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

Wilson Health Care Center at Asbury Methodist Village
301 Russell Avenue
Gaithersburg, MD 20877

Characteristics:

- A Non-Profit Corporation with 285 Beds
- Legal Business Name – Asbury Atlantic, LLC
- Ownership – Asbury Communities Inc
- www.asbury.org/asbury-methodist-village/health-services
- Managing Employees – Deborah Hedges and Jason Hershey

Researching Nursing Homes on the internet

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 Wilson Health Center in Gaithersburg, MD. Periodically they do inspections as complaint surveys which should be public record.

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

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

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

2) Fax : 410-402-8179

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

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

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

AsBURY
Methodist Village
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201 Russell Ave., Gaithersburg, MD 20877 | 301.216.4001 | AsburyMethodistVillage.org

July 15, 2019

Dear Mrs. Reed and Mrs. Melodini,

Please see the attached plan of correction for The Wilson Health Care Center, provider number 121-5099, for the survey conducted on June 25, 2019 during which it was determined that the facility was not in substantial compliance with Federal requirements for nursing homes participating in the Medicare and/or Medicaid programs. Should you have any questions, please contact me at 301-216-4085.

Yours truly,

Rachel S. Karish

Rachel S. Karish, LNHA
Administrator, The Wilson Health Care Center

MARYLAND
Department of Health

*Larry Hogan, Governor · Boyd **K.** Ruther.ford, Lt. Governor · Robert R. Neall, Secretary*

Office of Health Care Quality
7120 Samuel Morse Dr.
Columbia, MD 21046

July 2, 2019

Ms. Rachel Karish, Administrator
Wilson Health Care Center
301 Russell Avenue
Gaithersburg, MD 20877

PROVIDER# 215099
RE: NOTICE OF CURRENT DEFICIENCIES AND POSSIBLE IMPOSITION OF REMEDIES

Dear Ms. Karish:

On June 25, 2019, a complaint survey was conducted at your facility by the Office of Health Care Quality to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey was also conducted for the purpose of State licensure. This survey found that your facility was not **in** substantial compliance with the pm1icipation requirements.

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations (C.F.R.), COMAR Title 10, and the State Government Article.

I. PLAN OF CARRE 'TI<JN (PoC)

A PC for the deficiencies must be submitted within 10 days after the facility receives its Form CMS 2567. Failure to submit an acceptable POC within the above time frames may result in the imposition of a civil money penalty twenty (20) days after the due date for submission of the PoC.

Your PoC must contain the following:

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

How you will identify other residents having the potential to be affected by the same

deficient practice and what corrective action will be taken;

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

- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what qua1ity assurance program will be put into place and;

- Specific date when the corrective action will be completed.

- References to a resident(s) by Resident# only. This applies to the PoC as well as any attachments to the PoC. It is un-acceptable to include a resident(s) name in these documents since the documents are released to the public.

II. IMPOSITION F REMEDIES

The following remedies will be recommended for imposition by the Center for Medicare and Medicaid Services (CMS) Regional Office if your facility has failed to achieve substantial compliance by August 9, 2019. Informal dispute resolution for the cited deficiencies wi11 not delay the imposition of the enforcement actions recommended on this date. A change in the seriousness of the noncompliance may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

If you do not achieve substantial compliance within 3 months after the last day of the survey (September 25, 2019) identifying non-compliance, we must deny payments for new admissions. (§488.417(a)) Also, if the denial of payment for new admissions sanction is imposed, your facility is prohibited from operating a nurse aide training program for two years from the last day of the survey. (§483.151)

If your facility has failed to achieve substantial compliance by December 25, 2019, your Medicare provider agreement will be terminated.

III. ALLEGATION OF COMPLIANCE

If you believe that the deficiencies identified in the CMS form 2567 have been corrected, you may contact me at the Office of Health Care Quality, 7120 Samuel Morse Drive, Columbia, MD 21046-3422 with your written credible allegation of compliance **(i.e. attached lists of attendance at provided training and/or revised statements of policies/procedures and/or staffing patterns with revisions or additions).**

If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance **and credible evidence** of your allegation of compliance until substantiated by a revisit or other means. In such a case, the previously proposed remedy(ies) will not be imposed at that time.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we may impose remedies previously mentioned in this letter beginning June 25, 2019 and will continue until substantial compliance is achieved. Additionally, we may impose a revised remedy(ies), based on changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

IV. NFORMAL DISPUTE RESOLUTION

In accordance with §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request, along with the specific deficiency(ies) being disputed, and an explanation of why you are disputing those deficiencies, to Ms. Margie Heald, Deputy Director, Office of Health Care Quality, 7120 Samuel Morse Drive, Columbia, MD 21046-3422, fax 410-402-8234. This request must be sent during the same 10 days you have for submitting a PoC for the cited deficiencies. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

V. L CE SURE ACTION

As you are aware, the cited Federal deficiencies have a counter part in State regulations. These deficiencies are cited on the enclosed State Form. Please provide a plan of correction for these deficiencies within 10 days of receipt of this letter. 1n the event a revisit determines that substantial compliance has not been achieved, appropriate administrative action may be taken against your State license.

If you have any questions concerning the instructions contained in this letter, please contact me at 410-402-8201 or by email at patricia.melodini@maryland.gov.

S -·

Patti Melodini
Health Facilities Survey Coordinator
Long Term Care

Enclosures: CMS 2567
State Form

cc: Stevanne Ellis
Jane Sacco
File II

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215099	A. BUILDING ______ B WING ______	C 06/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HEALTH CARE CENTER	**301 RUSSELL AVENUE GAITHERSBURG, MD 20877**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	**INITIAL COMMENTS** On 06-25-19, a survey was conducted at this facility by the Office of Health Care Quality to investigate complaint #MD00141272 and facility reported incidents #MD001141060 and #MD00141686, and #MD00142073. Survey activities included review of residents' medical records, interview of facility staff, and observation of resident and staff practices. The following deficiencies are the result of this visit. This finding was identified during the investigation of facility reported indents #MD00141686.	F 000	**Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and/or State Law.** **F656 Dcvelo12/Im12lcmcnt Coml!rehensivc Care Plan** **With respect to the specific resident/situation cited:**	
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 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	F 656	Resident #3's care plan was updated on 6/13/l9 to include the resident's health condition of "history of injury related to brittle bones secondary to osteoporosis." **With respect to how the facility will identify residents/situations with the potential for the identified concerns:** The Director of Nursing (DON) audited residents with a diagnosis of osteoporosis on 7/11/2019 to evaluate the presence of a care plan to address osteoporosis within the clinical record. Variances noted were corrected.	1/isAr

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE NHA — (X6) DATE 7/

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215099	A BUILDING _____ B WING _____	C 06/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HEALTH CARE CENTER	301 RUSSELL AVENUE GAITHERSBURG, MD 20877

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER 'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
F 656	Continued From page 1 provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced **by:** Based on surveyor record review, and interview with facility staff, it was determined that the facility failed to develop and Implement a comprehensive person-centered care plan to meet a resident's medical and nursing needs . This was evident for 1 of 3 residents (#3) identified during the survey. The findings include: On 06-25-19 at 09:15 **AM,** Surveyor review of resident #3's medical records revealed that resident #3 was admitted to the facility from the hospital after a fall with a fracture. Further review revealed multiple diagnoses that included, but were not limited to, osteoporosis (osteoporosis is a medical condition in which the bones become brittle and fragile from loss of tissue). However, review of the resident's care plan that was initiated on 01-13-19, did not reveal any plan	F 656	**With respect to what systematic measures have been put into place to address stated concern:** The DON in-serviced the Minimum Data Set (MDS) Coordinators on 7/10/19 and 7/12/19 on initiating care plans for osteoporosis (and triggered Care Area Assessments) for residents who are noted to have a diagnosis of osteoporosis. **With respect to how the plan of correction will be monitored:** The DON will audit residents with a diagnosis of osteoporosis to evaluate the presence of a care plan to address osteoporosis weekly for four weeks, and then monthly for three months. During and at the conclusion of the audit and reporting period, the QAPI committee will re-evaluate and initiate any necessary action or extend the review period. The DON is responsible for confirming implementation and ongoing compliance with the components of the Plan of Correction and addressing and resolving variances that may occur.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215099	A BUILDING _ _ _ _ _ _ _ _ _ _ B WING _ _ _ _ _ _ _ _ _ _	C **06/25/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HEALTH CARE CENTER	**301 RUSSELL AVENUE GAITHERSBURG, MD 20877**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
F 656	Continued From page 2 as to how the facility was going to manage resident #3 health condition of brittle and fragile bones. It was not until after Resident #3 sustained a fracture on 06/12/2019 that the facility initiated a care plan that addressed resident's health condition of "history of injury related to brittle bones secondary to osteoporosis". On 06/25/2019 at 3:10 PM, surveyor interview with the Director of Nursing revealed no new information.	F 656		

Office of Health Care Qualit1i

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215099	A BUILDING: _ _ _ _ _ _ _ _ B. WING _ _ _ _ _ _ _ _	C 06/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE. ZIP CODE
WILSON HEALTH CARE CENTER	301 RUSSELL AVENUE GAITHERSBURG, MD 20877

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETE DATE
S 000	Initial comments On 06-25-19, a survey was conducted at this facility by the Office of Health Care Quality to investigate complaint #MD00141272 and facility reported incidents #MD001141060, #MD00141686, and #MD00142073. Survey activities included review of residents' medical records, interview of facility staff, and observation of resident and staff practices. The following deficiencies are the result of this visit. This finding was identified during the investigation of facility reported indents #MD 00141686.	S 000		
S1730	10.07.02 .37 E Care Planning; Organization of plan .37 Care Planning . 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:	S1730	Ple ase see POC for F656.	7/25/19

ABORATORY DIRECTOR R'S ORI'PROVIDER/S PPLI ER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

7/15/19

TATE FORM 6899 0CP211 continuation sheet 1 of 2

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215099	A BUILDING : _ _ _ _ _ _ _ _ B WING _ _ _ _ _ _ _ _ _ _	C 06/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HEALTH CARE CENTER	301 RUSSELL AVENUE GAITHERSBURG, MD 20877

(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
S1730	S1730 Continued From page 1 Refer to CMS 2567 F656	S1730		

AsBURY
Methodist Village
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201 Russell Ave., Gaithersburg, MD 20877 | 301.216.4001 | AsburyMethodistVillage.org

June 7, 2019

Dear Mrs. Reed and Mrs. Melodini,

Please see the attached plan of correction for The Wilson Health Center, provider number 21-5099, for the survey conducted on May 23 and 24, 2019 during which it was determined that the facility was not in substantial compliance with Federal requirements for nursing homes participating in the Medicare and/or Medicaid programs. Should you have any questions, please contact me at 301-216-4085.

Yours truly,

Rachel S. Karish, LNHA

Rachel S. Karish, LNHA
Administrator, The Wilson Health Care Center

MARYLAND
Department of Health

Larry Hogan, Governor · Boyd K. Rutherford, U. Governor • Rohert R. Neall, SecretalJ'

Office of Health Care Quality
7120 Samuel Morse Dr.
Columbia, MD 21046

June4,2019

Ms. Rachel Karish, Administrator
Wilson Health Care Center
301 Russell Avenue
Gaithersburg, MD 20877

PROVIDER# 215099
RE:NOTICE OF CURRENT DEFICIENCIES AND POSSIBLE IMPOSITION OF REMEDIES

Dear . Kaiish:

On May 23 and 24, 2019, a complaint survey was conducted at your facility by the Office of Health Care Quality to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey was also conducted for the purpose of State licensure. This survey found that your facility was not in substantial compliance with the participation requirements.

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations (C.F.R.), COMAR Title 10, and the State Government Article.

I. PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within 10 days after the facility receives its Form CMS 2567. Failure to submit an acceptable PoC within the above time frames may result in the imposition of a civil money penalty twenty (20) days after the due date for submission of the PoC.

Your PoC must contain the following:

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

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

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

- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place and;

- Specific date when the corrective action will be completed.

References to a resident(s) by Resident# only. This applies to the PoC as well as any attachments to the PoC. It is un-acceptable to include a resident(s) name in these documents since the documents are released to the public.

II. LMr>osm N OF REMEDIES

The following remedies will be recommended for imposition by the Center for Medicare and Medicaid Services (CMS) Regional Office if your facility has failed to achieve substantial compliance by July 8, 2019. Informal dispute resolution for the cited deficiencies will not delay the imposition of the enforcement actions recommended on this date. A change in the seriousness of the noncompliance may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

If you do not achieve substantial compliance within 3 months after the last day of the survey (August 24, 2019) identifying non-compliance, we must deny payments for new admissions. (§488.417(a)) Also, if the denial of payment for new admissions sanction is imposed, your facility is prohibited from operating a nurse aide training program for two years from the last day of the survey. (§483.151)

If your facility has failed to achieve substantial compliance by November 24, 2019, your Medicare provider agreement will be terminated.

III. AL.LR AT IO N *OF* COM PU.N E

If you believe that the deficiencies identified in the CMS form 2567 have been corrected, you may contact me at the Office of Health Care Quality, 7120 Samuel Morse Drive, Colwnbia, MD 21046-3422 with your written credible allegation of compliance **(i.e. attached lists of attendance at provided training and/or revised statements of policies/procedures and/or staffing patterns with revisions or additions).**

If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance **and credible evidence** of your allegation of compliance until substantiated by a revisit or other means. In such a case, the previously proposed remedy(ies) will not be imposed at that time.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we may impose remedies previously mentioned in this letter beginning May 24, 2019 and will continue until substantial compliance is achieved. Additionally, we may impose a revised remedy(ies), based on changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

IV. INFORMAL DTSPUTE RESOLUTION

In accordance with §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request, along with the specific deficiency(ies) being disputed, and an explanation of why you are disputing those deficiencies, to Ms. Margie Heald, Deputy Director, Office of Health Care Quality, 7120 Samuel Morse Drive, Columbia, MD 21046-3422, fax 410-402-8234. This request must be sent during the same 10 days you have for submitting a PoC for the cited deficiencies. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

V. LICENSURE A TI.ON

As you are aware, the cited Federal deficiencies have a counter part in State regulations. These deficiencies are cited on the enclosed State Form. Please provide a plan of correction for these deficiencies within 10 days of receipt of this letter. In the event a revisit determines that substantial compliance has not been achieved, appropriate administrative action may be taken against your State license.

If you have any questions concerning the instructions contained in this letter, please contact me at 410-402-8201 or email at patricia.melodini@maryland.gov.

Sincerely,

Patti Melodini
Health Facilities Survey Coordinator
Long Term Care

Enclosures: CMS 2567
State Form

cc: Stevanne Ellis
Jane Sacco
File II

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215099	A BUILDING _____ 8 WING _____	C 05/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY , STATE, ZIP CODE
WILSON HEALTH CARE CENTER	301 RUSSELL AVENUE GAITHERSBURG, MD 20877

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
F 000	INITIAL COMMENTS On May 23 and May 24, 2019 , a survey was conducted at this facility by the Office of Health Care Quality to Investigate facility reported incidents MD00136555, MD00136720 , MD137070 , MD00137354 , MD00137615. MO00138324, MD00139298 , MD00139379 , MD00139 449 , MD00140121 , and MD00140247. Sl1rvey activities included review of residents' records, interviews with staff, residents and resident representatives, and observation of staff practices . This survey identified noncompliance with Federal regulations that were reviewed in relationship to the facility reported incident MD00138324.	F 000	**Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and/or State Law.**	
F 758	Free from Unnec Psychotropic Meds/PRN Use SS=D CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, .the facility must ensure that- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the rnedication is necessary to treat a	F 758	**F758 Free from Unnecessary Medications** **With respect to the specific residenf/situatioo cited:** Res iden t' #7's rde r for th e PRN p ·ych t tropic m dicalio n was disconti nued b th physician n 5/24/19. **with_respect to ho the facility will identify residents/situations with the potential for the identified concerns:** The Assistant Directors of Nursing (ADON s) audited residents with orders for PRN psychotropic medications to evaluate the presence of a stop date , and corrected noted variances on 5/24/ 19. **With respect to what systematic measures have been put into place to address stated concern:** The ADONs will in-service licensed nurses on obtaining a stop date for PRN psychotropic medication. .	6/20/19

Rachel D. Karish — TITLE — DATE 7/19

y deficiency statement ending with an asterisk (*) denotes a deficiency which the institu — from cor
er safeguards provide sufficient protection to the patients. (See instructions) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility If deficiencies are cited, an approved plan of correction is requisite to continued program participation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CL/A IDENTIFICATION NUMBER:	{X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215099	A BUILDING _____ B WING _____	C 05/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HEALTH CARE CENTER	301 RUSSELL AVENUE GAITHERSBURG, MD 20877

(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 758	F 758 Continued From page 1 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 necessary to treat a diagnosed specific condition th·at 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 appropriate for the PRN order to be extended beyond 14 days, he or she should document their rational e in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychoti c ‹tru‹ s are limited to 14 days a17d cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication This REQUIREMENT is nol met as evidenced by: Based on surveyor review of clinical records and interview with facility staff, it was determined that the facility failed to limit the initial duration of an as needed psychotropic drug to 14 days or document how long the as needed psychotropic drug needed to be extended beyond the initial 14 days. This finding was evident for 1 of 11 (#7) residents selected for *review* during the complaint	F 758	**With respect to how the plan of correction will be monitored:** The ADONs will audit residents with orders for PRN psychotropic medications to evaluate the presence of a stop date weekly for four weeks, and then monthly for three months. During and at the conclusion of the audit and reporting period, the QAPI committee will re-evaluate and initiate any necessary action or extend the review period. The DON is responsible for confirming implementation and ongoing compliance with the components of the Plan of Correction and addressing and resolving variances that may occur.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215099	A BUILDING _____ B WING _____	C 05/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HEALTH CARE CENTER	301 RUSSELL AVENUE GAITHERSBURG, MD 20877

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
F 758	Continued From page 2 survey. The findings include· On 05-24-19, surveyor review of resident #l's clinical record revealed he/she was prescribed an as needed psychotropic medication on 03-25-19. On 04-10-19, resident #7 was examined by the psychiatrist and he/she recommended to continue the medication but did not indicate a stop date. Review of resident #l's April and May 2019 medication administration record revealed that resident #7 received 19 doses of the as needed psychotropic medication in April 2019 and 7 doses in May 2019. There was no evidence that the initial duration of the medication was limited to 14 days. Additionally, there was no evidence that the facility indicated how long the duration of the as needed psychotropic medication should be extended. On 05-24-19 at 12:40 PM, interview with the Director of Nursing revealed the facility should have indicated a duration for the as needed psychotropic medication.	F 758		

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER /CU A IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215099	A. BUILDING:_____ 8 WING _____	C 05/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET I.\DDRESS , CITY, STATE, ZIP CODE
WILSON HEALTH CARE CENTER	301 RUSSELL AVENUE GAITHERSBURG, MD 20877

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial comments On May 23 and May 24, 2019, a survey was conducted at this facility by th e Office of HealU1 Care Quality to investigate facility reported incidents MD0013'6555 , MDOO1 36720, MD137070,MD00137354, MD00137615, MD00138324, MD00139298, MD00139379, MD00139449 , MD00 140121, and MD00140247. Survey activities included review of residents' records, interviews with staff, residents and resident representatives, and observation of staff practices. This survey identified noncompliance with State (COMAR) regulations that were reviewed in relationship to the facility reported incident MD00138324.	S 000		
S6285	10 .07 .09.14 C **(1)** Phys/Chem Restr; Psycho Drugs,indication.. ,14 Physical and Chemical Restraints. C. Use of Psyct1opharmacologic Drugs. When a physician prescribes psychopharmacologic drugs 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 F758	S6285	Please see POC for F758	1/20/19

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Rachel D. Parish
NTATIVE'S SIGNATURE

TITLE
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DATE
7/19

6899 7NV011

BURY, -S., 201 Russ1:II Av1:., Gaithersburg, MD 20877 301.216.4001 AsburyMcthodlstVillagc.org

Methodist Village),
Anticipate More

April 26, 2019

Dear Mr. Borisevic, Mrs. Reed, and Mrs. Melodini,

Please see the attached plan of correction for The Wilson Health Care Center, provider number 121-5099, for the survey conducted on April 10, 2019 during which it was determined that the facility was not in substantial compliance with Federal requirements for nursing homes participating in the Medicare and/or Medicaid programs. Should you have any questions, please contact me at 301- 216-4085.

Yours truly,

Rachel S. Karish

Rachel S. Karish, LNHA
Administrator, The Wilson Health Care Center

MARYLAND
Department of Health

Larry Hogan, Gol'ernur • Boyd K. Ruthe,:ford, Lt. Governor · Roher/ R. Neall, SecretatJ'

Office of Health Care Quality
7160 Samuel Morse Dr.
Columbia, MD 21046

April 17, 2019

Ms. Rachel Karish, Administrator
Wilson Health Care Center
301 Russell Avenue
Gaithersburg, MD 20877

PROVIDER #: 215099
RE: NOTICE OF CURRENT DEFICIENCIES

Dear Ms. Karish:

On April **10,** 2019, a survey was conducted at your facility by the Office of Health Care Quality to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. The survey was also conducted for the purposes of State licensure. As documented in the attached CMS form 2567, this survey found that your facility was in substantial compliance but deficiencies were identified that posed no actual harm with potential for minimal harm.

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

I. PL/\N OF CORRECTION (PoC)

A PoC for the deficiencies identified in the attached CMS 2567 must be submitted within 10 days of your receipt of this notice. Failure to submit an acceptable PoC by this date may result in the imposition of remedies.

Your PoC must contain the following:

What conective action will be accomplished for those residents found to have been affected by the deficient practice;

How you will identify other residents having the potential to be affected by

the same deficient practice and what corrective action will be taken;

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

How the co1Tective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place, and;

Specific date when the corrective action will be completed.

