized in the patient's medical record. F. Retention and Preservation of Records. Medical records shall be retained for a period of not less than 5 years from the date of discharge or, in the case of a minor, 3 years after the patient becomes of age or 5 years, whichever is longer.	S1090			
	G. Current Records—Location and Facilities. The facility shall maintain adequate space and equipment, conveniently located, to provide for efficient processing of medical records (reviewing, indexing, filing, and prompt retrieval). H. Closed or Inactive Records. Closed or inactive records shall be filed and stored in a safe place (free from fire hazards) which provides for confidentiality and, when necessary, retrieval. This Regulation is not met as evidenced by: Refer to CMS 2567 F661, F 842		SEE F661, F842		
S1119	10.07.02.21 G Inf Control Program; Prevent Spread of Infec	S1119		5-11-18 on-going	

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S1119	Continued From page.11 21 Infection Control Program. G. Preventing Spread of Infection. (1) The facility shall assess any residents with signs and symptoms of an infectious illness for the possibility of transmission to another resident or employee. (2) The facility shall take appropriate infection control steps to prevent the transmission of a communicable disease to residents, employees, and visitors as outlined in the following guidelines: (a) Guideline for Isolation Precautions in Hospitals; and (b) Guideline for Infection Control in Health Care Personnel. (3) The facility shall prohibit employees with a communicable disease or with infected skin lesions from direct contact with residents or their food if direct contact could transmit the disease. (4) The facility shall require employees to perform hand hygiene after each direct resident contact for which hand hygiene is indicated by accepted professional practice. (5) The facility shall handle, store, process, and transport linens so as to prevent the spread of infection. This Regulation is not met as evidenced by: Refer to CMS 2567 F 880	S1119		
S1121	10.07.02.21-1 B Employee Health Program; Tuberculosis Control .21-1 Employee Health Program.	S1121	SEE F880	

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S1121	Continued From page 12 B. Tuberculosis 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 following guidelines: (a) Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health-Care Facilities; and (b) Guideline for Infection Control in Health Care Personnel. (2) The facility shall ensure that all employees who may provide services that require direct access to residents may not provide such services without documented evidence that the employee is free from tuberculosis in a communicable form. (3) The facility shall monitor the purified protein derivative (PPD) status of employees at any time that symptoms suggestive of tuberculosis develop, and periodically, consistent with the tuberculosis control plan. All employees shall be assessed for risk of tuberculosis following guidelines referenced in §B of this regulation. (4) The facility 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; (b) Results of chest x-rays required in this regulation; and (c) Documentation of any tuberculin skin tests, chest x-ray, chemotherapy, and chemoprophylaxis, which are the basis for the certification that the individual is free from tuberculosis in a communicable form.	S1121	S1121 No residents were adversely affected by this citation. All employees have the potential to be affected by this citation. An audit of employee health files for employee #1, #3, #4, and #5 will be completed by 5-15-18 to ensure the proper evidence of immunization screenings for MMR, varicella, and Hepatitis B. Any outstanding screenings will be completed and HR Coordinator will file accordingly. The results will be reported to QAPI monthly. Administrator will monitor for compliance.	5-24-18 On-going

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S1121	Continued From page 13 (5) The facility shall screen all new employees for immunity to common childhood infections such as mumps, rubella, measles, and chicken pox (varicella), through the use of pre-employment questionnaires and, if appropriate, serologic testing for presence of antibodies of these diseases, to prevent adult exposure of new employees to residents with communicable forms of such disease organisms. (6) The facility shall request that all new employees receive immunization for Hepatitis B. The employee may refuse to be immunized if medically contraindicated, against the employee's religious beliefs, or after being fully informed of the health risks of not being immunized. If the employee refuses to be immunized, the facility shall document the refusal and the reason for the refusal. (7) The facility shall request that each employee receive immunization from influenza virus in accordance with Health-General Article, §18-404, Annotated Code of Maryland. The facility shall make information available to all employees concerning other conditions in which pneumococcal vaccine may be of benefit for certain other underlying medical conditions. The facility shall document refusals and shall conduct surveillance of nonimmune employees during the recognized influenza season. (8) The facility shall inquire about a history of varicella for each new employee. If the employee's history is unclear, then the facility shall request a serology for varicella. If the serology for varicella is nonreactive, the facility shall request that the employee receive immunization for varicella. If the employee refuses to be immunized, the facility shall document the refusal and the reason for the refusal.	S1121		