References to a resident(s) by Resident# only. This applies to the PoC as well as any attachments to the PoC. It is unacceptable to include a resident(s) name in these documents since these the PoC is released to the public.

II. ALLEGATION OF COMPLIANCE

If you believe that the deficiency identified in the CMS 2567 form have been corrected, you may contact me at the Office of Health Care Quality, Spring Grove Center, 55 Wade Avenue, Catonsville, Maryland 21228 with your written credible allegation of compliance **(i.e. attached lists of attendance at provided training and/or revised statements of policies/procedures and/or staffing patterns with revisions or additions).**

If you choose, and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance **and credible evidence** of your allegation of compliance until substantiated by a revisit or by other means.

If upon a subsequent revisit or by other means, we verify that the facility has not corrected the deficiencies or if the seriousness of non compliance changes from the original survey findings, remedies may be imposed. If this occurs, you will be advised of any change.

Ill. INFORMAL DISPUTE RESOLUTION

In accordance with 488.331, you have one opportunity to question cited deficiencies through an info1mal dispute resolution process. To be given such an opportunity, you are required to send your written request, along with the specific deficiency being disputed, and an explanation of why you are disputing the deficiency, to Ms. Margie Heald, Deputy Director, Office of Health Care Quality, Spring Grove Center, 55 Wade Avenue, Catonsville, Maryland 21228. This request must be sent within l 0 days of your receipt of the CMS form 2567.

IV. LICENSURE ACTION

As you are aware, the cited Federal deficiencies have a counter part in State regulations. These deficiencies are cited on the enclosed in the State Form. Please provide us with your plan of correction for these deficiencies within 10 days of receipt of this letter. In the event a revisit determines that compliance has not been achieved, appropriate administrative action may be taken against your State license. If you have any questions concerning the instructions contained in this letter, please contact me at 410-402-8201 or by email at patricia.melodini@maryland.gov.

Sincerely,

Patti Melodini
Health Facilities Survey Coordinator
Long Term Care

Enclosures: CMS Form 2567
State Form

cc: File II

STATE ENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUM0 ER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215099	A BUILDING _____ B WING _____	C 04/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY. STATE ZIP CODE
WILSON HEALTH CARE CENTER	301 RUSSELL AVENUE GAITHERSBURG, **MD 20877**

(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)	(X51 COMPLETIO DATE
F 000	INITIAL COMMENTS On 4/10/19, a survey was conducted at this facility by the Office of Health Care Quality to investigate complaint #MO00138895. Activities included an audit of the residents' personal funds records maintained by this facility. The complaint was substantiated. This survey identified noncompl!ance with Federal requirements that were reviewed in relationship to the complaint. (SEE F569)	F 000	Responses to the cited deficiencies do **not constitute an admission or agreement by the facility of the truth** of facts alleged or conclusions set **forth in the Statement of Deficiencies. The Plan or Correction is prepared** solely as a matter of compliance with **Federal and/or State Law.**	
F 569	Notice and Conveyance of Personal Funds SS=B CFR(s) ; 483.1O(f)(1O){iv)(v) §483 .10(f)(10)(iv) Notice of certain balances The facility must notify each resident that receives Medicaid benefits- (A) When the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3}(B) of the Act; and (B} That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSr. §483.1O(f)(1O)(v) Conveyance upon discharge, eviction, or death. Upon the discharge, eviction, or death or a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with State law. This REQUIREMENT is not met as evidenced by·	F 569	FS69 Notice and Convcvance of **Personal Funds** With respect to the specific **resident/situation cited:** Resident)A's persona] funds were deposited back into the resident's personal fund account on 2/2/19. Resident 2A's personnel funds were re• deposited into the resident's personal fund account on 3/6/19. The cost of care overpayment for 12/18 was deposited back into the resident's personal fund account on 4/15/19. Resident 3A' s personal funds were placed in a burial account for resident 3A's spouse on 4/16/19. **With respect to how the facility will identify residents/situations with the potential for the identified concerns:** With oversight from the Central Billing Office staff, the Facility Billing Counselor will audit the current trial balance to evaluate deceased residents' funds for misappropriation of property and if applicable, inclusion on the unclaimed property report.	1/10/19

RY OIRECTOR'S OR PRO VIDER/SUPPLIER REPRESENTATIVE·s SIGNATURE

TITLE

(X6) DATE

N

26/19

Deficiency statement ending with an asterisk (*) der
safeguards provide sufficient

Any eficiency slalement ending wilh an asterisk (•) denotes a deficiency which the Instilulion may be excused from correcling providing it Is determined that other safeguards provide sufficient prolecUon to the patients_ (See instructi ons.) Except for nursing homes, the findings staled above are d1sclosable 90 days rouo wfng the date of survey Whether or not a plan or correction is provided, For nursing homes , lhe above find1ngs and plans or correcllon are di sclosable 14 days fa.lowing lhe date lhese documents are made available to the facility. If deficiences are c ted, an approved plan of correct1on is requisite to continued program participa tion.

STATEMENT OF DEFICIENCIES AND f'LAN OF CORHECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215099	A. BUILDING _____ e WING _____	C 04/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY. STATE, ZIP CODE
WILSON HEALTH CARE CENTER	301 RUSSELL AVENUE GAITHERSBURG, MD 20877

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INmRMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD 8E CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	jl<SJ CO .IP1sno DATE
F 569	Continued From page 1 Based on the review. on 4/10/19, of the personal funds records of deceased residents, including individual resident's account summaries, closed account summaries. and transaction reports, this facility failed to convey within 30 days, a resident's personal funds and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate, Findings Include: **1.** Resident 1A expired on- This facility received and deposited additional resource checks on 8/1 and 9/4/18, which totaled $6,067.64. The facility transferred a total of $5,907.64 from the resident's personal fund account to a facility account, as cost ofcare payments for 8/18 and 9/18. The resource agency was not appropriately notified until 11/29/18. The resulting reclamation was taken from lhe resident's available savings, reducing the interest earning potential of not only the resident's account, but also the Residents' Trust Fund. The misappropriated resident's personal funds were not deposited back into the resident's personal fund account until 2/21/19. 2. Resident 2A expired on On 12/3/18, this facility transferred a total of $4,695.82 from the resident's personal fund account to a facility account. **as a** cost of care payment for 12/18. A reclamation on 12/4/18, of one of the resident's resource checks, was taken from the resident's available savings. The reclamation reduced the interest earning potential of the resident's personal fund account and the Residents' Trust Fund. The facility did not re-deposit the misappropriate ted resident's personal funds back into the resident's personal fund account until 3/6/19. Additionally, as of	F 569	**With respect to what systematic measures have been put into place to address stated concern:** The Nursing Home Adminis1ra1or will in•service the Facility Billing Counselor on conveying within 30 days a resident's personal funds and a final accounting of those funds 10 lhe individual or probate jurisdiction administering lhe resident's estate, ensuring that expired resident resource checks are not inappropriately deposited into resident funds, ensuring the facility does not transfer resident funds lo a facility account inappropriately, and reporting unclaimed resident property timely. The Nursing Home Administrator will support this effort. **With respect to how the plan of correction will be monitored:** The Facility Billing Counselor will audit the current trial balance to evaluate deceased residents' funds for misappropriation of property and if applicable, inclusion on the unclaimed property report weekly for four weeks and monthly for three months. These audits will be reviewed as completed with the Centralized Billing Office Staff and the Nursing Home Adminis1rator with timely adjustments being made as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETED
	215099	A BUILDING _____ B. WING _____	C 04/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY, STATE. ZIP CODE
WILSON HEALTH CARE CENTER	!101 RUSSELL AVENUE GAITHERSBURG, MD 20877

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED I3Y 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) COMPLETIOI DATE
F 569	F 569 Continued From page 2 4/10/19, there was no evidence that the cost of care overpayment for 12/18 had been deposited back into the resident's personal fund account or refunded to their estate. 3. Resident 3A expired on As of 4/10/19, this facility was In possession of the resident's personal funds, totaling 51,280.54.	F 569	During and at the conclusion of the audit and reporting period, the QAPl committee will re-evaluate and initiate any necessary action or extend the review period. The Facility Billing Coordinator is responsible for confirming implementation and ongoing compliance with the components of the Plan of Correction and addressing and resolving variances that may occur.	

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215099	A. BUILDING _____ B. WING _____	C 04/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY STATE, ZIP CODE
WILSON HEALTH CARE CENTER	301 RUSSELL AVENUE GAITHERSBURG, MD 20877

(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
S 000	Initial comments On 4/10/19, a survey was conducted at this facility by the Office of Health Care Quality to investigate complaint #MD00138895. Activities included an audit of the residents' personal funds records maintained by this facility. The complaint was substantiated This survey identified noncompliance with State requirements that were reviewed in relationship to the complaint. (SEE S6480, S6565, & S6580)	S 000		
S6480	10.07 09.18 F (1) Protect res funds; estab res acct .18 Protection of a Resident's Personal Funds, F. Establishment or Resident Accounts. When a nursing facility manages a resident's financial affairs, the nursing facility shall establish and maintain a system that: (1) Ensures a full, complete, and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the nursing facility; and This Regulation is not met as evidenced by: SEE F569	S6480	See POC for FS69	S/fr,/If
S6565	10.07.09.19 E (1) Recs Pers Funds;Death of Resident .19 Records of Resident Personal Funds. E. Death of a Resident. Upon the death of a resident for whom a nursing facility is holding funds, the nursing facility shall notify the resident's agent or interested family member and:	S6565	See POC for f569	0/19

)HCQ
FORM

TORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — DATE 6/19

STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215099	A. BUILDING _____ B WING _____	C 04/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HEALTH **CARE** CENTER	301 RUSSELL **AVENUE** GAITHERSBURG, **MD 20877**

(X4) ID PREFIX TAG	SUMMARY STATEMENT Of DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COM?LETE DATE
	S6565 Continued From page 1	**S6565**		
	(1) Convey within 30 days a final accounting of the resident's personal funds which are deposited with the nursing facility; This Regulation is not met as evidenced by: SEE F569			
	S6580 10.07.09.20 Misuse Resident Funds .20 Misuse of Resident's Funds , A. A person may not misappropriate a resident's assets or income, including spending the resident's assets or income against or without the resident or resident's agent's consent, except as permitted by Regulation .198(4) of this chapter. B. A person who believes that there has been an abuse of a resident's funds may make a complaint to the: (1) Local department of social services; (2) Director of the Office on Aging if the resident is 65 years old or older; or (3) Director of the Licensing and Certification Administration, regardless of the resident' s age. This Regulation is not met as evidenced by: SEE F569	**S6580**	**See POC for F569**	sl,o/1q

i\..SBURY ,
MethodisL Village/.
Anticipate More

201 Russell Ave, Gaithersburg, MD 20877 | 301 216 4001 | AsburyMethod1stVdlage org

May 1,2018

Dear Mrs. Schoonover and Mrs. Melodini,

Please see the attached plan of correction for The Wilson Health Care Center, provider number 121-5099, for the annual survey conducted on March 27-20, 2018 during which it was determined that the facility was not in substantial compliance with Federal requirements for nursing homes participating in the Medicare and/or Medicaid programs. This plan of correction reflects the changes that were requested on 4/30/18 to remove the word "designee." Should you have any questions, please contact me at 301-216-4085.

Yours truly,

Rachel S. Karish, LNHA
Administrator, The Wilson Health Care Center

RECEIVED
MAY 22 RECD
OFFICE OF HEAlTH CARE QUAlllY

MARYLAND
Department of Health

Larry Hogan, Governor • Boyd K. Rutherford, Lt. Governor • Robert R. Neall, Secretary

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SS Wudc Ave. - nlnnd Dry11n1 Building
C:11onsvillc, MD 21228
410-402-H201

April 19. :?018

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lkur Ms. Karish:

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All n:ro:n:nccs lo n:llululnry n.-quin:mcnls c:onlninccd in this h:llcr are found in Title 42, Code or F1,-dcml Rc:llulntions (C.l'.R,), COMAR Title 10, ond the SIDie Cio,·enmu:111 Anidi:.

I. Pl.AN 011COllRl:C'l'ION (roC)

A P11C fnr 1hc dclicicncics must be:s11hn1it11."!1 wilhin 10 dnys oner 1hc fucilit)' n. c:in-s illi l'onn CMS 2567. Fnilun:10 submit nn1H:ccp1ublc l'oC within the abo,·c lime ftJmes moy l\:sull in the imposition of ll civil-money penally l\1·en1y (:?O)®)'saficr lhc:due dale li.>r· submission ol"lhc: l'oC.

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- Refcn:nccs to II n::;idcnt(s) by RL'Sidc:nl II only. l'bis appli "li to the PoC us well as any nm1chments to the l'oC. It is un•nccep1uhle to include n n!Sidcnt(s) nnmc in tl1L>sc doeumc111s:.ince the doc11111cnts 11n: n:lc: -d to1hc public.

II. IMCQSITJQN Ql' REMEDIES

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Iryou do nnt nchie\'c:111b 1i1111ial compli11m:c IVithin J mu111bs 11ftt:r 1hc IDS! dn)'oftht: s11r,,·cy (i.eJunc JO. 2018) idt:ntir>•ing non-compli11ncc. we mw,1den)' payn11:nts for nc\\' :idmisi;ions. (§,188.417(11)) Also, if the denial ofpaymcnl forne\\' admissionssanclion is impoS&.'11,)'our facilily is prohibited from operating n nurse aide tr.1ining progn1m for two yc111s from the lwi1 day oftl1c s11rvcy. (§483.15 I)

If your fucili1y hos fnilcd 10 nchic\'c:.11bs1anti:il compliance by September 30.:!0IH,)"our Medicare pro,·ider agrccmcnl \\'ill be tcm1i m1tcd.

III. At,1.EQAIIQN Ql[1] COMPI.IANCE

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IV. INl:QRMAI, DISPUTE RESOI.UTION

In occordnnce with §488,33I, you hovi: oni:opponunity to question cited deliciencics 1l1ro11gh on it1fom1ul dispute n:solulion process. To be giwn such :111 opponunit)', you un: n:quin:d 10 send your wrim:n n:ques1. along wilh 1hc -pccilie deliciency(iL"S)111:ing dispu1 -d.- and nn cxplnnnlion of wh)' you ari: dispulini; those deficiencies. lo Ms. Margie lk-.1ld, Dcpuly Din."1:lllr. Office or Ile11l1h Can:QUPlity. IJl11nd 81')'Dlll Building. Spring Gro\'C Center. SS Wudt: A\·enuc. C11ll1n ,•ille, M111ylnnd 21228, liix 410-402-8::?34. This l\."qllCSI must bl: sent during the same 10 do)'S you hll\'e for submitting a PoC for the cited delicienciL-s. An im:omplete'infom1ul dispulc ri:solution p s.1will not dt:l:i)' the cfti.-cti,·e dote of WI)' enforcement aetil1n.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215089	A. BUILDING _____ B. WING _____	C 03/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HEALTH CARE CENTER	301 RUSSELL AVENUE GAITHERSBURG, MD 20877

IX4JID 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)	ix•1 COMPL5TION CAiE

RECEIVED
MAY 22
OFFICE OF HEALTH CARE QUALITY

F 000 INITIAL COMMENTS

The following deficiencies are the result of the annual Medicare/Medicaid Long Term Care Recertification Survey conducted on March 27, 28, 29 and 30, 2018. In addition to standard survey protocols, complaint MD 00123442 were investigated and noncompliance was identified.

In addition, complaint MD 00122243, facility reported incidents MD 00121248 and MD 00122243, MD 00122345 and 3 additional facility reported incidents were also investigated. This survey did not identify noncompliance with Federal requirements that were reviewed in relationship to these facility reported incidents and complaint.

Survey activities consisted of a review of 70 resident records, observations of resident care and staff practices. and interviews of residents, residents' family members, and facility staff. Additionally, administrative records and resident care policies were reviewed.

The facility is licensed for 285 comprehensive beds. At the time of this survey, the facility census was 235 beds.

F 558 Reasonable Accommodations Needs/Preferences
SS=B 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:

F 000

Responses to the cited deficiencies do not constitute an admission or agreement hy the facility of the truth of facts alleged or conclusions set forth in **the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and/or State Law.**

FS58 Reasonable Accommodations Needs/Preferences

With respect to the specific resident/situation cited:
Resident #29's call light was placed wichin reach at the time of sun·ey.

Resident #114 no longer resides at the facility.

With respect to how the facility will identify residents/situations with the potential for the identified concerns:
Resident c:111 lights were audited on 3/27/18 to ernluate placement. Call lights that were identified as not within

F 558 reach were corrected on 3/27/18.

With respect to what systematic , measures ha,·e been put into place to address stated concern:
The Director of Nursing (DON) will in-sen·ice licensed nursing staff and Geriatric Nursing Assistants (GNA 's) on call light placement within resident rooms.

5/1/18

PROVIDER REPRESENTATIVE'S SIGNATURE: Rachel D Varcus
TITLE: NHA
(X6) DATE: 5/1/18

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATIONNUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215099	A. BUILDING _____ B. WING	C 03/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HEALTH CARE CENTER	301 RUSSELL AVENUE GAITHERSBURG, MD 20877

(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)	COMPLETION DATE
F 558	Continued From page 1 Based on surveyor observation, it was determined that the facility staff failed to keep residents' call lights within reach in order lo allow residents to call for staff assistance. This finding was evident for 2 of 38 residents selected for review during the survey (#29 and #114). The findings include: 1. On 03-27-18 at 8:19 AM, observation of resident #29's room revealed the call light was rolled and pinned to the wall. Resident #29 was ambulatory and alert and oriented and staled that "they always take it away from me" when asked if he/she pinned the call light to the wall. This was reported to the unit manager immediately. 2. On 03-27-18 at 8:25 AM, observation of resident #114's room revealed the call light was on the resident's bedside lamp table. the resident ', was alert and oriented, however, does not speak English. On 03-27-18 at 09:30 AM, surveyor interview with resident #114's responsible party revealed that the call light was always "kept away from" resident #114. On 03-27-18 at 09:30 AM, following surveyor intervention, all call tights on the unit were placed within reach for all alert and oriented residents. On 03-27-18 al 11:10 AM, surveyor interview with the administrator and the Director of Nursing revealed no additional information. F 580 Notify of Changes (Injury/Decline/Room, etc.) **SS=B** CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes.	F 558	With respect to how the plan of correction will bemonitored: The Unit Managers will audit call lights weekly for four weeks and monthly for three months to evaluate light placement within resident rooms. During and at the conclusion of the audit and reporting period, the **QAPI** committee will re-evaluate and initiate any necessary action or extend the review period. The Nursing Home Administrator is responsible for confirming implementation and ongoing compliance with the components of the Plan of Correction and addressing and resolving variances that may occur. **F 580 Notif\· of Changes** **With respect to the specific** **F 580 resident/situation cited:** Resident #104"s responsible party was notified of the resident's weight loss and diet change.	'5/'if/,"8

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUFPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSIRUCTION	(X3) DATE SURVEY cor.lPLETi:D
	215099	A BUILDING _____ B.WING	C 03130/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE. ZIP CODE
WILSON HEALTH CARE CENTER	301 RUSSELL AVENUE GAITHERSBURG, MD 20877

(X4)1D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC ID NTIFV11'G INFORMATION)	ID PREFIX TAG	PROVIDER'S FLAN OF CORRECTION (EACH CORRECTNEACTION SHOULO BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ex>; C0MPLCIIC'11 0.:...re
F 580	Continued From page 2 (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 lo adverse consequences, or to commence a new form of treatment); or (0) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if *any,* when there is• **(A) A** change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(9)(15)	F 580	**With respect to how the facility will identify residents/situations with the potential for the identified concerns:** Current residents with significant weight loss and diet change will be audited by the Unit Managers to ernluace responsible party notification of significant weight loss and diet change. **With respect lo what systematic measures have been put into place to address stated concern:** The DON will in-service licensed nurses on notifying the responsible party of significant weight loss and diet change. **With respect to how the phm of correction will be monitored:** The Unit Managers will audit residents with significant weight loss and diet change weekly for four weeks and monthly for three months to evaluate responsible party notification. During and at the conclusion of the audit and reporting period. the **QAPI** committee will re-emluate and initiate any necessary action or extend the re\"iew period. The Nursing Home Administrator is responsible for confirming implementation and ongoing compliance with the components of the Plan of Correction and addressing and resoh'ing variances that may occur.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215099	A. BUILDING _____ WING	C 03130/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HEALTH **CARE** CENTER	**301 RUSSELL AVENUE GAITHERSBURG, MD 20877**

(X4)1D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST B: PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
F 560'	Continued From page 3 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 l 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 facility staff interviews, ii was determined that i the facility failed to notify a resident's responsible : *party* of a significant weight loss. This finding was evident for 1 of 38 residents selected for review during the survey (#104). The findings include: i On 03129/18 al 9:03 AM, surveyor review of ; resident #104's clinical record revealed that, on ', on 10-04-17, he/she weighed 95.40 lbs. Further , review of the weight record revealed that, on , 01-15-18, resident #104 weighed 90.3 lbs. This ; was over a 5 lb (18%) weight Joss in 90 days. On 1 01-17-18, the facility's dietitian documented that · resident #104 was assessed for significant weight '. loss and their diet was changed from regular to · mechanical soft (a type diet designed for people 1 who have trouble chewing and swallowing; ·. chopped, ground and pureed foods are included · in this diet). However, there is no evidence that , resident #104's responsible party was notifled of the significant weight loss and the diet change. '. On 03-29-18 at 10:10 AM, surveyor interview wtth the dietitian revealed that facility nursing staff are responsible for notifying the resident's responsible *party* of the weight loss and changes in the diet.	F 580		

STATEMENT OF DEFICIENCIES ANO PIAN OF CORRECTION	(X1) PROVJDER/SUPPUER/CLIA IDENTIFICAI'IOtl NUMBER:	(X2) MULTIPLE CONSTRUCTIO"	IX3) DATE SURVEY COMPLETED
	215099	A. BUILDING _____ S.WING	C 03/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS. CITY, STATE, ZIP CODE
WILSON HEALTH CARE CENTER	301 RUSSELL AVENUE GAITHERSBURG, MD 20877

IX4) ID ' PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BYFULL REGUIATORY OR LSC IDENTIFYING INFORMATION)	10 PREFIX TAG	PROVIDER'S PIAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFER NCED TO TIIE APPROPRIATE DEFICIENCY)	IXSi COMPLETION DAiE
F 580	Continued From page 4 , On 03-29-18 at 10:35 AM, surveyor interview with the unit manager and the Director of Nursing . revealed no additional information.	F 580	**F 582 l\ledicaid/l\ledicare Coverage** **With respect to the specific resident/situation cited:** Resident #29 was provided with the advanced beneficiary notification. Resident #57 was provided with the advanced beneficiary notification. **With respect lo how the facility will identify residents/situations with the potential for the identified concerns:** The Director of Social Ser.·iccs will audit residents who were discharged from a Medicare co,·ered Part A stay who remained in the facility within the past thirty days to e,·aluate ad,•:mced beneficiary notification completion. **With respect lo what systematic measures ha,·e been put into place to address stated concern:** The Director of Social Services will in-ser.·ice social workers, social services coordinators, and admission team members on completion of the ad\'anced beneficiary notification. **With respect lo how the plan of correction will be monitored:** The Director of Social Ser\'iccs will audit residents who were discharged from a Medicare covered Part A stay who remained in the facility monthly for three months to evaluate advanced ._b_e_ne_fi_1c_i_ar · notification completion.	5/8/18
F 582	, Medicaid/Medicare Coverage/liability Notice SS=B CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- . (A) The items and services that are included in nursing facility services under the Slate plan and · for which the resident may not be charged; **(B)** Those other Items and services that the facility offers and for which the resident may be : charged, and the amount of charges for those , services; and · (ii) Inform each Medicaid-eligible resident when changes are made to the items and services : specified in §483.10(g)(17)(i)(A) and (B) of this ! section. §483.10{g){18) The facmty must inform each resident before, or at the lime of admission, and ! periodically during the resident's stay, of services available in the facility and of charges for those '. services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered **by** Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the · facility must inform the resident in writing at least	F 582		

STATEMENT OF DEFICIENCIES AND PIAN OF CORRECTION	(X1) PROVIDER/SUPPLIERICLIA IDENTIFICATION NUMBER.	(X2) MULTIPLE CONSTRUCI'ION	(X3) DATE SURVEY COMPLETED
	215099	A. BUILDING _____ B WING	C 03/30/2018

NAME OF PROVIDER OR SU?PLIER	STREET ADDRESS, CfiY, STATE. ZIP CODE
WILSON HEALTH CARE CENTER	301 RUSSELL AVENUE GAITHERSBURG, MD 20877

(X4) ID PREFIX, TAG	SU L\IARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYIIIG INFOR IATION)	ID PREFIX T. G	PROVIDER'S PIAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 582	Continued From page 5 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on survey or review of administrative and clinical records and interview of staff, it was determined that facility staff failed to issue the necessary notification to residents no longer covered under the Medicare part A benefit. This finding was evident for 2 of the 38 residents reviewed during the survey.(#29 and #57) The finding includes: 1. On 03-30-18, review of the administrative records revealed that resident # 29 began receiving skilled nursing care on 11-28-17. Resident #29's last covered day under Medicare part A skilled nursing care benefits was 12-08-17. There was no evidence in the administrative or clinical records to reflect that the resident received advanced notification of services or items that would not be covered under Medicare	F582	During and at the conclusion of the audit and reporting period, the QAPI committee will re-ernluate and initiate any necessary action or extend the re,·iew period. The Nursing Home Administrator is responsible for confirming implementation and ongoing compliance with the components of the Plan of Correction and addressing and resoh·ing \'ariances that may occur.	

STATEMENT OF DEFICIENCIES AND PIAN OF CORRECTION	(X1) PROVIDERISUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DAT!a SURVEY COMPLETED
	215099	A. BUILDING _____ B,WING	C 03/30/2018

NAM: OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HEALTH **CARE** CENTER	301RUSSELL AVENUE **GAITHERSBURG, MD 20877**

(X4) ID PREFIX IAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIEIICY MUST BE PRECEDED BY FULL **REGULATORY OR LSC IDENTIFYING INFORMATION}**	ID PREFIX TAG	PROVIDER'S Pl.AN OF CORRECTIOtl (EACH CORRECTIVE ACTION SHOULD BE CROSS,REFERENCED TO TIIE APPROPRIATE DEFICIENCY)	1.<S) CCMPLEliON o.:..TE
	F 582 Continued From page 6 part A, prior to the initiation of skilled services. The advanced beneficiary notification was necessary to give resident #29 the option to accept or decline offered services that would not be covered under Medicare Part A. **2.** On 03-30-18 review of the administrative records revealed resident# 57 began receiving skilled nursing facility care on 12-16-17. Resident #57's last covered day under Medicare part A skilled nursing care benefits was 01-23-18. There was no evidence in the administrative or clinical records to reflect that the resident received advanced notification of services or items that would not be covered under Medicare part A prior to the initiation of skilled services. The advanced beneficiary notification was necessary to give resident #57 the option to accept or decline offered services that would not be covered under Medicare Part A. On 03-30-18 at 3:50 PM, interview with the facility administrator revealed no additional information.	F **ss2'**		
F 625	• Notice of Bed Hold Policy Before/Upon Trnsfr SS=B 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	F **625**	**F 625 Notice of Bed-Hold Polic.·** **With respect to the specific resident/situation cited:** Resident #I 02 no loneer resides *at* the facility. Residem #I 82 w:Is pro,·ided with the facility bed-hold policy. Resideru #202 was pro,·ided with the facility bed-hold policv.	5/'8/rr

STATEMENT OF DEFICIENCIES ANO PiAN OF CORRECTION	(XI) PROVIDERISUPPUEn/CLIA IDENTIFICATION NUMBER.	(X2) MULTIPL!;: CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215099	A BUILDING _____ B 11'/ING	C 03/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HEALTH CARE CENTER	301 RUSSELL AVENUE GAITHERSBURG, MD 20877

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F 625 Continued From page 7

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 and administrative records and interview of staff. it was determined that facility staff failed to provide notification of bed hold at the time of transfer from the facility to the hospital. This finding was evident for 3 of 38 records reviewed during the survey (#102, #182 and #202). The findings include:

1. On 03-30-18, review of the clinical record for resident# 102 revealed the resident was from the facility to the hospital on There was no evidence in the clinical or administrative records that the resident received written notification *of* the facility bed hold policy at the time of transfer as required.

On 03-30-18 at 3:10 PM, interview with the

With respect to h0 ,--thc-racility will

lidentif,· residents/situations with the

F **62Slpotential for the identified concerns:**

!The Unit Managers will audit residents who have transferred to the hospital within the past thirty d,lys to evaluate resident notification of the facility bed-hold policy.

With respect to what systematic measures ha\·e been put into place to **address stated concern:**

The DON win in-service licensed nurses on providing the facility bed-hold policy to residents upon transfer to the hospital.

With respect to how the plan of correction will be monitored:

The Unit Managers wil1 audit residents who have transferred to the hospital within the past thirty days to e\·aluate resident notification of the facility bed-hold policy weekl)' for four weeks and monthly for three months.

During and at the conclusion of *the* audit and reporting period, the **QAPI** committee will re-e\·alunte and initiate any necessary action or extend the re\·icw period.

The Nursing Home Administrator is responsible for confirming implementation and ongoing compliance with the components of the Plan of Correction and addressing and resolving variances that may occur.

STATEMENT OF DEFICIENCIES AND PLA.'11 Of CORRECTION	(X1) PROVIDERJSUPPLIfR/CUA IDENTIFICATION NUMBER:	{X2) MUI.TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215099	A. BUILDING _____ 8/"flNG	C 03/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HEALTH **CARE CENTER**	301 RUSSELL AVENUE GAITHERSBURG, MD 20877

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F 625	Continued From page 8 : director of nursing revealed no additional information. 2. On 03-29-18, review of the clinical record for resident # 182 revealed the resident was nsi d from the facility to the hospital on **and** – There was no evidence in the clinical or administrative records that the resident received written notification of the facility bed hold policy at the time of transfer as required. On 03-30-18 at 3:1OPM, interview with the director of nursing revealed no additional information. 3. On 03-30-18, review of the clinical record for resident # 202 revealed the resident was transferred from the facility to the hospital on 11111111111111 There was no evidence in the clinical **stratlve** records that the resident received written notification of the facility bed hold policy at the time of transfer as required. On 03-30-18 at 3:10 PM, interview with the director of nursing revealed no additional information.	F6251		
F 641	Accuracy of Assessments **SS=D; CFR(s): 483.20(9)** §483.20(9) 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 resident and facility staff interview it was determined that facility staff failed to accurately code the Minimum Data Set (MDS) to reflect the	F 641	**F64 l Accurac,· of Assessments** **With respect to the specific resident/situation cited:** Resident #114 no longer resides at the facility. Resident # I 20 no longer resides at the facility. Resident #182's MDS was modified. Resident #234"s MDS was modified. Resident #238 no longer resides at the facility.	18/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDERISUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 641	F 641 . Continued From page 9 : resident's status. This finding was evident for 5 of 38 residents reviewed during the survey. (#114, #120, #182, #234 and #238). The findings 'include: The Minimum Data Se! (MOS) is a mandated process for clinical assessment of all residents in Medicare or Medicaid certified nursing homes. This process provides a comprehensive assessment of each resident's functional capabilities and health problems to assist nursing home *staff* provide appropriate care. MOS assessments are required for residents on admission lo !he nursing facility and !hen periodically, within specific guidelines and lime frames. 1. On 03-29-18 at 10:10 AM, surveyor review of !he clinical record for resident #114 revealed Iha! he/she fell on 12-23-17 and 02-03-18 with no injuries. However, review of section J1800 of the MOS , submitted on 03-16-18 revealed facility staff answered Iha! resident #114 had zero falls within ' !he assessment period. Additionally, MOS section J1900 was *not* answered al all although facility staff documenlalion revealed resident #114 did not sustain any injury on either falls. On 03-29-18 at 11:15 AM surveyor interview with the MOS coordinator and Director of Nursing (DON) revealed no additional information. 2. On 03-31-18 surveyor review of the clinical record for resident #120 revealed section K "Swallowing/Nutritional Status" of the MOS	F 641	With respect to how the facility will identify residents/situations with the potential for the identified concerns: The Director of Minimum Data Set (MDS) will audit residents who hm·e had a fall within the past thirty days lo e,·aluate MDS coding for falls. The Director or MDS will audit residents who have had significant weight loss within the past thirty days to evaluate MDS coding for weight loss. The Director of MDS will audit admission M DS assessments from the past thirty days to e,·aluate MDS coding for oral assessment. The Director or MDS will audit quarterly MDS assessments from the past thirty days to evaluate MDS coding for bcha,·ior. The Director of MDS will audit admission MDS assessments from the past thirty d,1ys lo evaluate MDS coding for prognosis. **With respect lo what systematic measures ha,·e been put into place** to **address stated concern:** The DON will in-sen·ice MDS coordinators, the Registered Dietitian.	

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F 641	Continued From page 10 • assessment dated 01-04-18 indicated the resident weighed 193 pounds. Review of an MOS assessment completed on 02-15-18 section K "Swallowing/Nutritional Status" revealed that resident #120 weighed 172 pounds. Further review of Section Kon the 02-15-18 assessment revealed question K0300 'Weight Loss- Loss of 5% or more in the last month or loss of 10% or more in the last 6 months" was coded "0- No or unknown". However, the correct coding would have been "2-Yes, not on physician prescribed weight-loss regimen". On 03-30-18 at 1 PM surveyor interview with the DON provided no additional information. 3. On 03-27-18 at3PM, surveyor interview with resident #182 revealed he/she had missing teeth, On 03-29-18 at 11AM, surveyor review of resident #182's clinical record revealed Section L of the Minimum Data Set (MOS) was coded as Z, no dental conditions present. The assessment reference date (ARD) was 03-20-18. On 03-29-18 at 11:30AM, surveyor interview with the 2 North nursing unit charge nurse revealed resident #182 has 3 missing teeth on the top, and 3 missing teeth on the bottom. On 03-29-18 at 12PM, surveyor interview with the 2 North MOS coordinator revealed Section L was incorrectly coded should have reflected resident #182 was edentulous (missing teeth). On 03-30-18 at 3PM, surveyor interview with the	F 641	and Social Sen·ic.:s coordinators on accurate coding of the MDS. The DON will in-ser\'ice the MDS coordinators on re\'iewing all sections of the I\·IDS for accuracy prior to closing the assessment. **With respect to how the plan of correction will be monitored:** The Director of MDS will audit IO'k of MDS assessments completed monthly for three months to evaluate coding for falls, weight loss, oral assessment, behavior, and prognosis. During and at the conclusion of the audit and reporting period, the QAPI committee will re-evaluate and initiate any necessary action or e tend the review period. The Nursing Home Administrator is responsible for confirming implementation and ongoing compliance with the components of the Plan of Correction and addressing and resolving variances that may occur.	

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F 641 1	Continued From page 11 DON revealed no additional information. 4. On 03-30-18 surveyor review of the clinical record for resident #234 revealed nursing notes written on 03-01-18, 03-02-18, 03-03-18, 03-05-18, 03-06-18, and 03-07-18 that indicated the resident had been wandering on the unit. Review of resident #234's 03-08-18 MOS assessment revealed that Section E "Behavior", question E0900 - "Has the resident wandered?", was coded "0- Behavior not exhibited". However, the correct coding would have been ""2- Behavior of this type occurred 4 lo 6 days". On 03-30-18 at 1 PM surveyor interview with the DON provided no additional information. 5. On 03-29-18 surveyor review cf the clinical record for resident #238 revealed an admission history and physical that staled that the resident was admitted with a terminal diagnosis. Review of the admission MOS assessment revealed that Section J "Prognosis", question J1400- "Does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months?" was coded "O" indicating the answer was no. However, the correct coding would have been "1" indicating the answer was yes. On 03-30-18 at 1 PM surveyor interview with the DON provided no additional information.	F641'.	**F656 Comprehensh·e Careplan** **With respect to the specific resident/situation cited:** Resident # I 02 no longer resides at the facility. Resident #l82's care plan was updated to reject the use of the antipsychotic medication. **With respect to how the facility will identify residents/situations with the potential for the identified concerns:** The Unit Managers will audit residents who have fallen in the past thirty days 10 ernluate fall care plan interventions and goals. The Unit Managers will audit current residents with orders for Risperidonc to evaluate presence of antipsychotic care plan.	'/8/13
F 656· SS=D:	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §<83.21(b) Comprehensive Care Plans	F 656		

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F 656	Continued From page 12 §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 : (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 I recommendations. If a facility disagrees with the ' findings of the PASARR, it must indicate its I rationale in the resident's medical record. ' (iv)In consultation with the resident and the 1 resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (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. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the . requirements set forth in paragraph (c) of this	F656	**With respect to what systematic measures have been put into place to address stated concern:** The DON will in-service Unit Managers on initiating care plan interventions and l't!\'ising care plan goals as needed after a resident falls. Falls will be reviewedd during the Interdisciplinary Team morning meeting 10 ernluate fall interventions put into place. The DON will in-senvice Unit Managers on initiating a care plan for residents on antipsychotic medications for residents on Rispcridone. **With respect to how the plan of correction will be monitored:** The Unit Managers will audit residents who ha\'e fallen weekly for four weeks and monthly for three months 10 ev'aluate presence of fall care plan interventions and appropriate goal. The Unit Managers will audit residents on Risperidone weekly for four weeks and monthly for three months *to* evaluate presence of antipsychotic care plan.	I

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F656	Continued From page 13 'section. This REQUIREMENT is not met as evidenced by: Based on surveyor review of the clinical records, and staff interview, it was determined that the facility staff failed lo revise the plan of care to accurately reflect the resident's status. This finding was evident for 2 of the 38 residents selected for review during the survey (#102 and #182). The findings include: 1. On 03-30-18 at 12:03 PM, review of the clinical record for resident #102 revealed nursing notes which identified multiple falls. On 03-05-18 the resident sustained a fall with no injury. The next day, on 03-06-18 the resident sustained another fall which resulted in a hematoma of the head (a hematoma is a solid swelling of clotted blood between the tissue). Further review of resident #102's clinical record revealed 2 additional falls; on 03-28-18, with no injury, and on 03-30-18 which resulted in another head injury (hematoma). There was a total of 4 falls during the month of March 2018. Further review of resident #102's clinical record revealed no evidence that the care plan was revised lo implement appropriate interventions to minimize the risk of head injury after any of the falls. In addition, there is no clear evidence in the plan of care that other interventions were added after subsequent falls. The two previous facility identified goals that resident #102 would ambulate without fall related injuries and would not sustain any serious injury from falls had not been met, as evidenced by head injury (two hematomas). The facility did not revise the care	F 656	biiifog and at the conclusion of the audit and reporting period, the QAPI committee will reevaluate and initiate any necessary action or extend the review period. The Nursing Home Administrator is responsible for confirming implementation and ongoing compliance with the components of the Plan of Correction and addressing and resoh·ing ,·ariances that may occur.	

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F 656	Continued From page 14 plan to reflect updated goals related to falls. On 03-30-18 at 4:00 PM, interview with the director of nursing revealed no additional information. 2. On 03-29-18, review of the clinical record for resident #182 revealed resident had received the antipsychotic medication, risperidone 0.25mg, every evening since his/her admission to the facility in early February, 2018. There was no care plan in the clinical record to address the antipsychotic drug utilization. On 03-30-18 at 4:05 PM. interview with the director of nursing revealed no additional information.	F656		
F 6581	Services Provided Meet Professional Standards SS=D CFR(s): 483.21{b)(3)(i) §483.21{b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on surveyor review of the clinical records and staff and resident interviews, it was determined that the facility staff failed to ensure that all nursing care met professional standards of quality. This finding was evident for 2 of 38 residents selected for review during the survey process (#206 and #436). The findings include: 1. On 03-29-18 at 1 PM *surveyor* review of resident #206's medical record revealed that on 03-04-18 the physician ordered a urinalysis with	F658	**1'658 Services Provided Meet Professional Standards** **With respect to the specific resident situation cited:** Resident #206 no longer resides at the facility. Resident #436's stool was collected, and the resident was treated for c-diff. **With respect lo how the facility will identify residents/situations with the potential for the identified concerns:** The Unit Managers will audit current residents with an order for Urinalysis Culture and Sensitivity (UA C&S) to evaluate physician notification timeliness.	8/18

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F 658	Continued From page 15 culture and sensitivity to determine if there was a urinary tract infection. A nursing progress note, written on 03-05-18 at 4:42 AM, noted that the urine was collected and sent to the lab(oratory) that morning. Further review of the clinical record revealed that the preliminary results of the urinalysis were available to the facility staff on 03-05-18 and the final results of the culture and sensitivity were available to the facility staff on 03-07-18. However, review of the physician order sheet revealed that an antibiotic to treat the infection wasn't ordered until 03-09-18. On 03-29-18 at 1 PM, surveyor interview with the unit manager revealed that the nursing staff hadn't informed the physician of resident #206's culture and sensitivity report until 03-09-18. Per the Nurse Practice Act 10.27.09.03 F (2) (bl the RN shall consult with health care providers for patient care. · 03-30-18 at 2:15 PM interview with the director of nursing (DON) revealed no further information 2. On 03-27-18 at 9 AM during surveyor interview with resident #436 he/she stated that he/she might have a C-Diff (costridium difficile) infection (an intestinal infection that causes diarrhea and is easily transmitted from person to person; the infection is treated with an antibiotic). On 03-29-18 at 11 AM surveyor review of of resident #436's clinical record revealed that on 03-22-18, the physician ordered a stool sample for C-Diff analysis due to multiple instances of diarrhea. Further review of the record revealed that the stool sample hadn't been sent to the lab until 03-27-18. On 3-27-18 the physician wrote	F **658,**	residents which orders for c-d,ff culture to evaluate whether an anti-diarrheal medication was given prior to sending a stool sample to the lab. **With respect to what systematic measures ha,·e been put into place to address stated concern:** The DON will in-sen·ice licensed nurses on physici,m notification timeliness of UA C&S results. The DON will in-service licensed nurses on discontinuing/holding orders for anti-diarrheal medications for residents who have an order for c-diff culture. **With respect to how the plan of correction will be monitored:** The Unit Managers will audit residcnls with an order for UA C&S to evaluate physician notification timeliness weekly for four weeks and monthly for three months. The Unit Managers will audit residents with orders for c-diff culture to evaluate whether an anti-diarrheal medication was given prior to sending a stool sample. to the lab weekly for four weeks and monthly for three months.	

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F658 Continued Frem page 16

an order *to* "send stool for c-diff (in the fridge)." The lab result that indicated a C-Diff infection was available on 3-28-18 at which time the physician ordered the antibiotic.