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S1121	Continued From page 14 This Regulation is not met as evidenced by: Based on surveyor review of personnel and staff interviews, it was determined that the facility staff failed to provide evidence of immunization screening for MMR, Varicella and/or Hepatitis B for 4 of 8 employee records selected for review. (#1, #3, #4, #5) The findings include: On 04-16-18, surveyor review of the employee files for staff #1 and staff #4 revealed no evidence of the facility obtaining immunization screening for MMR, varicella and Hepatitis B. Further review of the selected employee files for staff #3 and staff #5 revealed no evidence of the facility obtaining immunization screening for MMR and varicella. On 4-16-18, interview with the administrator revealed no additional information.	S1121		
S1200	10.07.02.24 A (8) Emergency and Disaster Plan A. Emergency and Disaster Plan (8) Upon request, a licensee shall provide a copy of the facility's emergency and disaster plan to the local emergency management organization for the purposes of coordinating local emergency planning. The licensee shall provide the emergency and disaster plan in a format that is mutually agreeable to the local emergency management organization. This Regulation is not met as evidenced by: Refer to CMS 2567	S1200		

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S1200	Continued From page 15 F922	S1200	SEE F922	
S1666	10.07.02.34 D Hskpg; Laundry, existing facilities .34 Housekeeping Services, Pest Control, and Laundry. D. Laundries—Existing Facilities. In existing facilities where a physical separation is not possible, exceptions as to approved laundry facilities may be made at the discretion of the Department. There shall be provision for the laundering of patients' clothing. Hot water temperatures in laundries shall conform to applicable standards of the International Fabric Care Institute for laundry water supply.	S1666	S1666 No residents were adversely affected by this condition of the facility. This set up has been approved via the waiver since the existence of the facility for 42 years plus. The facility administrator completed the waiver request and submitted it to the surveyor coordinator on 4-9-18.	
	This Regulation is not met as evidenced by: Based on surveyor observation and interview with the facility administrator, the facility failed to have a physical separation between the "clean" and "soiled" areas in the laundry department. The findings include: On 04-09-18 at 9AM, surveyor initial tour of the facility's laundry department revealed no physical separation between the "clean" and "soiled" areas. On 04-09-18 at 10:30AM, during an interview, the facility administrator provided the completed waiver request form for submission to the state agency.		The facility administrator and Director of Maintenance will oversee the compliance of the Approved Waiver of Provision.	4-9-18 On-going
S1666	10.07.02.36 D Resident Status Assessment; assessments .36 Resident Status Assessment.	S1666		

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S1686	Continued From page 16 D. The facility shall complete all assessments in accordance with the provisions of 42 CFR §§483.20 and 413.343. This Regulation is not met as evidenced by: Refer to CMS 2567 F641	S1686	SEE F641	5-15-18 on-going	
S1700	10.07.02.37 A Care Planning;interdisciplinary team,7 days .37 Care Planning. A. An interdisciplinary team shall complete a resident specific care plan for each resident within 7 calendar days following completion of all assessments.	S1700			
S1725	This Regulation is not met as evidenced by: Refer to CMS 2567 F 656 10.07.02.37 D Care Planning;conference due .37 Care Planning. D. The facility shall hold the care planning conference not later than 7 calendar days after completion of the assessment, but may hold the conference earlier if agreed to by the resident, a family member, or a resident's representative. This Regulation is not met as evidenced by:	S1725	SEE F656	5-11-18 on-going	

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S1725	Continued From page 17 Refer to CMS 2567 F 657	S1725	SEE F657	5-15-18 on-going
S1745	10.07.02.37 G Care Planning; Availability .37 Care Planning. G. Availability of Resident Care Plan. Resident care plans shall be readily available for use by all health care personnel. This Regulation is not met as evidenced by: Refer to CMS 2567 F656	S1745	SEE F656 .	5/15/18 on-going
S1850	10.07.02.46 C Q A Plan; Ongoing Monitoring .46 Quality Assurance Plan. C. Ongoing Monitoring. The quality assurance plan shall include: (1) A description of the measurable criteria for ongoing monitoring of all aspects of resident care including: (a) Medication administration; (b) Prevention of decubitus ulcers, dehydration, and malnutrition; (c) Nutritional status and weight loss or weight gain; (d) Accidents and injuries; (e) Unexpected death; and (f) Changes in physical or mental status; (2) The methodology for collection of data; (3) The methodology for evaluation and analysis of data to determine trends and patterns; (4) A description of the thresholds and performance parameters that represent	S1850		