, On 03-30-18 at 11 AM further review of resident · #436's clinical record revealed the physician's progress note, written on 03-23-28, the physician . wrote "explained to him/her (resident #436) not to • take imodium Iii (sic) stool sample collection." However, review of the March 2018 Medication Administration Record revealed that the lmodium was given to the resident 3 limes before the stool . sample was collected; on 03-23-18 at 11:08 PM, on 03-24-18 at 7:06 AM and on 03-27-18 at 3:46 PM. The use of the medication lmodium, which slows intestinal motility, is typically not . recommended in persons wit C-Diff infection. In addition, administration of the lmodium may have caused the delay in obtaining the stool sample - . for laboratory analysis and therefore delay the start of antibiotic treatment.

, Per the Nurse Practice Act 10.27.09.02 E, the RN shall implement interventions in a competent, · safe, and appropriate manner consistent wilh · knowledge of scientific principles.

• On 03-30-18 at 2 PM surveyor interview with the DON revealed no additional information.

F 689 , Free of Accident Hazards/Supervision/Devices SS=D CFR(s): 483.25(d)(1)(2)

§483.25(d) Accidents.
The facility must ensure that -
§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and

, During and al the conclusion of the audit F 658 and reporting period, the QAPI committee will re-evaluate and initiate any necessary action or extend the review period.

The Nursing Home Administrator is responsible for confirming · implementation and ongoing compliance with the components of the Plan of Correction and addressing and resol\'ing ,·ariances that may occur.

F 689 **F689 Free of Accident Hazards**

With respect to the specific resident/situation cited:

Resident #SS is currently stable and is transferred ,·ia mechanical lift. Staff# I was in-ser\'iced on utilizing two staff members during the mechanical lift transfer.

8/18

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F 689	Continued From page 17 §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 review of the clinical record and interview of resident #88 and the facility staff, it was determined that the facility staff failed to transfer an individual by using a Hoyer lift (mechanical lift) with 2 person assistance. This finding was identified during complaint investigation MD 00123442, which is valid. The findings include: On 03-27-18 at 8:30 AM, interview of resident #88 revealed the resident was alert and oriented. Due to physical limitation, the resident required two persons to assist with transfer by using a Hoyer lift. However, there was one lime that the resident was transferred by a Hoyer lift with one person only. Review of resident #88's care plan related to generalized weakness revealed the facility should transfer the resident by using **a** mechanical lift with 2 person assistance. On 03-27-18, review of the clinical record revealed resident **#88's** spouse reported to the facility staff on 02-23-18 that the resident reported left leg pain because the resident was dropped during transfer in the afternoon on 02-23-18. Routine pain mediation was administered on the same *day,* which was effective. The next *day,* resident #88 clarified with the 4 North Unit Manager that there was no drop during transfer on 02-23-18, but the transfer was done by one person only, which was inconsistent with the care plan.	F 689	**With respect to how the facility will identify residents/situations with the potential for the identified concerns:** The Unit Managers will audit current residents who utilize a mechanical lift For transfer to evaluate the use of two staff members during mechanical lift transfer. With respect to what systematic measures h1we been put into place to **address stated concern:** The Clinical Educator will in-service Geriatric Nursing Assistants on utilizing twostaff members during mechanical-lift transfer. **With respect to how the plan of correction will be monitored:** The Unit Managers will conduct random audits of current residents who utilize a mechanical lift for transfer to evaluate the use of two staff members during mechanical lift transfer weekly for four weeks and monthly for three months. During and at the conclusion of the audit and reponing period, the **QAPI**	

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F 689 Continued From page 18

03-28-18 at 10 AM, interview of staff #1 revealed staff #1 was assigned to resident #88 during the 7-3 shift on 02-23-18. Staff#1 understood that 2 persons were needed lo transfer resident #88 from bed to a wheelchair by using the Hoyer lift. However, staff #1 still transferred resident #88 alone in the afternoon on 02-23-18 by using the Hoyer lift. Staff #1 further explained that no other facility staff could be found on the unit when resident #88 requested to be seated in the wheelchair prior to their spouse's arrival at 4 PM.

On 03-28-18 at 1 PM, interview of the director of nursing (DON) and 4 North Unit Manager revealed the DON conducted an internal investigation and concluded that resident #88 was transferred by using the Hoyer lift with one person only on 02-23-18.

However. there was no evidence that additional education and monitoring was done after 02-23-18 to ensure staff transferred an individual properly.

F 758 Free from Unnec Psychotropic Meds/PRN Use
SS=E CFR(s): 483.45(c)(3)(e)(1)-(5)

§483.45(e) Psychotropic Drugs.
§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited lo, drugs in the following categories:
(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

committee will re-evaluate and initiate

F689 any necessary action or extend the review period.

The Nursing Home Administrator is responsible for confirming implementation and ongoing compliance with the components of the Plan of Correction and addressing!! and resolving!! variances that may occur.

F 758, **F758 Free from Unnecessan· Ps.·chotropic Meds**

With respect to the specific resident/situation cited:

Resident# 182"s diagnosis for Risperidone was clarified, the attending physician documented on the clinical indication for the use of the Risperidone in his progress note, and the resident·s careplan and bchavior sheets were updated.

$"/if(Y

STATEMENT OF OEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIERJCLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURV:Y COMPLETED
	215099	A. BUILDING _____	C 03/30/2018

N"1,1E OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HEALTH **CARE** CENTER	301 RUSSELL AVENUE **GAITHERSBURG, MO 20877**

(X4) ID **PREFIX.** TAG .	SUMMARY Statement OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED av FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID **PREFIX TAG**	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION S OULD BE **CROSS-REFERENCED TO THE AP?ROPRIAiE** DEFICIENCY)	**(XS) C0!.1PLEIION ilA.TF**
F 758	Continued From page 19 Based on a comprehensive assessment of a resident, the facility must ensure that-- ' §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary lo treat a . specific condition as diagnosed and documented ' in the clinical record; I §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 necessary *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)(S), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic 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, ii was determined that	F 758	**With respect to** how **the facility will identify residents/situations with the potential for the identified concerns:** The Uni! Managers· will audit current residents on Rispcridonc 10 evalua1e 1he diagnosis, physician documentation of clinical indica1ion for the Risperidone, and accuracy of care plan and behavior monitoring sheets related to the use of Risperidone. **With respect to what systematic measures have been put into place to address stated concern:** The DON will in-service licensed nurses on obtaining an appropriate diagnosis for Risperidonc, and updating 1he car plan and behavior sheets as needed. The DON will in-service Ihc attending physician on pro,·iding an appropriate diagnosis for Risperidone. **With respect to how the plan of correction will be monitored:** The Unit Managers will audit currelll residents on Risperidone 10 ev'aluate the diagnosis, physician documentation of	

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F 758	. Continued From page 20 the facility staff failed to prevent the use of an unnecessary psychotropic drug to treat a specific condition as diagnosed and documented in the clinical record. This finding was evident for 1 of 38 residents (#182) selected for this survey. The finding includes: A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: anti-psychotic, anti-depressant, anti-anxiety, and hypnotic. On 03-29-18 at 2:00 PM, surveyor review of the clinical record for resident **#182** revealed he/she received the anti-psychotic medication. Risperidone, nightly. Resident **#182 was** prescribed the medication at the hospital on 02-01-18. however there was no diagnosis or indication for the use of this antipsychotic medication. Resident #182 was re-admitted to the facility in early February, 2018 with a physician's order to continue the antipsychotic medication with no diagnosis or indication for its use. On 02-07-18, resident #182 was examined by the facility attending physician. There was no I am supporting diagnosis or indication for the use of the antipsychotic medication Risperidone in the physician's documentation. On 03-29-18, upon further investigation it was determined that the pharmacist had made a recommendation to the attending physician to obtain a diagnosis for the use of the antipsychotic medication for resident#182 on 03-23-18.	F 758	clinical indication for the Risperidone. and accuracy of care plan and behavior monitoring sheets related 10 the use of Risperidone weekly for four weeks and monthly for three months. During and al the conclusion of the audit and reporting period, the QAPI commiuec will re-ernluale und initiate any necessary action or e. tend the review period. The Nursing Home Administrator is responsible for confirming implementation and ongoing compliance with the components of the Plan of Correction and addressing and resolving Variances that may occur.	

STATEMENT OF DEFICIENCIES AND PIAN Or CORRECTION	(X l) PROVIDER/SUPPLIER/CLIA IDENTIFICATIONNUMBER:	(X2) MU'.TIPLE CONSTRUCTION	!Xl) DATE SUR•JEY COMPLETED
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F 758	F 758 Continued From page 21 • However the recommendation was not in the clinical record. ' Following surveyor intervention, facility staff were able to locate the pharmacy recommendation for resident#182 on 03-29-18 and obtained a diagnosis of psychosis from the attending physician. However, further review of the clinical record for resident **#182** revealed no evidence of a supporting diagnosis or clinical indication for the use of an antipsychotic medication noted in the physician's history and physical, or physician's progress notes, and the care plan and behavior monitoring sheets addressed depression and anxiety only. There were no symptoms of psychosis found upon review of the clinical record. A comprehensive psychiatric consultation dated 01-31-18 which was in the clinical record slated under the section "thought content" that resident #182 had "no overt psychosis". On 03-30-18 al 1:30 PM, surveyor interview with the 2 North Minimum Data Set Coordinator revealed the attending physician had provided a diagnosis of psychosis via telephone as a result of the surveyor intervention, even though the documentation in the clinical record did not support any evidence of psychosis and the resident had not been seen by a physician between 03-29-18 and 03-30-18. On 03-30-18 at 3:00 PM, surveyor interview with the director of nursing revealed no additional information.	F 758		

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F 812 Continued From page 22

F 812 Food Procurement.Store/Prepare/Serve-Sanitary
SS=D · CFR(s): 483.60(i)(1)(2)

§483.BO(i) Food safety requirements.
The facility must -

§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.
(i) This may include food items obtained direcUy from local producers, subject to applicable State and local laws or regulations.
(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.
(iii) This provision does not preclude residents from consuming foods not procured by *the* facility.

§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.
This REQUIREMENT is not met as evidenced by:
Based on surveyor observation and interview of the facility staff, it was determined that the facility staff failed to store and serve food to an individual under sanitary conditions. The findings include:

· 1. Based on observation of staff practice in 4N unit and interview of the facility staff, it was determined that the facility staff failed to store milk, a potentially hazardous food, under proper temperature.

On 03-27-18 at 9:30 AM, two breakfast trays were observed on 4 North's TV room for resident #420 and #425. There were two 8 oz milk cartons found on the breakfast *trays* at room temperature.

F 812· **With respect to the specific resident/situation cited:**
The milk was remo,·ed from resident #420's breakfast tray.

The milk was removed from resident #425's breakfast tray.

Staff members were in-serviced on storing milk on ice or in the refrigemtor until the resident tray is sen·ed.

Staff members were i - ervic: on_ hand washing and hand samuzer ut1hzut1on prior to serving residents and in between assisting residents to eat.

With respect to how the facility will identity residents/situations with the potential for the identified concerns:
The Unit Managers will audit resident meal service on the TCU, 2"[d] Floor and 3n1 Floor to ernluate milk storage prior to deli"ery and hand washing/hand sanitizing practices of staff members during meal service.

With respect to what systematic measures has been put into place to address stated concern:

STATEMENT OF DEFICIENCIES AND PIAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COM?LETEO
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F B12	Continued From page 23 On 03-27-18 al 9:38 AM, interview of staff #3 revealed residents #420 and #425 were *still* asleep. They preferred lo *eat* breakfasts later. Therefore, !heir breakfast !rays were left in the TV **room.** On 03-27-18 al 10:51 AM, *staff*# 3 assisted residents #420 with breakfast and poured milk inlo the oatmeal. The milk temperature was tested, which was 69 degrees Fahrenhett. Following surveyor intervention, the milk was removed from residents #420 and #425's breakfast *trays.* On 03-27-18 al 4:30 PM, interview of the facility administrator revealed no additional information. 1 Failure to maintain milk under 41degrees Fahrenheit could lead to a food borne illness. 2. On 03-27-18 at 12:20 PM surveyor observation of facility staff #1, #4, #5 and #6 in lhe 3 North dining room when lunch cart was delivered revealed a hand sanitizer mounted on lhe left wall upon entrance. However, the surveyor did not observe facifily staff washing their hands or applying hand sanitizer prior lo serving residents meals. Additionally, surveyor observed *staff* #6 feeding two residents without washing hands or applying hand sanitizer between feeding these two residents. 'On 03-27-18 at 12:30 PM, surveyor interview with the *unit* manager revealed no further information.	F 812	The Clinical Educator will in-service caregivers and licensed nurses on storing milk on ice or in the refrigerator until the resident tray is served and on hand washing/hand sanitizer utilization prior to serving residents and in between assisting residents to cat. **With respect to how the plan of correction will be monitored:** The Unit Managers will conduct random audits of resident meal sen•ice to evaluate milk storage prior to delh·ery and hand washing/hand s,mitizing practices of staff members during meal service weekly for four weeks and monthly for three months. During and at the conclusion of the audit and rcponing period, the QAPI committee will reevaluate and initiate any necessary action or extend the review period. The Nursing Home Administrator is responsible for confirming implementation and ongoing compliance with the components of the Plan of Correction and addressing and reasoning rnrianccs that may occur.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDERISUPPLIER/CLIA IDENTIFICATION NUMBER	(X'2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETED
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	s ooo' Initial comments ; The following deficiencies are the result of the ! annual survey conducted on March 27, 28, 29 ; and 30, 2018, for the purpose of determining the , facility's compliance with State COMAR requirements. In addition to standard survey protocols, complaint MD 00123442 were investigated. Noncompliance was identified. ; In addition, complaint MD 00122243, facility 'reported incidents MD 00121248 and MD '00122243, MD 00122345 and 3 additional facility reported incidents without assigned case numbers were also investigated. This survey did ; not identify noncompliance with Federal requirements that were reviewed in relationship to , these facility reported incidents and complaint. ' Survey activities consisted on a review of 70 · resident records, observations of resident care ; and staff practices, and interviews of residents, 1 residents' family members, and facility staff. Additionally, administrative records and resident 1 care policies were reviewed. ! The facility is licensed for 285 comprehensive 1 beds. At the time of this survey the facility · census was 235 beds. S 292 10.07.02.07-10(1) Emp Train on Cog Impairment 1 and Mental Illnes , .07-1 Employee Training on Cognitive Impairment I 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	S 000 5292	*S292* Employee Training on Cognitive impairment and Mental Illness **With respect to the specific resident/situation cited:** Both staff members recei,·ed the required training. With respect to how the facility will identify residents/situations with the **potential for the identified concerns:** The Administrator will audit team members who has been hired in within the past six months to evaluate cogniti,·e impairment training completion. **With respect to what systematic** measures ha,·e been put into place to **address stated concern:** The cognitive impairment training has)teen added to the onboarding	5/1(1?

REGULATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TInE	(XS)DATE
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STATEMENT OF DEFICIENCIES AND Pl.AN OF CORRECTION	IX1J PROVIDER/SUPPLIER/Cl.IA IDENTIFICATIONNUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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s 292	Continued From page 1 Occupations Article, Annotated Code ol Maryland, or who assist residents with activities of daily living; an This Regulation is not met as evidenced by: Based on surveyor review of employee files and interview with the facility administrator it was determined that the facility staff failed to ensure . that all employees receive a minimum of 8 hours · of training on cognitive impairment and mental : illness within the first 90 days of employment. : This finding was evident for 2 of 7 employee files reviewed during the survey process. The findings · include: On 03-30-1B at 12 PM surveyor review of the ' sampled employee files revealed that 2 of the 7 . employees had not received the minimum **8** · hours of training on cognitive impairment and , mental illness within the first 90 days of · employment. This included staff #6 who was hired 12/11/17. The second employee was hired ; on 1/15/18. · On 03-30-18 at 2 PM during surveyor interview i with the facility administrator it was confirmed : that the 2 employees hadn't received the required , training due to changes in the personnel whose · responsibility it was to provide the training. The administrator stated that an audit of all employees was done and any employee who needed the training was scheduled for a class to be held on 04-10-18.	S 292	orientation (classroom orientation) for licensed employees. **With respect to ho\\' the plan of correction will hemonitored:** The Administrator will audit team members who ha\'e been hired monthly for three months to evaluate cognitive impairment mining completion. During and at the conclusion of the audit and reponing period, the QAPI committee will re-evalualc and initiate any necessary action or extend the rc\·iew period. The Nursing Home Adrninis1rutor is responsible for confirming implementation and ongoing compliance with the components of the Plan of Correction and addressing and resolving variances that may occur. -	
S 506	10.07.02.12 0 Nsg Svcs;Care 24 Hrs per Day .12 Nursing Services.	S 506	2 POC for F658, F689	3/18

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STATEMENT OF DEFICIENCIES AIID PLAN OF CORRECTION	(X1J PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2J MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 506	S 506 Continued From page 2 , 0. Nursing Care--24 Hours a Day. There shall be 1 sufficient licensed and supportive nursing service i personnel on duty 2 hours a day to provide appropriate bedside care to assure that each patient: • (1) Receives treatments, medications, and diet as 1 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. ; This Regulation is not met as evidenced by: · Refer to CMS 2567 F658,F689	S 506		
S1686	10.07.02.36 D Resident Status Assessment; assessments · .36 Resident Status Assessment. D. The facility shall complete all assessments in accordance with the provisions of 42 CFR 1 ! §§483.20 and 413.343. This Regulation is not met as evidenced by: Refer to CMS 2567 F641	S1686	22 POC for F656	5/8/18

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51730	Continued From page 3	S1730		
51730, 10.07.02.37 E Care Planning; Organization of , plan		S1730	See POC for F656	5/8/18
	1 .37 Care Planning.			
	I E. Organization of Care Plan. 1 (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 i 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.			
S5093 10.0 7.09.08 C (1) Right to reasonable 1 accommodation		55093	See POC for F5588	5/8/18
	.. 08 Resident's Rights and Services.			
	· C. A resident has the right to: · (1) Reside and receive services in a nursing 1, facility with reasonable accommodations of individual needs and preferences, except when accommodations would endanger the health or			

STATEMENT OF DEFICIENCIES AND PIAIIOF CORRECTION	CX11 PROV1DERISUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSI'RUCIIDN	(X31DATE SURVEY COf,1?LETED
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S5093	S5093, Continued From page *4* : safety of the resident or other residents; This Regulation is not met as evidenced by: Refer to CMS 2567 F558	S5093		
ss10s	10.07.09.09 H Res Bill Rights; Notify resident of r 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	ele POC for F580	1/8/18
S6175	10.07.09.11 D Involl Transf/Dischg; Contin Care facil .11 Involuntary Discharge or Transfer of a Resident. D. A continuing care facility certified under Article 70B, Annotated Code of Maryland, is not subject to §8 of this regulation if the: (1) Facility transfers a resident to a lesser level of care within the same facility in accordance with a This Regulation is not met as evidenced by: Refer to CMS 2567 F580	S6175	2 POC for F582	1/8/18

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S6175	Continued From page 5 contract between the facility and the resident; and (2) Transfer is approved by the resident's attending physician. ; This Regulation is not met as evidenced by: ' Refer to CMS-2567. • F582	S6175		
ss21t	10.07.09.12 C (2) Res Reloc/bed hold;notice at , transfer I j.12.Resident Relocation and Bed Hold, . C. Notice. '. (2) Notice of Bed-Hold Policy at Time of Transfer. : Al the time of transfer of a resident *to* a hospital ' or for therapeutic leave, a nursing facility shall 1 provide a written notice to the resident, or when i applicable, the resident's representative or interested family member, which specifies the duration of the bed-hold policy described in §C of this regulation.] j This Regulation is not met as evidenced by: I Refer to CMS-2567. : F625. i	S6217	) yoC. for r&J.S	s/1/ie
S6285,	10.07.09.14 C (1) Phys/Chem Restr;Psycho · Drugs,indica!ion.. I .14 Physical and Chemical Restraints. C. Use of Psychopharmacologic Drugs. When a . physician prescribes psychopharmacologic drugs - for a resident, the residenfs clinical records shall · contain all of the following documentation:	S6285	r)U.. y()C f,r 'FJS'S'	5//1Y

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	S6285 Continued From page 6	S6285		
	(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. ; F758			
	S6647. 10.15.03.06 A Food Protection During Storage, : Service and T	56647	ee Poc for FSK	12/19
	.06 Food Protection During Storage, Service, and , Transport. . The person-in-charge shall ensure that: A. Al all times: (1) Food is: (a) Not adulterated; and			
	(b) Protected from contamination during storage, 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 microorga:,isms 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 §8(7) of this regulation;			

PRINTED: 04/19/2018
FORM APPROVED

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215099	A. BUILDING _____	C 03/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HEALTH CARE CENTER	301 RUSSELL AVENUE GAITHERSBURG, MD 20877

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S6 647	Continued From page 7 This Regulation is not met as evidenced by: Refer to CMS F 812	56647		
56655	10.15.03.06 B (7) Food Protection During Storage, Service and T .06 Food Protection. B. When Storing and Holding. (7) Except as provided in §8(8)-(14) of this regulation, the internal temperature of a potentially hazardous food is kepi a: 41F or less or 135F or greater; This Regulation is not met as evidenced by: Refer to CMS 2567 F 812.	56655	see POC for F812	5/8/18

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Meth od is t Vil]age
Anticipate More

201 Russell Ave., Gaithersburg, MD 20877 | 301.216.4001 | AsburyMethodistVillage.org

August 24, 2017

Dear Mrs. Schoonover and Mrs. Melodini,

Please see the attached plan of correction for The Wilson Health Care Center, provider number 121-5099, for the complaint survey conducted on June 19, 2017 during which it was determined that the facility was not in substantial compliance with Federal requirements for nursing homes participating in the Medicare and/or Medicaid programs. Should you have any questions, please contact me at 301-216-4085.

Yours truly,

Rachel S. Karish, LNHA
Administrator, The Wilson Health Care Center

MARYLAND
Department of Health
La rry Hog:m, Go\'cmor · Iloy<l Rutherford, **Lt.** Governor · Dennis Schrader, Secretary

August 14, 2017

Ms. Rachel Karish, Administrator
Wilson Health Care Center
301 Russell Avenue
Gaithersburg, MD 20877

RE: NOTICE OF PAST NON-COMPLIANCE ACTUAL HARM, AND POSSIBLE IMPOSITION OF OTHER REMEDIES

Dear Ms. Karish:

On June 19 and 20, 2017 , a complaint survey was conducted at your facility by the Office of Health Care Quality to determine if your facility was in compliance with Federal requirements for nursing homes participating in the Medicare ai1d/or Medicaid programs. This survey found that your facility was not in compliance with the requirements that were reviewed in relationship to the facility reported incidents and complaints investigated during this survey. This survey did identify past non-compliance at the actual harm level.

All references to regulatory requirement s contained in this letter are fou•, J in Title 42, Code of Federal Regulations (C.F.R.), COMAR Title I0, and the State Government Article..

I. PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within IO days after the facility receives its Form CMS 2567. Failure to submit an acceptable PoC within the above time frames may result in the imposition of a civil money penalty twenty (20) days after the due date for submission of the PoC.

Your PoC must contain the following:

Whal corrective action will be accomplished for those residents found to have been affected by the deficient practice;

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

What measures will be put into place or what systemic changes you will make to ensure

that the deficient practice docs not recur;

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place and;

Specific date when the corrective action will be completed.

References to a residcnt(s) by Resident# only. This applies to the PoC as well as any attachments to the PoC. It is un-acccptablc to include a resident(s) name in these documents since the documents are released to the public.

II. IMPOSITION OF REMEDIES

The following remedies will be recommended for imposition by the Center for Medicare and Medicaid Services (CMS) Regional Office if your facility has failed to achieve substantial compliance by September 30, 2017. Informal dispute resolution for the cited deficiencies will not delay the imposition of the enforcement actions recommended on this date. A change in the seriousness of the noncompliance may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

If you do not achieve substantial compliance within 3 months after the last day of the survey (Le.September 30, 2017) identifying non-compliance, we must deny payments for new admissions. (§488.417(a)) Also, if the denial of payment for new admissions sanction is imposed, your facility is prohibited from operating a nurse aide training program for two ye<1:rs from the last dayof the survey. (§483.15))

If your facility has failed to achieve substantial compliance by December 20,2017, your Medicare provider agreement will be tcm1inated.

111. ALLEGATION OF COMPLIANCE

If you believe that the deficiencies identified in the CMS form 2567 have been corrected, you may contact me at the Office of Health Care Quality, Spring Grove Center, Bland Bryant Building, 55 Wade Avenue, Catonsville, Maryland 2 I228 with your written credible allegation of compliance (i.e. **attached lists of attendance at provided training and/or revised statements of policies/procedures and/or staffing patterns with revisions or additions).**

If you choose and so indicate, the PoC may constitute your allegation of co·: jJliance. We may accept the written allegation of compliance **and credible evidence** of your allegation of compliance until substantiated by a revisit or other means. In such a case, the previously proposed remedy(ics) will not be imposed at that time.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we may impose remedies previously mentioned in this letter beginning June 20, 2017 and will continue until substantial compliance is achieved. Additionally, we may impose a revised remedy(ics), based on changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

IV. INFORMAL DISPUTE RESOLUTION

In accordance with §488.331 , you have one opportunity to question cited deficiencies through an infom1al dispute resolution process. To be given such an opportunity, you arc required to send your written request, along with the specific dcficicncy(ics) being disputed, and an explanation of why you arc disputing those deficiencies, to Ms. Margie Heald, Deputy Director, Office of Health Care Quality, Bland B1)'anl Building, Spring Grove Center, 55 Wade Avenue, Catonsville, Maryland 21228 , fax 4 I0-402-8234. This request must be sent during the same l0 days you have for submitting a PoC for the cited deficiencies. An incomplete infomrnl dispute resolution process will not delay the effective date of any enforcement action.

V. LICENSURE ACTION

As you are aware, the cited Federal deficiencies have a counter part in State regulations. These deficiencies arc cited on the enclosed State Form. Please provide a plan of correction for these deficiencies within IO days of receipt of this letter. In the event a revisit determines that substantial compliance has not been achieved , appropriate administrative action may be taken against your State license.

If you have any questions concerning the instructions contained in this letter, please contact me at 4I0-402-8201 or fax 410-402-8234.

II Sincerely ,

Executive Director
Office of Health Care Quality

Enclosures: CMS 2567
State Fonn

cc: Paul Ballard
Jane Sacco
Ronda Washington
Stevanne Ellis
rile II

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215099	A. BUILDING _____ B. WING	C 06/20/2017

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F 000	INITIAL COMMENTS	F 000		

On 06-19-17 and 06-20-17, a survey was conducted at this facility by the Office of Health Care Quality to investigate complaint MD0011251 and facility self report MD00114409. In addition, 7 other facility self reports were presented by the facility and investigated. Survey activities included review of clinical and personnel records, interview of residents and facility staff and observation of resident and facility staff practices.

The following Federal deficiencies are the result of this visit:

F 241 SS=C — 483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY

(a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident.
This REQUIREMENT is not met as evidenced by:
Based on surveyor observation, review of the clinical record and staff interview, it was determined that the facility staff failed to prevent access to medical information by others not directly involved with resident care. This finding was identified during the investigation of facility self report MD00114409. This finding was evident on all nursing units throughout the facility. The finding includes:

On 06-20-17, a closed record review of a resident care plan form for resident #2 revealed documentation of medical information which included code status (Cardiopulmonary

Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and/or State Law.

F 241

F241 Dignity and Respect of Individuality

With respect to the specific resident/situation cited:
The care plan form for Resident #2 was removed on 6/21/17.

With respect to how the facility will identify residents/situations with the potential for the identified concerns:
The care plan forms for all residents in the facility were removed on 6/21/17.

With respect to what systematic measures have been put into place to address stated concern:
Geriatric Nursing Assistants (GNA) will be reeducated on accessing and utilizing the Resident Summary Template careplan via the secure Vision kiosk system.

9/7/17

LA _9B :"T?RYDREC [O R'S JI PR? | W OER/IOF LIET;RE).PRESENTA ISNSIGNATURE TITLE (X6) DATE

r .Y JI\La iiffA J Nl-+A 8/24/17

Any yifetlciency 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 dale 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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F 241	Cont inued From page 1 Resuscitation); Comfort Care or Hospice; amount of assistance provided for eating, dressing, toileting, bathing and transfers; and incontinence care, in addition to other medical information. On 06-20-17 at 1:40 PM, interview with the Director of Nursing revealed the aforementioned resident care plan form was called a "closet care plan" as it is maintained on the inside of each resident's closet throughout the facility to provide bedside information to caregivers. On 06-20-17 at 2:25 PM, surveyor observation of resident rooms on all floors of the facility revealed the presence of the "closet care plans" inside resident closets in both private and semi-private rooms. On 06-20-17 at 4:20 PM, interview with the Administrator revealed that facility staff have no way of knowing who is reading the information posted in the resident's closets pertaining to the individual resident's physical or mental health condition (protected health information).	F 241	**With respect to how the plan of correction will be monitored:** The Nurse Manager or designee will conduct random audits to confirm GNA access and utilizatio n of the Resident Summary Template via the secur e Vision kiosk system weekly for four weeks, and then monthly for two months. The Director of Nursing or designee will report the results of the audits at the Quality Assurance and Performance Improvement (QAPI) mee tings. During and at the conclus n of the audit and reporting period, the QAP I commit tee will re-evaluate and initiate any necessary action or exte nd the review period. The Nursing Home Administrato r is res ponsible for confirming implementation and ongoing compliance with the components of the Plan of Correction and addressing and resolving variances that may occur.	
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care	F 309		q_}J/17

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F 309	Continued From page 2 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, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on review of the closed clinical record, it was determined that the facility staff failed to follow the physicians treatment order for a deteriorating sacral wound, and failed to adequately coordinate care for a resident with a wound. This finding was identified during the investigation of complaint MD00112551. The finding includes: 1. a. On 06-20-17, review of the closed clinical record revealed that resident #1 was assessed as having a sacral wound in February of 2017. On 02-18-17 at 10:42 PM, the charge nurse	F 309	**F309 Provide Care and Services for Highest Well Being** **With respect to the specific resident/situation cited:** Resident #1 has been discharged from the facility. **With respect to how the facility will identify residents/situations with the potential for the identified concerns:** The Director of Nursing or designee will audit residents with current orders for pressure ulcer treatment to confirm order transcription and order follow-through. The Director of Nursing or designee will audit wound physician recommendations for current residents with pressure ulcers who are followed by the wound physician, to confirm primary care physician (PCP) notification of recommendatio ns and wound status. The Director of Nursing or designee will audit current residents with pressure ulcers who are followed by the wound physician, to confinn the notification of the wound physician of deterioration of wound status if applicable.	

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F 309	Continued From page 3 documented that resident #1 was observed with a stage Ill sacral wound . (A stage Ill wound is a full thickness loss of skin in which fat is visible). The attending physician was notified and ordered a daily treatment and wound care consultation. 02-22-17 , the wound doctor visited resident #1, and diagnosed a right buttock abscess. 100% of the necrotic (dead) tissue was removed at that time. On 02-23-17, the attending physician visited resident #1 and documented a small decubitu s (pressure ulcer) on the sacrum. There was no change in the treatment on that date. On 02-27-17, the attending physician again visited resident #1 and documented the presence of a "deep sacral wound". Based on the deterioration of the wound, the attending physician increased the frequency of the wound treatment to twice daily, however, there was no evidence in the clinical record that the treatment was administered twice daily on 02-27-17 . On _____, the resident was transferred to the emergency room and admitted to the hospital with an infected pressure ulcer. b. In addition, the facility staff failed to adequate ly coordinate care between the attending physician and the wound doctor. On 02-22-17, the wound doctor removed the necrotic tissue and recommended warm compresses and a topical (applied on the body) antibiotic ointment on the area. This recommendation, located in the closed clinical record, was·received by the facility on	F 309	The Director of Nursing or designee will audit current reside nts with pressure ulcers who are followed by the wound physician to confirm the presence of wound physician documentation in the chart. **With respect to what systematic measures haYe been put into place to address stated concern:** The Director of Nursing or designee will reeducate licensed nurses on timely order transcription for pressure ulcer treatments, pressure ulcer treatment order follow-thr ough, timely PCP notification of wound physician recommendations, wound physician notification of PCP observations when appropriate, and maintaining wound physician documentation on the resident chart. The Medical Director or designee will reeducate the wound physician on providing notes and recommendations in a timely fashion to the facility. **With respect to how the plan of correction will be monitored.** The Director of Nursing or designee will audit current orders for pressure ulcer treatment to confirm order transcription and order follow -through weekly for four weeks, and then monthly for two months .	

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F 309	Continued From page 4 one day after the residenthad been admitted to the hospital with a wound infection. The investigation also revealed that, on 06-23-17 at 8:50 AM, during an inteNiew with the attending physician, it was noted that he/she was unaware of the wound doctor's recommendation for treatment to the debrided area, or of the recommendation for oral antibiotics. There were no notes written by the wound doctor in the clinical record related to his/her consultation and wound debridement for the attending physician to review. Further review of the clinical record revealed no documented evidence that the facility staff had informed the attending physician of the wound doctor's diagnosis of an abscess right buttock, or of any recommendations after the debridement. There was also no evidence that the facility staff notified the wound doctor of the deterioration of the wound, or the change from an abscess to a deep sacral decubitus. On 06-23-17 at 10:25 AM, inteNiew with the Assistant Director of Nursing revealed that the wound doctor makes rounds in the facility each week, but does not document in the clinical record. The facility receives the wound doctors written notes, including recommendations, about a week after the visit..	F 309	The Director of Nursing or designee will audi t wound physician recommendations for current residents with pressure ulcers to confirm primary care physician(PCP) notification of recommendations weekly for four weeks, and then monthly for two months. The Director of Nursing or designee will audit current residents with pressure ulcers to confirm the notification of the wound physician when appropriate weekly for four weeks, and then monthly for two months. The Director of Nursing or designee will audit current residents with pressure ulcers who are followed by the wound physician to confirm the presence of wound physician documentation in the chart weekly for four weeks, and then monthly for two months. The Director of Nursing or designee will report the results of the audits at the Qua lity Assurance and Performance Improvement (QAPI) meetings. During and at the conclusion of the audit and reporting period, the QAPI committee will re-evaluate and initiate any necessary action or extend the review period.	
F 323 SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) Theresident environment remains as free	F 323		?us} n11A - r 6,""(ll1<Ml(_

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F 323	Continued From page 5 from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on surveyor observation, review of the closed clinical records and administrative records, it was determined that the facility staff failed to prevent a resident from sustaining a fall with resulting injury. This finding was identified during the investigation of facility self report MD00114409. This finding was evident in 1 of 11 residents selected in the survey sample. Review of the facility's plan of correction implemented immediately after the incident resulted in the citation being cited as past non-compliance. The findings include: On 06-19-17, a review of the closed clinical record revealed that resident #2 sustained a fall	F 323	The Nursing Home Adm.inistrator is responsible for confirming implementation and ongoing compliance with the components of the Plan of Correction and addressing and resolving variances that may occur. Past noncompliance: no plan of correction required.	

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F 323	Continued From page 6 from a raised bed during the provision of care b a Geriatric Nursing Assistant (GNA), on requiring transport to an acute care hospital. The resident was diagnosed with a right clavicle (collarbone) and rib fractures in the emergency room. Further review of the clinical record revealed that resident #2 had a care plan which instructed facility staff that the resident required 2 staff members for transfer, as well as 2 staff members, for turning and repositioning. This care plan was located in the clinical record, with a copy posted in the resident's room inside the closet door. On 06-19-17, a review of administrative records revealed that a family member approached the nurses station to request assistance for resident #2. Two GNA's transferred resident #2 from the wheelchair to the bed, however, one GNA exited the room prior to the provision of care, leaving only **1 GNA** to turn and reposition the resident during incontinence care. On 06-19-17 at 11:00 AM, interview with the Director of Nursing revealed that administrative records accurately de vents resulting in resident #2's fall on he Director of Nursing stated that care plans are placed in each resident's closet to allow direct caregivers ready access to information regarding the provision of care. The Director of Nursing stated that the GNA did not follow the facility's protocol to check the closet **rior** to providing care to resident #2 on	F 323		

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F 323	Continued From page 7 On 06-20-17 at 1:40 PM, interview with GNA staff member #1 revealed that he/she failed to look at the care plan in the closet prior to turning and repositioning resident #2. He/she acknowledged awareness that the resident required two people for turning and positioning, and normally had assistance to perform this task GNA staff member #1 stated that, on [redacted] as he/she turned the resident to apply an incontinence brief, resident #2 reached for something and fell off the opposite side of the bed landing on the floor. Further review of administrative records revealed that the facility had identified and implemented immediate corrective action on 05-26-17. The corrective action included: acknowledgement by the facility that all residents had the potential to be affected by the deficient practice of failing to follow the plan of care. As a result, a review of all current physicians orders, care plans in the clinical records, and closet care plans was conducted to ensure consistency and accuracy of the information utilized by the direct caregivers in the provision of care. 100 % of all clinical records were reviewed for compliance. Discrepancies were immediately corrected. This was completed on 05-26-17. The DON provided evidence of the reviews by presenting completed audit tools for surveyor verification. The audit tool also reflected the changes made when inaccuracies were discovered. The surveyor also verified that resident #2 was included in the audit, and that corrective action had been taken to revise his/her care plan to reflect the current physicians orders for transfer. Surveyor observation of random rooms on each	F 323		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HEALTH CARE CENTER	301 RUSSELL AVENUE **GAITHERSBURG, MD 20877**

(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 323	Continued From page 8	F 323		

nursing unit, on 06-20-17, verified that the information reflected in the closet care plan was consistent with the plan of care in the clinical record and the physician order sheet in the clinical record.

90% of the nursing staff had been inserviced on the importance of adhering to the information provided in the plan of care, with particular attention given to safe transfer of residents, by 06-05-17. The remaining staff had been scheduled to receive the inservice education on the next scheduled day of their return to work, with a plan to have the remaining 10% completed by 07-05-17. A review of the signature sheets by the surveyor reflected both licensed and non-licensed signatures for staff members on all three shifts. The agenda for the training included turning and repositioning, transferring, and adherence to the number of staff members required for each, as reflected in the plan of care.

The Unit Managers were assigned the responsibility to audit the clinical record of all new admissions to verify consistency and accuracy between physician orders, care plans, and closet care plans, to prevent recurrence.

Additionally, the Unit Managers were responsible for random observation of the direct caregivers compliance with the instructions reflected on the closet care plans on a monthly basis. The surveyor requested, and received for review, the audits that had been conducted prior to the complaint survey. Additionally, the surveyor verified (by interview of the Unit Managers) that the audits were based on observation of care, and comparison of care, as per the physicians order sheet and plan of care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215099	A. BUILDIN_G _ _ _ _ _ _ _ 8 WING _____	C 06/20 /2017

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F 323	Continued From page 9 The Director of Nursing stressed that the audits were unscheduled, random observations. The Director of Nursing also informed the surveyor that the evening and weekend supervisors had also been instructed to conduct the same audits on off shifts. Results of the audits and compliance rates are to be presented to the Quality Assurance Committee. Surveyor review of the May 2017 Quality Assurance Minutes reflected the fall and injury of resident #2 and the corrective action taken immediately and plan for additional corrective action and ongoing monitoring. The corrective action also included ongoing compliance monitoring during their Nurse Manager meeting (held twice weekly) once consistent compliance has been achieved to prevent recurrence.	F 323		
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (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; (iii) Readily accessible; and (iv) Systematically organized	F 514	**F514 Resident Records- Complete, Accurate and Accessible** **With respect to the specific resident/situation cited:** Resident #1 has been discharged from **the facility.** **With respect to how the facility will identify residents/situations with the potential for the identified co cerns:_** The Director of Nursing or des1gnee will audit current residents with pressure ulcers to confirm the presence of wound site/location, condit ion of the wound, and presence of drainage documentation within the Daily Skilled Assessment Form.	9/7/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X 2) MULTIP LE CONSTRU C TION	(X3) DATE SURVEY COMPLETED
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F 514	Continued From page 10 (5) The medical record must contain- (i) Sufficient information to identify the resident: (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services 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 review of the closed clinical record, it was determined that the facility staff failed to insure the clinical record accurately reflected the deterioration of a wound. This finding was identified during the investigation of MD00112551. This finding was evident in 1 of 11 residents selected in the survey sample. The findings include: On 02-18-17 at 10:42 PM, the charge nurse documented that resident #1 was observed with a stage III sacral wound. (A stage III wound is a full thickness loss of skin in which fat is visible). The attending physician was notified and ordered a daily treatment and a wound care consultation. 02-22-17, the wound doctor visited resident #1, and diagnosed a right buttock abscess. 100% of the necrotic (dead) tissue was removed at that	F 514	The Director of Nursing or designee will audit current residents with pressure ulcers to confirm the presence of licensed nurse documentation of pressure ulcer progression within the clinical record. The Director of Nursing or designee will audit current residents with pressure ulcers to confirm the presence of PCP documentation of wound description within the clinical record. The Director of Nursing or designee will audit current residents with pressure ulcers who are followed by the wound physician to confirm the presence of wound physician documentation in the cha1t. **With respect to what systematic measures have been put into place to address stated concern:** The Director of Nursing or designee wm reeducate licensed nurses on completion of the Daily Skilled Assessment Form and on documenting pressure ulcer progression within the clinical record. The Medical Director or designee will reeducate PCPs on documenting pressure ulcer wound descriptions within the clinical record.	

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F 514	Continued From page 11 time (debrided). On 02-23-17, the attending physician visited resident #1 and documented a small decubitus (pressure ulcer) on the sacrum. On 02-27-17, the attending physician again visited resident #1 and documented the presence of a "deep sacral wound". On 06-20-17, review of the closed clinical record for resident #1 revealed incomplete documentation by the licensed nurses on the Daily Skilled Assessment form, omitting the description of the wound's site/location, omitting the condition of the wound, and omitting details such as the presence of drainage within the wound, on 02-23-17, 02-25-17, 02-26-17, and 02-27-17. There were two additional undated assessment forms which lacked the aforementioned documentation. Further review of the clinical record revealed no documentation by facility staff between the attending physician's visits from 02-22-17 until 02-27-17 to address the apparent progression of resident #1's wound. (the wound deteriorated from a "small decub" (pressure injury), to a "deep sacral wound". The attending physician also failed to write a description of the wound (i.e. measurements, percent of necrosis, drainage etc). in the progress note. Finally the wound care physician failed to provide documentation in the clinical record for the facility staff and the primary care physician to review his/her assessment and recommendations until after the resident had been discharged to the hospital with a wound infection. The facility	F 514	The Medical Director or designee will reeducate the wound physician on providing notes and recommendations in a timely fashion to the facility. **With respect to how the plan of correction will be monitored.** The Director of Nursing or designee will audit current residents with pressure ulcers to confirm the presence of wound site/location, condition of the wound, and presence of drainage documentation within the Daily Skilled Assessment Form weekly for four weeks, and then monthly for two months. The Director of Nursing or designee will audit current residents with pressure ulcers to confirm the presence of licensed nurse documentation of pressure ulcer progression within the clinical record weekly for four weeks, and then monthly for two months. The Director of Nursing or designee will audit current residents with pressure ulcers to confirm the presence of PCP documentation of wound description within the clinical record weekly for four weeks, and then monthly for two months.	