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215060	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/16/2018
NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 9101 SECOND AVENUE SILVER SPRING, MD 20910		
(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
S1850	Continued From page 18 acceptable care for the measured criteria; (5) Time frames for referral to the quality assurance committee; (6) A description of the plan for follow-up to determine effectiveness of the recommendations; and (7) A description of how the quality assurance activities will be documented. This Regulation is not met as evidenced by: Refer to CMS 2567 F867	S1850	SEE F867	
S1885	10.07.02.48 Posting of Staffing .48 Posting of Staffing.	S1885		4-11-18 on-going
	A. A nursing home shall post on each floor or unit of the nursing home, for each shift, a notice that explains the ratio of licensed and unlicensed staff to residents. B. The posting on each floor shall include: (1) Names of the staff members on duty and the room numbers of the residents that each is assigned; (2) Name of the charge nurse or person in charge of the unit; and (3) Name of the medicine aide or person responsible for medication administration. C. The posting shall be on a form provided or approved by the Department. This Regulation is not met as evidenced by: Refer to CMS 2567			

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215080	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/18/2018
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NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 9101 SECOND AVENUE SILVER SPRING, MD 20910
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S1885	Continued From page 19 F 732	S1885	SEE F732	5/15/18 on going
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 2587 F 558	S5093	SEE F558	4/14/18 on-going
S6095	10.07.09.09 F Res Bill Rights; Implem, inform legal repres .09 Implementation of Residents' Bill of Rights. A nursing facility shall: F. Inform the resident and the appropriate legal representative, or interested family member, and promptly consult with the resident's physician if any of the following incidents occur: (1) An accident involving the resident which results in injury; (2) A significant change in the resident's physical, mental, or psychosocial status; (3) A need to alter treatment significantly; or (4) A decision to transfer or discharge the resident from the nursing facility;	S6095		

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S6095	Continued From page 20 This Regulation is not met as evidenced by: Refer to CMS 2567 F580	S6095	SEE F580	5/15/18 on-going
S6105	10.07.09.09 H Res Bill Rights; Notify resident of change .09 Implementation of Residents' Bill of Rights. A nursing facility shall: H. Notify the resident and, when applicable, the appropriate representative, or interested family member, when there is a change in: (1) Room or roommate assignment; (2) The Residents' Bill of Rights; or (3) Federal or State law and regulations relating to residents' rights;	S6105	SEE F559	5/15/18 on-going

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215060	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/16/2018
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S6217	Continued From page 21 duration of the bed-hold policy described in §C of this regulation. This Regulation is not met as evidenced by: Refer to CMS 2567 F625	S6217	SEE F625	5/11/18 on going
S6352	10.07.09.15 D (2) Investigations; appropriate action to prevent .15 Abuse of Residents. D. Investigations. A nursing facility shall: (2) Take appropriate action to prevent further incidents of abuse while the investigation is in progress, and after that.	S6352		
S6647	This Regulation is not met as evidenced by: Refer to CMS 2567 F 610 10.15.03.06 A Food Protection During Storage, Service and T .06 Food Protection During Storage, Service, and Transport. The person-in-charge shall ensure that: A. At all times: (1) Food is: (a) Not adulterated; and (b) Protected from contamination during storage,	S6647	SEE F610	5/15/18 on going

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NAME OF PROVIDER OR SUPPLIER REGENCY CARE OF SILVER SPRING, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 9101 SECOND AVENUE SILVER SPRING, MD 20910		
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S6847	Continued From page 22 preparation, display, service, and transportation; (2) The internal temperature of a food is maintained according to the requirements of this chapter to preclude the growth of pathogenic bacteria and other microorganisms that could cause spoilage; (3) Except during necessary periods of preparation and service, a potentially hazardous food is refrigerated or held hot as set forth in §B(7) of this regulation; This Regulation is not met as evidenced by: Refer to CMS 2567 F800	S6847	SEE F800	5-1-18 on - going	

(Tags: Coronavirus attorney, nursing home lawyer, nursing home attorney, medication error, pressure sores, bed sores, sepsis, wrongful death, wounds, falls, attorney handling medication errors, nursing home abuse attorney, assisted living attorney, assisted living accidents, dehydration, malnutrition claim, Maryland elder abuse attorney, nursing home injury, skilled rehab injury, skilled rehab attorney, drugs, pharmaceutical drugs, antipsychotic drugs, negligence attorney, nursing home abuse attorney, adult protective service lawyer, overdose, legal liability for overdose, nursing home abuse lawyer, nursing home chains, statistics on nursing home abuse, wrongful death case or claim, Maryland Nursing abuse attorney, Maryland nursing home attorney, pressure sores, Regency Care of Silver Spring, Silver Spring malpractice attorney, Montgomery County malpractice attorney)