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F 514	Continued From page 12 staff failed to ensure sufficient and accurate information in the clinical record related to the debrided wound.	F 514	The Director of Nursing or designee will audit cmTent residents with pressure ulcers who are followed by the wound physician to confirm the presence of wound physician documentation in the chart weekly for four weeks, and then monthly for two months. The Director of Nursing or designee will report the results of the audits at the Quality Assurance and Performance Improvement (QAPI) meetings. During and at the conclusion of the audit and reporting period, the QAPI committee will re-evaluate and initiate any necessary action or extend the review period. The Nursing Home Administrator is responsible for confirming implem entation and ongoing compliance with the components of the Plan of Correction and addressing and resolving variances that may occur.	

Office of Health Care Quality

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S 000	10.07.02 Initial comments On 06-19-17 and 06-20-17, a survey was conducted at this facility by the Office of Health Care Quality to investigate complaint MD0011251 and facility self report MD00114409. In addition, 7 other facility self reports were presented by the facility and investigated. Survey activities included review of clinical and personnel records, interview of residents and facility staff and observation of resident and facility staff practices. The following state COMAR deficiencies are the result of this visit:	S 000		
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. This Regulation is not met as evidenced by: Refer to CMS F-309 and F-323	S 512	Please see POC for F309	q)7)t)
S1090	10.07.02 .20 Clinical Records .20 Clinical Records. A. Records for all Patients. Records for all	S1090	Please see POC for F5l 4	C/)7)P

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X 6) 0 ATE

Rachel D. Davis — /VF!A — . I(/::i.'-f)t)

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S1090	Continued From page 1 patients shall be maintained in accordance with accepted professional standards and practices. B. Contents of Record. Contents of record shall be: (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; {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; (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; (4) Authentication of hospital diagnoses {discharge summary, report from patient's attending physician, or transfer form); {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}; {6} Medical and social history of patient; {7) Report of physical examination; (8) Diagnostic and therapeutic orders; (9) Consultation reports; (10) Observations *and* progress notes; (11} Reports of medication administration, treatments, and clinical findings; (12} Discharge summary including final diagnosis and prognosis; {13) Discipline assessment; and (14) Interdisciplinary care plan. C. Staffing. An employee of the facility shall be designated as the person responsible for the overall supervision of the medical record service.	S1090		

Office of Health *Care* Quality

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S1090	Continued From page 2 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 F-514	S1090		
S5090	10.07.09.08 A Res Rights/Svcs;general .08 Resident's Rights and Services.	S5090	Please see POC for F241	7/7/17

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STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S5090	Continued From page 3 A. A nursing facility shall provide care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect, and in full recognition of the resident's individuality. This Regulation is not met as evidenced by: Refer to CMS F-241	S5090		

BURY ' 1 ,
Methodist Village
Anticipate More
201 Russell Ave.. Gaithersburg, MD 20877 30 1.216.40 01 AsburyMcthod1stV1llagc.org

February 21, 2019

Dear Mrs. Reed and Mrs. Melodini,

Plea see th intacbed plan of orrection for The Wils0rl Health Car e nter, pr vider number 121-5099, for th"-annual urvey c nducted on January 28l11 through eb rua ry I , 2019 during which it was deteni1ined t hat the fac ility was not in substan.tial compliance with Federal requir m n for nur sing home · parti i pating in the Medicare and/or Medieaid program . h uld yo.u hav.e any question , pleas contact m at 30 l -216-4 085.

Yours truly,

Rachel D. Karish

Rachel S. Karish, LNHA

Rachel S. Karish, LNHA

Administrator, The Wilson Health Care Center

STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION	()(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATIONNUMBER:	(X2) MULTIPLE CONSTRUCTION	(XS) DATE SURVEY COMPLETED
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WILSON HEALTH CARE CENTER	3D1 RUSSELL AVENUE GAJTHERSBURG, MD 20877

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F 000	INITIAL COMMENTS The following deficiencies are the result of the annual survey conducted by the office of Health Care Quality on January 28, 29, 30, 31 and February 1, 2019, to determi,ln.e the facility's compliance with Medicare/Medicaid requirements. Survey activities consisted of a review of 41 residents' records, observationof 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 In addition to standard survey protocols, complaints #MD00134750, #MD00134974, #MD00135081 and facility reportei;I incidents #M00134436, #M000135727 and an additional facility reportedIncident which was provided to the survey tearn was reviewed, This surveydid not Identify noncompliance with Federal requirements that were reviewed in relationship lo these complaints and facility reported incidents. The faolllly Is licensed for 285 comprehensive beds. At Ume of this survey the facility census was 232.	F 000	**Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of facts alleged or conclusions set forth in the Statement of Deficiencies.** The **Plan** of Correction is prepared solely as n matter of compliance ,vith Federal and/or State Law.	
F 561 SS=D	Self-Determination CFR(s): **483.1**O(f){1**)-(3)(8)** §483.10{f} Self-determination. The resident has the right to and the faollity must promote and facilitate resident self-determination through support of resident choice. Including but not limited to the rights specified in paragraphs (f}	F 561	**F561 Self•**Dete rmination **With respect to the specific resident/situation cited:** The Director of Nursing (DON) contacted resident #91's responsible party (RP) on 1/31/19 and clarified the resident's morning routine preferences. These preferences were incorporated into resident #9I 's plan of care.	2/7/19

JORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATM!'S SIGNATURE TITLE (X)DA

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F 000	INITIAL COMMENTS The following deficiencies are the result of the annual survey conducted by the office of Health Care Quality on January 28, 29, 30, 31 and February 1, 2019, to determine the facility's compliance with Medicare/Medicaid req1,1irements. Survey activities consisted of a review of 41 residents' records, observation of resident care and staff prac tices, interviews of residents, residents' family members, the ombudsman, and facility staff. Additionally, administrative records and resident care policies were reviewed. In addition to standard survey protocols, complaints #MD0013475 0, #MD001349 4, #MD00135081 and facility rep o,rted incidents #MO0 1344 36, #MDOO135727 and an additional facility reported incident which was provided to the survey team was reviewed. This survey did not identify noncompliance with Federal requirements that were reviewed in relationship to these complaints and facility reported incidents. The facility is licensed for 285 comprehensive beds. At time of this survey the facility census was 232.	F000	**Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and/or State Law.**	
F 561 SS=D	Self-Determination CFR(s): 483.1O(f)(1)-(3)(8) §483.1O(f) Self-determination. The .resident has tl'le right to and the faaillty must promote and facllltate resident self-determlhat,lon fh.rough support of resident cholCEt, includIngbut not limited to tl:le rights specified In paragraphs (f)	F 561	**F561 Self-Determination** **With respect to the specific resident/situation cited:** The Director of Nursing (DON) contacted resident #91' s responsible party (RP) on 1/31/19 and clarified the resident's morning routine preferences. These preferences were incorporated into resident #91's plan of care.	7/19

Y DIRECTOR'SOR ROVIDER/SUPPLIER R RESENTATIVE'S SIGNATURE TITLE (X)OAT_E

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F 561	Continued From page 1 (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, review of the clinical record and interview of resident#9, their responsible party and facility staff, it was determined that the facility staff have a set schedule for waking residents up from bed, without consideration of resident preference. This finding was evident for 1 of 2 residents selected for the choices review (#91). The findings include: On 01-28-19, Surveyor review of resident#91's clinical record revealed that the resident was unable to make his/her own decisions. The resident was totally dependent on facility staff for all activities of daily living (basic task that must be	F 561	**With respect to how the facility will identify residents/situations with the potential for the identified concerns:** The Assistant Directors of Nursing (ADONs) will audit current residents who are unable to express their morning routine preferences verbally to evaluate documentation of **RP** contact to determine morning routine preferences, and inclusion of morning routine preferences in the plan of care. **With respect to what systematic measures have been put into place to address stated concern:** The Director of Education will in-service Licensed Nurses and Geriatric Nursing Assistants (GNAs) on obtaining and followine resident morning routine preferences, and documenting those preferences in the clinical record and plan of care. **With respect to how the plan of correction will be monitored:** The ADONs will audit newly admitted residents who are unable to express their morning routine preferences verbally to evaluate documentation of responsible party contact to determine morning routine preferences, and inclusion of rrioqiing ro1:1.t\ne preferences in the plan	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIACATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X:I) DATE SURVEY COMPLETED
	215099	A.B ULDING _ _____ B WING _ _ _ _ _ _ _	C 02101/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HEALTH CARE CENTER	301 RUSSELL AVENUE GAITHERSBURG, MD 20877

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCEI S (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
F 561	Continued From page 2 a0complishedevery day. This includes bathing, d essfr1g, transfer and toilelin). On 01-28-19 at 10:15 AM, surveyor observed resident #91 In a wheelchair sitting at an activity area sleeping while an activity was in progress. Gn 0.1-29-19 at 08:20 AM, surveyo obs rved reslden t#91 sitting alone in the hallway in a whee1ehair, Further observ.atlon on 01-30-18 at 07:04 AM, revealed the resident was out of bed In their wheelchair sleeping. On 01-30-19 at 07:15 AM, surveyo interview with staff #4 revealed that the night shift staff get the resident up et 5:30 AM every day. On 01-30-19 at 07:20 AM, surveyor interview with staff #5, who was the charge nurse for the 11-7 am shift, revealed that night staff were required to get some of the residents up ,e?rly to help in adjusting the day shift assignment. On 01-30-19 at 09:15 AM, surveyor Interview wlth the unit manager and the director of nursing revealed that the resident was a fall risk and must be gotten up early or else he/she may get up unassisted. However, there was no evidence ln resident #91's record to indicate that facility discussed this with resident's family member whq was the declsian m.aker. In addition, there was *np* evidence in the resident's plan of c.are to Indicate that resident #9.1 prefers to get up early ln: the m0mlng. On 01-30-19 at 12:50 PM, surveyor interview with resident's family member revealed that he/she was not aware that resident was getting up that	F 561	of care weekly for four weeks and monthly for three months. The Director of Quality Assurance will perform random audits of GNA morning Activity of Daily Living (ADL) ea re to evaluate GNA adherence to resident mornin g rout i ne preferences weekly for four weeks and monthl y for th ree months. During and at the conclusion of the audit and reporting period, the QAPI committee will re-evaluate and initiate any necessary action or extend the review pe riod. The DON is responsible for confirming implementation and ongoing compliance with the components of the Plan of Correction and addressing and resolving variances that may occur.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215099	A. BUILDING _____ B. WING _____	C 02/0112019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HEALTH CARE CENTER	301 RUSSELL AVENUE GAITHERSBURG, MD 20877

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACrl OEPICrf"NCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX 'fAG	PROVIDER'S PI.AN OF CORRECTION (EACH CORBECTNEAOTION SHOULOBE CROSS-REFERENCEDTO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
F 561	Continued From page 3 early in the morning. Secondly, resident #91 was not used to waking up early. On 01-M-19 at 2:40 PM, interview with the Director ot Nursing (DON) revealed no new information.	F 561		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resld.ent, the faojllty musl- (i) Notify the residenHind the resident's representative(s} of the transfer or discharge and the reasons for the move In writing and in a languageantl manner they- understancl. The facility must send a copy0f the noticeto a represen tative of the Office of the State LongTenn Oare Ombudsman. (ii) Re.cord the reasons for the trans-fer or discharge in the resident'smedi al record in accordance With paragraph (c)(i) of.this sectlon; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except'as specifled in paragraphs (c)(4)(ii) and (c){8) of:this section, the notice of Jransfer *or* di scharge rec,Wlred uhqer this seo\ion rn.ust be rnaqe by the facility at least 30 days before the resident is tr.ansferred or discharged. (ii) N0tice must be made as soon as prak tit able before ransfer or discharge when- (A) The safety of Individuals in th e faelllty would be endangered under paragraph (c)(1) (l)(C) of this section; (B) The health of individuals in the facility would	F 623	**F623 Notice Rcquiremcnl Bcforn Transfcr/Discl1arge** **With respect to the specific resident/situation cited:** Resident #61 no longer resides at the facility. Resident #152 and their RP was provided with written notification of the resident's hospital transfer. **With respc *t* to how the facility ,vm identify resid ents/ ituations with th potential for the identified concerns:** The ADONs will ai1dit residents who have transferred to the hospital within the past thirty days to evaluate written notification of hospital transfer to the resident/RP. **With respect to what systematic measures have been put into place to 1i"ddr,css stated concern:** The Director of Education will in-service Licensed Nurses on providing	5/7/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215099	A. BUILDING ______ B. WING ______	C 02/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HEALTH CARE CENTER	**301 RUSSELL AVENUE GAITHERSBURG, MD 20877**

(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 623	Continued From page 4 be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufflciently to allow a more imm!:!diate transfer or discharge, under paragraph (c)(1)(i)(B} of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragrapt, (c)(1)(i)(A) of this section.;or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (II) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and ernall) end telephone number of the Office of the State Lcmg Term Care Ombudsman; (vi) For nursing facll.iy residents with intellectual and developrnental disabilities or related disqbllltles, jhe malling and em::iil address ar:id telephone number of the agency responsible for the protecf1qn and advocacy of Individuals with devel9pmental dfsabllitles established under Part C qHhe Developmental Oisabilities Assistance and BIii of Rights Aot of 2000 (Pub. L. 106-402, codified at 42 0.S.C. 15001 et seq.); and (vii) For nursing facility fesldents with a mental	F 623	written notification of hospital transfer to the resident/RP. **With respect to how the plan of correction will be monitored:** The ADONs will udit residents who have ran fi rred to the hospital to eval uate written notiCicati'on of ho pita! tr<JI1Sfer to the re$ident/RP weekly for fotlr we ks and monLhly or three months. IDuring and at th e conclu s ion of the audit and reporti ng p riod lhe QA.P c mmh tce wilf re-evaluate and initiate any necessary action or extend the review period. Tb DON i respon ible for cpnfintiJng im plem ntati on and 0 11croing oompli anee with the component of the Plan of o(r cti n and addcessing and resolving v.a l'ianc s that may oc ur.	

STATEMENT OF DEFICIENCIES AND PIA I'J' OF CORRECTION	(X1) PROVIDERiSUPPLI fVCUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	. 215099	A B,UILDING _____ B WING _____	C 02/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HEALTH **CARE CENTER**	301 RUSSELL **AVENUE** **GAITHERSBURG, MQ 20877**

(X4) ID PREFIX TAG	SUMMA Y STATEMENT QF QEFIOfENGIES . (EACH DEFICIENCY MUST8E P.8EC:g[)ED 8Y FULL f{EGULATORYOR LSC IDENTIFYINGINFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIOt DATE
F 623	Continued From page 5	F823		

disorder or related disabilities, the mailing and email address and tetephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the Information in the notice changes prior to effecting tbe transfer or dischargethe fao!lity must update the recipients of the notice as soon as practicable once the updated information becomes available.

§ 483.15(0)(8) Notice in advance of facility closure
In the case of fadlity closure, the individual who Is the administrator of th·e facility must provide written notification prior to the trnpendlng closure to the State $urvey Agency, the Office of the State Long-Term Car·e Ombudsman,resident of the facility, and the resident repteser:t tives, as well as the plan for the transfer and adeqt1ate relocati0n of the reslden ts,1 as r:ecquireq at § 48'3.7 0(1),.
This REQUIREMENT is not met as evidenced by:
Based on surveyor review of the clinical records and interviews with facility staff, it was determined that the facility failed to to ensure that residents and1or the respqnslble parties were provided with written notincc1Uon of the residents' hospital transfers.This finding was evident for 2 of 5 residents seleotee:f for the Hospitalization review. (#61, #152) The findings include:

1. On 01-30-19, surveyor review of the closed clinical record for resident #61 revealed that, in November 2018, the resident had a change in condition. Further review revealed that staff

STATEMENT OF 01:;PICIENCIES AND PIA N o F CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPL ETED
	215099	A. BUILDING _____ B.WING _____	C 021011io1s

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HEALTH CARE CENTER	**301 RUSSELL AVENUE** GAITHERSBURG, MD 20877

(X4) ID PREFIX TAG	SUMMA'RY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST B!= PRECEIDED BY FULL F,tE OULATORY OR LSC IDENTIFYI G I\IFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE°CTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE **DEFICIENCY)**	(XS) COMPLETIm DATE
F 623	Continued From page 6 notlfied the attending physician, who then ordereq that"th.e resident be transferred to the hospital for fu rthe-r evaluation, Review of 'the - nwsing clinical note and the . Patient Transfer Form revealed that both resident #61 and tt:ie r:esldent's re ponsible party w ere notified by the nurse of the attending physician's order to. 'h ave the resident transferred to the hospital fdr further evalu,atlon. However, further record review revealed no evidence that the facility had sent writt.en notification of the resident's hospital transfer either to resident #61 and/or the resident's responsible party. On 01-31-19 at 11:15 AM, interview with the facility's administrator and the Director of Nursing revealed no additional information. 2. *On* 01:30 19 al 10:30 AM, surveyor review of *tne* clinical record revealed th 152 was transferred to the hospital on Review of the nurse's note Written on t 12:02 PM, revealed that the resident's representative was called and made aware of the transfer:. Hawever, there was no evidence that.written notlflcaUon was provided to resident #152 or hi,s/her represent live about the transfer to the hespital. On 01-27-19 at 11-:10 AM, the unit manager said the notification to the resident's representative was given by telephone; no written notification	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER :	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215099	A. BUILDING _____ — — — B. WIN_G _ _ _ _ _ _ _	C 02/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CIIY, STATE, ZIP CODE
WILSON HEALTH CARE CENTER	301 RUSSELL AVENUE GAITHERSBLIRG, MD 20877

(X4) ID PREFIX TAG	Sl.:JMMAAY. STATEMENT OF DEFIG:fENCIES '{EACH 'DEFIOIENCYMUST.BE PRECf:QED BY,t="ULL REGULATORY OR LSC ffIENTIFYiNG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
F 623	Continued From page 7 was given to resident #152 or the representative when the transfer occurred. On 01 28 19 at2:10 PM, interview with the director ofNursing (DON) revealed no additional information.	F 623		
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 pefore transfer. Before a, nursing facllity transfers a resident to a hospital or the resident.goes on therapeutic leave, the nursing facility must provide written informatioti to the residen.t or resident representative that specifles- (1) The duration of the stale bed-hold policy, if any-, dltring wt:lloh the resident Is permitted to return and resume residence in the nu rsing facility; ,(ii) The reserve bed payment policy in the state plan, under§ 447.40 of this chapter, If any:. (Iii) The nurs i ng facilil}'.'s policies regarqing bed-h0lq perl0ds, which mu$t be consistent w.lth paragraph (e)(1) of this section, permitting a resident to return; amJ (iv) The Information specified in paragraph (e){1) of this section. §4 .15(d)(2) Be©lh old notice upon .transfer. At the Ume of transfer of a resident for 'h osplta1lzaUon dr therapeutic leave, a n rsing fac ility must provkle to the resident and th e resident representative written notlc-e -Whlch specifl s the duration of t e bed-hold policy described ln_paragraph (d)(1). of this section. This REQUIREMENT Is not met as evidenced	F 625	**F62S Notice of Bed-hold Policy** **With respect to the specific resident/situation cited:** Resident #61 no longer resides at the facility. Resident #210's RP was provided with the facility bed-hold policy. **With respect to how the facility will identify residents/situations with the potential fo the identified concerns:** The ADONs will audit residents who have transferred to the hospital within the past thirty days to evaluate resident/RP notification of the facility [1] bed-hold policy, and completeness of the bed-hold notice given to residents/RPs. **With respect to what systematic measpres have been put into place to address stated concern:** The Director of Education will in-service licel}sed nurses on completing	1/7/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(XJ) DATE SURVEY COMPLETED
	215Q99	A. BUILDING ___ B.WING ___	C 02/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HEALTH CARE CENTER	301 RUSSELL AVENUE GAITHERSBURG, D 20877

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F 625	Continued From page 8 by: 'Based ©n surveyor review of clinical records, and Interview with facility staff, it was determined that the facility failed to ensure that written Iriformation about the fa0ilitY's bed hold pol!cy was provided to residents and/or the res idents irespon Jp l e pa jes t the time of a trarisfer to tl'le hospltaL J his finding was evident for 2 of 5 residents selected for the Hospitalization review; (#61,#210). The findings Include: 1. On 01-30-19, surveyor revi ew of the closed clinical recorq for resid ent t/6:1 reveale,d hat, in November 2018, the residenl had a ahange in condition. Further review revealed that staff had notified-the attending physician, who then ordered that the resident be transferred to the ospital f.Or furtt:ier evaluatDn. Review of the- Patient Tran sfer Form revealed that resident #61 was transferred to the hospital as physician ordered. However, further record review revealed no evidence that the facility had sent written notification to either the reslQent or the resident's responsible party of the facility's bed hold policy at the time of the hospital transfer. On 01-31-19 at 11:15 AM, interview with the fac ilHi s administrator and the Oirectnr of Nursing revealed no additim al Iriformatton. 2. On 01-29-19, review of the cUnieal record for reslident.#21.0 revealed that the resident was transfefred out of the faclHty via Emergency Medical Se rvices (EMS) on Further review of the clinical record for resident #21O revealed a bed hold acknowledgement form, dated - with only the name and	F 625	and providing the facility bed-hold policy to residents/RP' s upon transfer to the hospital. **With respect to how the plan of correction wiJl be monitored:** The ADONs will audit residents who have transferred to the hospital to evaluate resident/RP notification of the facility bed-hold policy, and completeness of the bed-hold notice given to residents/RPS weekly for four weeks and monthly for three months. During and at the conclusion of the audit and reporting period, the QAPI committee will re-evaluate and initiate any necessary action or extend the review period. The DON is respons ible for confirmi ng implementation and ongoing co rnplianc with the components of th e Plan of Correction and addr ess ing a nd resolv ing variances that may occ ur.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215099	A. BUILDING _____ B. WING _____	C 02/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HEALTH CARE CENTER	301 RUSSELL AVENUE GAITHERSBURG, MD 20877

(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 625	Continued From page 9 address of the resident. All' areas that required Information related to fees and the tied hold were left blank, 1, e. ther.e was no ihformatlon related to the holding of the bed or the charges that- would be incurred if the re-sident/respohsibte party chose to held the bed. There was no signature of the resident and/or representative or an y other evid nce In tl\le clinical record to indlcate that the bed hold inform ation had been provided at the Ume of transfer. On 01-31-18 at 1:15 PM, interview of the director of nursing provided no additional information.	F 625		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): **483.21(b)(1)** §483.21(b) Comprehensive Care Plans §48 3.21(b)(1) The facllity tnust develop and implement a comprehensive person-cen tered 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 medica,lm,rsing, *anq* m nJijl 1:md psych0sooial needs tliat are identified Ii:, the comprehensive assessment. The comprehensive care plan must describe the foll0wing - (i} The services that are to be furnished to attain *0r* ma1ntaln the resident's highest practicable physical, m ental, and psychoso cial wel 1-being as required, llr\der §483.24, §483.26 QF 9483.40; and (ii) AnY services that wal!ld othel\Vise be re qulred under §483 24, §483.25 pr §,483.:40 t:, ut are not provided due to the resktent's exercise of rights under §4 83.10, lnch,1dlng the right to refuse treatment under §48'3.1'0{c)(6). (iii) Any specia li zedservices or specialized rehabilitative services the nursing facility will	F 656	**F656 Devclo(! Com rehcnsi vc Care Plan** **With respect to the specific resident/situation cited:** Resident #486 no longer resides al the facility. **With respect to how the facility will identify residents/situations with the potential for the identified concerns:** The Social Service Coordinators will audit current residents to evaluate the presence of a discharge careplan within the clinical record. **With respect to what systematic measures have been put into place to address stated concern:** The Director of Social Services will in-service the Social Service Coordinators on including discharge plans in the comprehensive careplan for residents.	317/lq

'STATEMENTOF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	()(2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215099	A BUILDING _ _ _ _ _ _ _ _ 8. WIN_G _ _ _ _ _ _ _ _	C 02/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HEALTH CARE CENTER	301 RUSSELL AVENUE GAITHERSBURG, MD 20877

(X<!) ID PREFIX' TAG	.SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVI0.6RS PLAN OF CORRECTION (EACH CQRRECTIVEA TION SHIJU li> BE CROSS-REFERENCED TOTHEAPPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
f 656	Continued From page 10 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) Th resld.ent's goals for admission and desired outcomes. (B) Th e, residenf s preference arid potenfial for future dis hc1rge. Facilities tnust document whether the r esident's desire to return t0 the comm1,1nily was assesse el and any reterra ls to local cor.itact agencies and/or other appropriate entiti es, for this purpose. (C) Discharge plans in the comprehe,nsive care plan, as appropr!ate, in accordance with tli e requirements set fort h in parag raph (c} of this section. This REQUIREMENT is not met as evidenced by: Based on interviews with facility staff and record review, It was, deter mined that the facility faile d to inc lude dlscha ge plans in the comprehensive care plan of a resident. This was evident for 1 of 41 residents (#486) selected for re lew of care plans during this survey. The findings included: On 01-30-19 at 11 AM, surveyor review o f resident #4Et6's clinical record revealed no evidence of dis i 1arge plan s in the oomprehen?ive care plan. On 02..01-19 a 9!21 AM, interview with social worker #3 reveale no new information. On 02-01-19 at 3 PM, intervrew with the facility administrator revealed no new information.	F656	**With respect to how the plan of correction will be monitored:** The Director and Assistant Director of Social Services will audit newly admitted , • ident s to evalua te the presence of a discharge careplan within the clinical record weekly for four weeks and monthly for three months . During and at the conclusion of the audit and reporting period, the **QAPI** committee will re-evaluate and initiate any necessary action or extend the review period. The Director of Social Services is responsible for confirming implementation and ongoing compliance with the components of the Plan of Correction and addressing and resolving variances that may occur.	
F 658 SS=E	Services Provided Meet Professional Standards CFR(s'): 483. 21(b)(3)(i)	F658	**F658 Services Provided Meet Professional Standards** **With respect to the specific resident/situation cited:** Resident #147's order for Klonopin was clarified with the atte nding physician.	3}1/1

STATEMENT OF DEFICIENCIES fl.ND PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICAr.IO N NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215099	A BUILDING _ _ _ _ _ _ _ _ B WIN_G _ _ _ _ _ _ _ _ _	C 02/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HEALTH CARE CENTER	301 RUSSELL AVENUE GAITHERSBURG, MD 20877

(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)	(XS) COMPLETIOI DATE
F 658	Continued From page 11 §483:21(b)(3) Comprehensive Gare Plans The servicesprovided or ammged by the facility, as outlined by the comprehensive c.are plan, mlJst- (i) Meet professional standards of ql,Jallty. This REQUIR EMENT is not me t as evidenced **by:** Based oh surveyor **review** of the clinical records and Inter:vlew with the facility staff, it was determined that the licensed nursing staff failed to ensure standards of nursing practice in obtaining clarification of physiclai'i orders for wound treatment an.d niedication administration. This finding was evident for 2 of 41 residents selected for review during the survey. (#147, #157) The findings Include: 1. On 01-31-W at 11:30 AM, review of the clinical record for resident#147 reveE!led a physician's order dated 03-22-18, for klonipin 0.5 mg daily. However, revie w a f thf;) physician's progress note, dated 04-06 18, r§lvealed that the physician doc1:1mented that resident #147 was on klonipin 0.25 mg daily. In addltron, te view of the t,Aedlcation Administration Reooi:dsrell(ealed that nursing staff a.ocumented hey admi,nistered klonlpin0;5 tng from March 2018 tnro).Jgh January 2019. However, review of tin Controlled Medication Records revealed t.hat klonipin 0.5 mg, ½ tablets (0.25 mg) wer:e dellv red by the pharmacy and .administered QY the nursing staffFrotn March 2018 to January 2019.	F658	Resident # 157's wound care orders were clarified with the attending physician. **\With respect to how the facility will identify residents/situations ·with the potential for the identified concerns:** The ADONs will audit current residents wHh orders for Klonopin to eval 1ate the need for order clarification, and correct any variances noted. The Wound Nurse will audit current residents with a pressure ulcer to evaluate the need to clarify treatment orders based on the wound physician documentation. **With respect to what system atic measures have been pui into place to address stated concern:** The Director of Education will in-service Licensed Nurses on notifying the primary physician when there is any discrepancy in order, and obtaining order clarifications when needed . The Director of Nursing will in-service the Registered Wound Nurse on reviewing the wound physician's documentation routinely, notifying the wound physician when there is any discrepancy in order, and obtaining wound care order clarifications when needed.	

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F658	Continued From page 12 On 01-31-19 PM at 04:40 PM, interview with DON and QA Director revealed no additional information. As a standard of nursing practice, a licensed nurse is required to notify the primary physician and clarify any discrepancies with the physician orders, as indicated in section 10.27.09.01 of the Nurse practice act under collaboration of care. 2. On 01-31-19, Surveyor review of the clinical record revealed that, upon admission to the facility in December 2018 resident #157 had a sacral pressure ulcer. Wound care ordered to the sacral pressure ulcer on [redacted] included clean the wound with normal saline, apply Santyl ointment (removes dead tissue from wounds) and apply optifoam dressing daily. Optifoam dressing is a type of highly absorbent wound dressing that creates an ideal moist healing environment that is used on pressure ulcers. Further record review of the initial assessment on [redacted] by the facility's wound physician consultant revealed that the sacral wound was assessed as unstageable with wound treatment that included the use of Santyl ointment once daily. An unstageable pressure ulcer is described as full thickness tissue loss in which the base of the ulcer is covered by slough and/or eschar (dark dead skin) in the wound bed. On 01-09-19, the wound physician consultant documented that the wound treatment for resident #167's sacral pressure ulcer included the use of Medi-Honey once daily to the wound bed. Additionally, on 01-20-19, documentation by the wound physician consultant revealed the wound	F658	**With respect to how the plan of correction will be monitored:** The ADONs will audit residents with orders for Klonopin to evaluate the need for order clarification weekly for four weeks and monthly for three months. The Wound Nurse will audit residents with pressure ulcers to evaluate the need to clarify treatment orders based on wound physician documentation weekly for four weeks and monthly for three months. During and at the conclusion of the audit and reporting period, the QAPI committee will re-evaluate and initiate any necessary action or extend the review period. the DON is responsible for confirming implementation and ongoing compliance with the components of the Plan of Correction and addressing and resolving any variance that may occur.	

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F658	Continued From page 13 treatment for the sacral pressure u.tcer was Medi-Honey, but at a frequency of twlt:e daily. Medi-Honey promotes the removal of necrotic tissue, which may advance the wound toward healing. On 01-0-19, surveyor review of the Jarwary 2019 TAB (TreatmentAdmlnlstrationRecord) revealed nursing staff documented daily wound treatment orders of Santyl aintr:nent once daily. However, there was no e idence of physician orders for the use of Medi-Honey treatment either once nor twice dally. In addit!o·n, review of the January 2019 nursing clinical documentation and the January 2019 physlcjan's orders for wound treatment revealed no evidenceof nursing docu,mentatio,:i regarding a change in the wound treatment from Santy! ointment to Medi-Honey, as ordered by the wound physician on 01-09-19 and 01-20-19. Further review revealed no evidence that licensed nursing staff t1ad obtained physician clarification of the wound treatment changes and appropriate orders for the changes In treatment. On 01-30-19 at 4:20 f=lM, and 01-31-19 at 11:12 AM. surveyor Interview with the Director of Nursfhg and the faGilily's wdund nurse revealed that, either the nurse on the unit or the wound nurse. reviews the wound physician's documentation when ifis received on the rw xt day after the phy,siclan's visit. At that time, the nurse should hav er.evlew ed the do0wmentation and obtained clarification for the treatment chahg with contacHo the residen,t's atteri'dirig physielan as well as the wouncl physician. Na additional In'formatlon was provided.	F658		

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F 658	Continued From page 14 According to the Maryland Nurse P.raetice Act 10.27.09.03 F (2) (a) (b), the nurse should collaborate w.lth. the *clien* family, significa nt others and other health care providers in the formulation t::>f overall goals, the plan of care, and decisions related to care and the delivery of services; and consult with health care providers for client care.	F 658		
F 684 SS=E	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 record review and t ff interviews, it was determined that the fapllity failed t0 provide treatment and car:e in c1pcordance with Physldian's orders, This wa sevident for 6 of 41 residei:its reviewed for th esurveyl{#-147, #170, #186,#207, #225.- qnd#168). The'fir,dlngs include: 1. On 01-31-19 at 11:30 AM, review of the clinical record for resident #147 revealed a physician order, dated 03-22-18, for klonipin 0.5 mg dally. Review of the Medication Administration Records (MAR) revealed that nursing staff documented they administered klonlpln 0.5 mg from March 2018 through Januar:y 2019.	F 684	F684 Quality of Care **With respe.ct to the specific resident/situation cited:** Resident #147's order for Klonopin was clarified with the attending physician. Reside nL #170 no longer resides at the facili ty. Resident #183's weight was obtained and the resident's order for weights was clarified. Resident #207 no longer resides at the facility. Resident #225 no longer resides at the j facility. Resident #158's ext re mities were float ed on two pillows at the time of the survey. **With r spect to how the facility will identify residents/situations with the potential for the identified concerns:** The **ADONs will** audit current residents with orders for Klonopin to evaluate the need for order clarification.	3/7/19

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F 684	Continued From page 15 However, review of the Controlled Med!ca.tion Records (CMR) revealed that nursing staff administered klonlpin 0.25 mg and not 0.5 *mg* as 9rdered from March 2018 to January 2019. On 01-31-19 PM at 04:40 PM, interview with DON and QA Director revealed no additional Information. 2. On O1-30-19 at 08:30 AM, review Of the clinical record' for resident #170 revealed a physician's order for wee ly weight checks starting on **12- 12- 18 .** Further review of the record revealed no weight as ordered for 12-12-18, 12-26-18 and 01-02"'.19. On 01-3-1-1 9 at 08:4 AM, interview with 4th floor unit manager revealed no additional ififorma tioti. On 02-01-1'9 at 10:00 AM, Interview with the DON revealed no additional information. 3'. 01-29-19 at 8;25fl.M, surveyor review of reslcil'ent #183's clinical record revealed a phy sician'sorder, w,;itten on 12-28-1 9, Instruotin§ the fr;1clli1y staff to weigh the resident-weekly. The resident was weighed on 12-27-18, 1-15-19, and 1-30 -19. There was no evlclence 1hat the resident was weighed on 01-'02-19,01-09-19, ot 01-2-3-19. On Q1- 31-19 at 12:15 PM, survey0r interview with dietle::ian t,1 reveal,ed 'thg.tth edieticians evaluate all new admission th t",the facility protocol is to weigh newly admitted residents weekly, for tt 1!;! first month and then re.evalua,te Nurses are responsible for netifylng the dieticians of any significant weight' loss.	F 684	The ADONs will audit current residents with orders for weekly weights to evaluate completion of the order. The ADONs will audit current residents with orders to elevate extremities to evaluate follow-through on the order. **With respect to what systematic measures have been put into place to address stated concern:** The Director of Education will in-service Licensed Nurses on notifying the prin1ary physicinn when there'is any discrepancy in order, and obtaining order clarifications when needed. The Director of Education will in-s rvice Licensed Nun, s on obtaining re ldenl weights as ordered. The Director of Education will in-service Licensed Nurses on elevating resident extremities as ordered. **With respect to how the plan of correction will be monitored:** The ADONs will audit residents with orders for Klonopin to evaluate the need for order clarification weekly for four weeks and monthly for three months. The ADONs will audit residents with orders for weekly weights to evaluate the completion of the order weekly for four weeks and monthly for three months.	

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F 684	Continued From page 16 On 01-31-19 at 1 PM, surveyor Interview with the Director of Nursing revealed no new Information regarding the missing weekly weights. 4. On 01-29-19 at 08:00 AM, surveyor review of resident #207's clinical record revealed a physlcian's orcler written on 0'1-09-19; instructing the facility staff to weigh the reside ht weekly. The resident was we'lghed on 01-23-19. There was no evidertoe that the resident was weighed on 01-09-19, 01-16-19, or 01-30-19. On 01-31-19 at 12;1'5 PM, surveyor interview with dieticia111f.1 revea led the dieticians evaluate all new admissions, that the facllfty prot0col is to weigh newly admjtted residents weekly for the first mo th and then reevaluate. Nurses are responsible (or notifying the dieticians of any significant weight loss. .On 01-31-19 at 1 PM, surveyor interview with the Director of Nursing rev ealed no new infprmation regarding the missing weekly weights. 5. 01-29-19 at 01:02 PM, surveyor review of resident #225 's clinical record revealed a physician's Order, writterl on 01-10-19, Instr.4crjr,g tlae facility staff to weighthe resident wee ly. The resident was weighedon 01.:22-19and 01-29 19. "f:h re w s .r,o evidence that the resid nt was weighed on 01-'15-19. On 01-31-19 at 12:15 PM, surveyor lnterv.tew with dietician #1 revealed the dletidans evaluate all new admissions, that h e facility ptotoool Is to weigh newly admitted residents wee ly for the first month and then reevaluate. Nurses are resporisible for notifying the dieticians of any	F 684	The Director of Quality Assurance will audit residents with orders to elevate extremities evaluate follow-through on the order weekly for four weeks and monthly for three months. During and at the conclusion of the audit and reporting period, the QAPI committee will re-evaluate and initiate any necessary action or extend the review period. The Director of Nursing is responsible for confirming implementation and ongoing compliance with the components of the Plan of Correction and addressing and resolving variances that may occur.	

STfi.,TeMENT OF DGFICIENCIES AND P.l.AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 684	Continued From page 17 significant weight loss. On 01.;31-1:9 at 1 PM, surveyor Interview with the Director of Nursing revealed no new information regarding the missing w ekly Weights; 6. On 01-28-19, surveyor review of the clinical record for resident #158 revealed a physician's order te "l: levate extremity by floating t:ieels on 2 pillows while In 'bed e very shift" On 0 1-28 19 at 0 9:30 AM, surveyc:ir observed the resident in bed. There was no evidence that the resident's lower extremlfies were fl0ated or elevated an pillows Additonal observation during surveyo r's vi sits 011 the followlng dates and fime revealed that resident #158s lower extremities wern not floate.d on pillows or elevatedas ordered 01-29-19 at 08:10 AM 01-30-19 at 09:10 AM 01-31-19 at 09:48 AM Surveyor review of resident #158's treatment administration record (TAR) revealed tht facility staff sighed off on the above dates as if resident #158's lower extremities/heels were floated on two pillows as ordered. On 01-31-19 at 09;51 AM, surveyor notified the unit manager that the heels were not floated as ordered. A search in resident'#168's room with the unit manager rev ,ealed rio **extra** plliows avallable tq be usedlo ffoat the resi'dent's heels.	F684		
F 756 SS=E	Drug Regimen Review. Report Irregular, Act On CFR(s): 483.45(c)(1)(2){4)(6)	F 756	**f756 Drug Regimen Review** **With respect to the specific resident/situation cited:** Resident #14 7's order for Klonopin was cla rified with the att ending phy, jcian, and the pharmacist completed an additional medication review.	7/19

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F 756	Continued From page 18 §483.46(c) Drug Regimen Revle,w- §483.45 (e)(1)The drug regimen of each resident must be reviewed at least once a month by a llczensed pharmacist §483.45(c)(2) This re·vfew must include a review of the resident's medical chart. §483.45(c)(4)The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not llmited to, any drug that meets the criteria set forth in paragraph {d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that Is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name., the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale In the resident's medical record. §483.45{c)(5) The facility must develop and maintaJn policies and procedures for the mohthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharn,acist must take when he or she identifies.an irregularity that .requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced **by:**	F 756	**With respect to how the facility will identify residents/situations with the potential for the identified concerns:** The ADONs will audit current residents with orders for Klonopin to evaluate the need for order clarification and additional pharmacist review. **With respect to what systematic measures have been put into p]ace to address stated concern:** The Director of Nursing will in-service the pharmacist on noting discrepancies of medication doses between the physician orders, Medication Administration Records, and ControHed Medication Records. **'With respect to how the plan of correction will be monitored:** The Director of Quality Assurance will audit the monthly medication reviews for residents on Klonopin to evaluate the pharmacist's documentation related to any to·nopi.n d,iscrepancies weekJy for four weeks and monthly for three months. During and at the conclusion of the audit and reporting period, the **QAPI** committee will re-evaluate and initiate any necessary action or extend the review period.	

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F756	Continued From page 19 B'ased on record review and staff Interviews, it was determined tha\ the facllity's pharmacist failed to Identify and report an irregularity to the attending physician and the director of nursing. This was evident for 1 of 5 residents reviewed for the unneeessary medication review (#147). The findings Include: 1. On 01-31-19 at 11:30 AM, review of the cllnlcal record for resident #147 revealed an order on the Medication Administration Records (MAR) from March 2018 through January 2019 for klonipin 0.5 mg. Review of the Controlled Medication Records (CMR) that klonipin 0.5 mg, ½ tablets (0.25 mg) were delivered by the phc:1rmacy and administered by the nursing staff from March 2018 to January 2019. H0wever, review of the Monthly Medication Reviews revealed that the pharmacist did net note the discrepancy oft he kl0nipln dose. between the Physician orders, MAR's and CMRs from March 2018 through January 2019. On 01-31-19 at 12:30 PM, in'terview with the 3rd floor unit manager revec:1led no additional information. On 01-31-19 PM at 04:40 PM, lntervleW with DON and QA Director revealed no additional information.	F 756	The Director of Nurs ing is responsible for confirming implementation and ongoing compliance with the components of the Plan of Correction and addressing and resolving variances that may occur.	
F 812 SS=C	Food Procurement, Store/Prepare/Sreve-Sanitary **CFR(s): 483.60(i)(1)(2)** §483.6.0(i) Food safety requirements. The fa0ility must-	F 812	**F812 Food Procurement** **With respect to the specific resident/situation cited:** The lemon was removed at the time of the survey.	1/7/19

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F 812	Continued From page 20 §483.60(i)(1) - Procure food from sources approv,ed or considered satisfactory by federal, state or local authorities. {i) This may include food Items obtained directly from local producers,subJectt0 applfcable State and loc::l laws or regulations. (ii) is P.rovislon does not prohibit or prevent faclflttes f(orn using produce gr0wn in fa lllty gardens, subject to compliance With applicable safe grnwlng and foog-har,igling practtces (Iii) This provision does not pr,eclude residents from consuming fopds not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on surveyor observation and staff interview, It was determined the faclllty staff failed to store food under sanitary conditions. This finding was evident for the facility's kitchen during the surveyor's itiitial tout. The findings include: On 01-26-19 at 8:31 **AM,** surveyor tour of the kitchen reve led the followlng: Observation of the walk-in produce refrigerator revealed: a. Mold covered lemon commingled in a box with good fruit. b. A variety of diced and whole vegetables on the refrlger tor floor. Additional observation of the walk-in dairy refriger tor r.evealed: a. Four bags of quarter full, opened, unlabeled bread slices.	F 812	The diced and whole vegetables were removed from the refrigerator floor at the time of the survey. The bags of bread slices were discarded at the time of survey. **With respect to how the facility will identify residents/situations with the potential for the identified concerns:** The Dietary Manager will audit boxes of fruit to evaluate the presence of moldy fruit. The Dietary Manager will audit refrigerator floors to evaluate the presence of vegetables. The Dietary Manager will audit bread bags to evaluate presence of open date label. **With respect to what systematic measures have been put into place to address stated concern:** The Dietary Manager will in-service kitchen personnel on checking for and discarding moldy fruit within comingled boxes of fruit, removing food debris from refrigerator floors, and proper labeling of bags of bread. **With respect to how the plan of correction will be monitored:** The Dietary Manager will audit boxes of fruit to evaluate the presence of moldy fruit daily for four weeks and weekly for three month .	

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F 812	Continued From page 20 §483.60(i)(1)- Procure food from sources approved or considered satisfactory by federal, state or local autt,orities. (i) Thls may lnct de food Items obtained directly from local producers1 subject to appllcable State eind local l:1ws or regulations (ii) Thls provlsiqi:i dc;,es n.ot prohlblt or prevent facilltle.s from using protluce grown in fa<::llitY gardens, sybject to com)jliatice with applicable safe growing and food-handllngpractices. (iii) This provision does n0t preclude residents fromcohsumlng foods not procured by the faelllty. §483.60(i)(2) - Store', prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced **by:** Based on surveyor observatlon nd staff lntervjew, It was.determined the faolllty staff failed to store foQq under sahltary oondlt)ons. This finding w s ev ldept fonhe facility's k,i tchendvring tbe surv!3yor's ln1tlal totlr. The findings iAclucle: On 01-28..-19 at 8:31 AM, surveyor tour of the kitchen revealed the following: Observation of the walk-in produce refrigerator revealed: a. Mold.covered lemon commingled in a box with good fruit... b. A variety of diced and whole vegetables on the refrigerator floor. Addition al observation of the walk-in dairy refrigerator revealed: a. Four bass of quarter full, opened, unlabeled bread slices.	F 812	The Dietary Manager will audit refrigerator floors to evaluate the presence of vegetables daily for four weeks and weekly for three months. The Dietary Manager will audit bread bags to evaluate presence of open date label daily for four weeks and weekly for three months. During and at the conclusion of the audit and reporting period, the QAPI committee will re-evaluate and initiate any necessary action or extend the review period. The Dietary Manager is responsible for confirming implementation and ongoing compliance with the components of the Plan of Correction and addressing and resolving variances that may occur.	

STATEMENT OF DEPICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(XS) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HEALTH **CARE** CENTER	301 RUSSELL AVENUE **GAITHERSBURG, MD 20877**

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F 812	Continued From page 21 On 01-28-19 at 11:00 **AM,** surveyor interview with the Dietary Manager revealed no further informqtion.	F 812		
F 880 SS=E	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 development and transmission of communicable diseases and infections. §483.80(a} Infection prevention and control program. The fc1cillly mustestablishan ih'fection prevehtion and control program (IPC.P,) that rii I:lst include, at a niinimurn, the follbwing elements: §483,ao(a).(1) A system for preventing, identifying, reporting, lnvestigat1119, and controllin lnfeclions and communlcabl disease s for all esld ents, staff, volu nteers, vis-ltors, and other lndlViduals provldlng services under a contractual arrangement based Uponthe facility assessment conducted according t0 § 483.70{e)and following accep{4?d nation ! standa'rds; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (l) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons In the facility; (li) When and to whom possible incidents of	F 880	**E'880 lnfection Prevention and Control** **Wi th respect to the specific resident/situation cited:** Residenr #66. 162; 232, 233,234,482; od 48S's oxygen tubing and humidifier bottl wer repl ced and labeled. Resiflenl #151's oxygen tubilrg was replac cl and labeled, and Lb nebullzer was cleaned and placed in a labeled, ventilated bag. With respect to how the facility will **identify residents/ ituations with the potential for the identified c nccrns:** The Dir ctor f Quality A su-rance wiU audil current re:idents wlth ,orders for Gxygea to evaluate tubing and humidifier b0,ules for presence of dated lab I• The Director of Quality Assurance will audil current resident with orders for nebnlizers to evaluate nebulizer cleanliness and placement in a labeled, vent ated bag.	3/7/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDERJsUPPLI.gR/CLIA IDENTIFICA:T!ON NUMBl;R:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HEALTH CARE CENTER	301 RUSSELL AVENUE GAITHER_SB RG$_1$ Mf? 0877

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F 880	Continued From page 22 communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of Infections; (iv)When and how isolation should be used for a resident; 1nohJdlt19 but na>t limited to: (A) The type a,rd durati:oli of the isolation, qepending uponth-e infeGtious agent or organism Involved, and (8) A requlrementthat the isolationshol:.lld be the leastrestriolilte posslele for the Fesioent under the circumstances. (v) The <!lirot,mstaAees under which the facility must prdhtbli empleyees with a communicable dlsea,se or infected skin lesions from direct contact wfth r esi,qent$or theirfood, rf direct contact wlll transmit the disease; and (vi) The ha,nd ygiene procedures to be followep y siaff i.nvolve<:l In direct residentc0Hlacl. §483 .80(a)'(4}A system for recording Incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.S0(e) Linens, Personnel must handle, store, process, and transport linens so as to prevent the spread of infection . §483.B0(f) Annual review. The facility will conduct an annual review of its IPCP and update their pro9:am, s n ecessary. This REQUIREMENT is not met a evidenced by: Based on surveyor observations, record reviews and staff interviews, it was determined that the facility failed to ensure the maintenance of infection and control procedures. This finding was evident for 8 of 17 residents (#66, #161,	F 880	**With respect to what systematic me ures ha, c been put into place to address stated concern:** The Director of Quality Assurance will in-service licen ed nurses on labe li·ng oxygen tubing, humidifier bottles, and on the d ea nlng, storage,. a nd labeling procedu for ne b 1liz e r . **With respect to how the plan of correction will be monitored:** The Director of Quality Assurance will audit residents with orders for oxygen to e valu ate LUbing and humidifier bottles for presence of dnle d la els week ly for four weeks and montl')ly for th ree months. The Director of Quality Assurance will audit residents with orders for nebulizers to evaluate nebulizer cleanliness and pine menl in a l abeled, ve.nfilnted bag weekly f rf: ur we ks and month ly for thr tn'Onth .	

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F 880	Continued From page 23 #162, #232, #233,# 234, #482, and #485) selected for the infectioncontrol care area review. The findings include: 1. On 01-28-19 at 9:41 AM, surveyor observation during the initial screening tour, revealed that oxygen was in use by resident #66. There wa-s no label to indicate what dijte the oxygen tubing and humidifier bottle were last .reAlaced, On 01-28-19 at 5:05 PM, surveyor interview with the Direct0r of Nursing added no new information. 2. On 01-28-19 at 08:30 AM, surveyor tour of resident #151's room revealed undated oxygen tubing and a nebul!zer mask wjth equipment (a drug delivery device used to administer r;nedlcation in the fo,rn qf a mist inhaled into the lur:ig s) propped up in the drawer of resident #151's bedside table. On 01-28-19 at 04:30 PM, surveyor review of the f'acility policy on nebuJizer 1se revealed that, after us , the parts of the n.ebullzer rnask and equlpment:are to be dissembled, thorough ly cleaned With soap and water;, rinse well with water, let dr,y and place in labeled ventilated plastic bag-and store In resjdent's room. On 01-28-19 at '05:05 PM, interview with the DON revealed no adoitional information. 3. On 01-28-19 af 08:4b AM, survey.or tour of r,esldent #162' room revea.lad oxygen tubing and a waterbottle used for humidification of oxyge11 both without a date indicating when It was replaced. On 01-28 19 at'OS:05 PM, intervlew with DON re ve a le d no additional informa tion.	F 880	During and at the conclusion of the audit' and reporting period, the QAPI committee will re-evalua te and initiate any necessary action or extend the review period. The Director of Quali ty Assurance is r pori i blef or confirmi rlg impl mema.tion and ongoing compliance With the components of the Pl an of o rrectio n and addr sing and resolving var iances that may occur.	

STATEMENT OF DEFICIENCIES AND PIAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X } DATE SURVEY COMPLETED
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F 880	Continued From page 24	F 880		

4. On 01-28-19 at 8:30 AM, during the initial facility tour, surveyor observation revealed that oxygen was in use by resident #232. There was no label to indicate what date the oxygen tubing and humidifier bottle were last replaced.

On 01-28-19 at 12:00 PM, record review of resident #232's clinical record revealed an active physician's order for continuous oxygen.

On 01-2 8-19 at 0 4:30 PM, additional surveyor observation revealed that oxygen was in use by resident#232. There was no label to indicate what date the oxygen tubing and humidifier bottle were last replaced.

On 01-28-19 at 5:00 PM surveyor interview with the Director of Nursing (DON) revealed no new information.

5. On 01-28-19 at 8:35 AM, during the initial facility tour, surveyor observation revealed that oxygen was in use by resident #233. There was no label to lhdlcate what date the axyg.en tubing and humidifier bo e were last replaced.

On 01-28-19 at 12:10 PM, record review of resident #233's clinical record revealed an active physician's order for continuous oxygen.

0n 01-28-19 at 04 :35 RM, addi;tlonalsurveyor observation revealed that oxygen was In use by resident #233. There "'(as no label to Indicate when the oxygen tubing and humidifier bottle were last replaced.

On 01- 8-19 at 5:00 PM, surveyor interview with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 25 the Director of Nursing (DON) revealed no new information. 6. On 01-28-19at 8:40 AM, during the initial facility tour, surveyor observation revealed oxygen was in use by resident #234. There was no label to indicate what date the oxygen tubing and humidifier bottle were last replaced. On 01-28-19 at 12:20 PM, record review of resident #234's clinical record revealed an active physician's order for continuous oxygen. On 01-28-19 at 04:40 PM, additional surveyor observation revealed that oxygen was in use by resident #234. There was no label to indicate what date the oxygen tubing and humidifier bottle were last replaced. On 01-28-19 at 5:00 PM, surveyor interview with the Director of Nursing (DON) revealed no new information. 7. On 01-28-19 at 8:45 AM, during the initial facility tour, surveyor observation revealed that oxygen was in use by resident #482. There was no label to indicate what date the oxygen tubing and humidifier bottle were last replaced. On 01-28-19 at 12:30 PM, record review of resident #482's clinical record revealed physician's orders for continuous oxygen and to change the humidifier bottle weekly and as needed when in use and label with date/time/initials. On 01-28-19 at 04:45 PM, additional surveyor observation revealed that oxygen was in use by resident #482. There was no label to indicate	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CL/A IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HEALTH CARE CENTER	301 RUSSELL AVENUE GAITHERSBURG, MD 20877

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F 880	Continued From page 26 what date the oxygen tubing and humidifier bottle were !ast replaced. On 01-28-1.Q at 5:00 PM, surveyor interview with the DON revealed no new Information. 8. On 01-28-19 at 8:50 AM, during the initial facility tour, surveyor observation revealed that oxygen was in use by resident #485. There was no label to indicate what date the oxygen tubing and hun:ildifler bottle were last replaced. On 01-28-19 at 12:40 PM, record review of resident #485's clinical record revealed active physician's orders for continllo s oxygen at 2 liters per minute, change nas-at cannula weekly and label with date/initiat, and change the l1umidifier bottle weekly snd as needed wMen In use and label with date/time/initials. On 01-28W1'9 at 04:60 PM, additional surveyor observation revealed that oxygen was in use by r esldeht #485. There was nQ label to indicate what date the oxygen tubing and humidifier bottle were last replaced. On 01-28-19 at 5:00 PM, surveyor interview with the DO revealed 1:10 n ew Information.	F 880		

Office of Health Care Qualily

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1l PROVID6R/SUPPLIER/CLIA IDEN11FIOATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HEALTH CARE CENTER	01 RllSSEL. **AVENUi; GAITHERSBURG, MD 20877**

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S 000	Initial comments The following deficiencies are the result of the annual survey conducted by the oHice of Health Care Quality on January 28, '29, 30, 31 anq February 1, 2019, to deterrnine the ciffty• compliance with COMAR re qulrements. Survey activities consisted of a review of 41 rE!sidents' records, 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. In addition to standard survey protocols, compl ints #MD00134750, #MD00134974, #MD00135oa1 and facllity reported incid nts #M000134436, #MD00135727, and an additional facility rep0rted incldentwllich Was pr-ovided to the survey team was reviewed. This survey did not identify noncompliance with Federal requirements that were reviewed in re lationship to these complaints and facility reported incidents. The facility is licensed for 285 comprehensive beds. At time of this survey the facility census was 232.	S000		
S 320-	10.07.02.08 E Admission and Discharge .08 Admission and Discharge E, Notification of Responsible Persons When Patient Moves. The administrator or the administrator's designee shall notify the private or public agency or relative responsible for the PEltient when the patient is transferred from the	S 320	**See POC for F6i3**	119

Rachel S. PAOVIDERfSUP LIER REPRESENTATIVE SIGNATURE TITLE (X6) DATE
FORM
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STATEMENT OF O!;ffCIENCIES AND PIJ>JJ QF CORRECTION	{X1) PROVIDER/SUPF!UER/OUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HEALTH CARE CENTER	301 RUSSELL AVENUE oA,fH eRsa uRG,10 2oa11

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S 320	Continued From page 1 facility for any reason □r at time of death. The attending physiqlan sh II alse be notified. This R gulation is not met as evidenced by: Refer to CMS 2567 F623	S 320		
S 506	10.07.02.12 0 Nsg Svcs;Care 24 Hrs per Day .12 Nursing Services. 0. 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: (1) Receives treatments, medications, and diet as prescribed; (2) Receives rehabilitative nursing care as needed; (3) Receives proper care to prevent decubitus ulcers and de.formitles; (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 actMties. This Regulation is not met as evidenced by: Refer to CMS 2567 F658 F684	S 506	See POC for F658 and F684	12/19
S 510	10.07.02.12 Q Nsg Svcs;Charge Nurse	S 510	See POC for F658	12/19

Office of Health Care Quality,

STATEMEf'IT OF DEFICIENCIES AN(i) PL.AN OF CORRECTION	(X1) PROV,IOER/SUPPUERI,OLIA IDENTIFIQATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	{X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HEALTH CARE CENTER	3Jl_1 US$ELJ,. AVENUE GAITHERSBURG, MD 20677

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S 510	Continued From page 2 .12 Nursing Services. Q. Charge Nurse. At lea tone licensed nurse shall b·eon duty. at all times and shall be dasignatea by the director of nursin_g to be In charg,eof the nwrsing aotMti during eaeh tour of d1:rty. The charge nurse or nurses shall have the abil[tyto recognize s'igniftcant changes In the condition of patients nd to take necessary c1ction This :Regl:llation is not met as evidenced by: Refer to CMS 2567 F658	S 510		
S 966	10.07.02.15 E(6) Pharm Svcs; Pharmacist S pervlse Svcs .15 Pharmaceutical Services. E. Pharmacist Supervises Setvlces. If the facility does not em'ploy a licensed pharmacist, it shall arrange for, by written contract, a l!censed pharmcicist to provide consultatlonon the adrnlnister_ing of the pharmacy services in accordance -with th·epolicies and procedures establfshed by the pharmaceutic ! service_s committee. The pharmaceutical services shall be under the general supervision of a qualified pharmacist who shall: (6) Brfhfj :to the attention of the attending physician any potential drug problems found during the drug regimen review.	S966	See POC for Il756	12/19

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S966	Continued From page 3 This Regulation is not met as evidenced by: Refer to CMS 2567 F756	S 966		
S1116'	10.07.02.21 F Inf Control Program; Policies and Procedures .21 Infection Control Program. F. Infection Control Policies and Procedures. (1) The infection control program shall establish written policies and proceduresto investigate, control, and prevent Infections in the facility including pollcies and procedures to: (a) Identify facility-associated infections and communicable diseasesin accordance with COMAR 10.06.01; (b) Report or.cmrences of certain communicable diseases and outbreaks of communicable diseases to the local health department in accordance with COMAR 10.06.01 and Health-General Article, §18-202, Annotated Code of Maryland; (c) Institute appropriate Infection control steps when an Infec'tion IS suspected or identified in order to c0ntrol Infection and prevent spread to other residents; (d) Perform surveillance of resider:its and emp loyees at ppreprlate intervals to monllo.r an-a Investigate causes of infection,facility-associated an-d community acquired, and the manner In whjch rt was spread; (e) Trainemployees about rnfecUon control nd, hygiene includin : (I) 1-'.land h ygl ne; (ii) Respiratory protection; (Hi) Soiled lauhdry ,and llnen processingi (Iv) Needles, sharps, or both; {v) Special medical waste handlingand 1:Usposal;	S1116	Sec PO for F880	5/7/19

Office of Health Care Quality

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S 1116	Continued From page 4	S1116		

and
(vi) Appropriate use of antiseptics and disinfectants.
(f) Train and monitor employee application of Infection control and aseptic techniques; and
(g) Review the infection control program at least annually and revise as necessary.
(2) The facility shall provide information concerning the communicable disease status of any resident being transferred or discharged to any other facility, including a funeral home.
(3) The facility shall obtain information concerning the communicable disease status of any resident being transferred or discharged to the facility.

This Regulation is not met as evidenced by:
Refer to CMS 2567
F880

S1119	10.07.02.21 G Inf Control Program; Prevent Spread of Infec	S1119	ec POC for **F880**	3J7/I

.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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDE/sUPPLIE;RJCUf\ IDENTIFIC)\TION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DArE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HEALTH CARE CENTER	301 RUSSELL AVENUE GAITHERSBURG, MD 20877

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETE DATE
S1119	Continued From page 5 Personnel. (3) The facility shall prohibit employees with a communtcable dlsease or with infected skin lesions from direct contact with residents or their food If direct contact could transmit tf:'ie disease. (4) l'he facility shall require employees to perform har,d hygiene after eaoh direct resident contact for Which hand h glene is indicated by accepted professional prac;:tfoe. ('5) The facility shall handle, stQre, process, and transport linens so as to prevent the spread of infection. This Regulation is not met as evidenced by: Refer t0 CMS 2567 F880	$1119		
S17;30	10.07.02.37 E Care Planning; Organization of plan .37 Care Planning. E. Organization df Care PlaA (1.) Problems and needs sba-ll e identified, based L1pon the Interdlsclpllnary assessment. The Cc!re plan shall a'ddressall of the res Ideht'sspecial eare requirements nece sary to improve o.r mafnlaln the resident's status. The. Interdisciplinary tf;lam shall incorporate resident Input Into the oare plan... (2) The team shall est;1blish goals for each pro!;jlem or n ed identifie . The goal shall be realistic, pra.ctl L and tailored to the resident's needs. Goc:11 outcome shall be measurable in time or degree, or both. (3) Approaches to accomplishlhgeach goal shall be established. Approaches shall communi te	S1730	Sc PO for F656	)) 7}1q

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV!DER/SUPPLIERICLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215099	A, BU!LDING: ---------- B.WING _____	C 02/01/2019

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S1730	Continued From page 6 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 GMS 2567 F656	S1730		
S5097	10.07.09.08 C (3) Right to dignified existence ,08 Resident's Rights and Services. C. A resident has the right to: (3) A dignified existence, self-determination, and communication with and access to individuals nd services inside and outside the nursing facility; This Regulation is not met as evidenced by: Refe r to CMS 2567 F561	S5097	**Sec POC for F561**	3/7/19
S6145	10.07.09.10.C Resident transfers/discharges;Notice .1O Resident Transfers and Discharges. **C. Notice.** (1) Transfer and Discharge. Except in emergency situations such as a hospitalization, or if the resident has not resided in the facility for 30 days, the nursing facility shall notify the resident, representative, or Interested family member, the State Long Term Care Ombudsman, and the Department at least: (a) 30 days before any proposed transfer or discharge If the nursing facility is not part of a	**S6145**	**See POC for F623**	3/7/19

STATEMENT OF OEFICIENOI ANO PLAN OF CORRECTION	(X1) Pf!OVIDl:R/SUPPUER/ClIA rDENTIFICATION NUMBER	(X2) MULTIPLE 09NSTRUCiTION	(X3) DATE SURVEY COMPLETED
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S6145	Continued From page 7 <mntinulng care retirement community s defined in Article 708, AnnotatedCode of Maryland; ,or (b) 60 days before anypr posed transfer or dlschargeIMhe nursing facillty Is part of a continuin eare retlternent community. (2) Em ergency Transfers, Discharges, and Reloc ations.In an emergency situatron, a nursing facility shall notify the fesident, representative, or interested famlly member of a transfer as soon as possible. This Regulation is not met as evidenced by: Refer to CMS 2567 F 623	S6145		
S6217	10.07.09.12 C (2) Res Reloc/bed hold;notice at transfer .12 Resident Relocation and Bed Hold. C. Notice. (2) Notice of Bed-Hold Policy at Time of Transfer. At the time of transfer of a resident to a hospital or for therapeuticleave, a nursing facility shall provide a written notice to the resident, or when applicable, the resident'srepresentative or interested family member, Which specifies the duration of the peel-hold policy described in §C of this regulation. This Regulation is not met as evidenced by: Refer to CMS 2567 F625	S6217	See POC for F625	12/19
S6647	10.15.03.06 A Food Protection During Storage, Service and T	S6647	See POC for F812	2/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER	{X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215099	A BUILDING:_____ B W I NG _ _ _ _ _ _ _ _	C 02/01/:2019

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S6647	Continued From page 8 .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) Protecte d from contamination during storage, preparation, display, service, and transpo rtatlon; (2) ,:he Interna temperatu e of a food is maintained according to the r.equlrements of this chapter to prech..lde the growtt, of pathogenic li>acter.ia and Gther microorganismsthat could cause spoilage; (3) Except during necessary periods of pr pa ation and service, a potentially haza,rdous food is re frigerated or held hot as set fqrth in §8(7) of this regulation; This Regulation is not met as evidenced by: Refer to CMS 2567 F812	S6647		