

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215015	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
NAME OF PROVIDER OR SUPPLIER Fairland Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2101 Fairland Road Silver Spring, MD 20904	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49815</p> <p>Based on staff interview and medical record review, it was determined that the facility failed to accurately document a Resident assessment on the MDS (Minimum Data Set) as evidenced by inaccurate coding for a Resident. This was found to be evident for 1 (Resident #1) out of 1 Resident reviewed for accuracy of MDS assessments.</p> <p>The findings include:</p> <p>The MDS (Minimum Data Set) is a health status screening and assessment tool used for all residents of long-term care nursing facilities. The MDS is part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes. This process provides a comprehensive assessment of each Resident's functional capabilities and helps nursing home staff identify health problems.</p> <p>On 5/9/24 at 11:00 am the surveyor conducted a review of Resident #1's medical record. The Admission MDS dated [DATE] revealed that the Resident did not use a wander/elopement alarm as documented in section P - Alarms of the MDS assessment, but review of the clinical physician orders revealed that the Resident had an order for a wander guard/wander elopement device as of 11/4/23.</p> <p>Further review of the medical record revealed that there was documentation by the nursing staff on the November 2023 Treatment Administration Records (TAR) that Resident #1 used a wander guard/wander elopement device.</p> <p>The Treatment Administration Record (TAR) is a report detailing the treatments administered to a Resident by a healthcare professional at a long-term care facility.</p> <p>In addition, there was an elopement evaluation completed on 11/14/23 at 1:44 pm which indicated that Resident #1 had a history of elopement, wandering and a desire to go home.</p> <p>At 2:15 pm on 5/9/24 the surveyors interviewed the Director of Nursing (DON) and communicated that the Admission MDS dated [DATE] had inaccurate coding in section P - Alarms that indicated Resident #1 did not use a wander/elopement alarm. The surveyors also conveyed that there was a physician order for the wander guard/wander elopement device as of 11/4/23 and the November 2023 Treatment Administration Record (TAR) documentation revealed that Resident #1 used a wander guard/wander elopement device.</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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NAME OF PROVIDER OR SUPPLIER Fairland Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2101 Fairland Road Silver Spring, MD 20904	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42783</p> <p>Based on medical record reviews and interviews it was determined that the facility failed to ensure accurate medical records in accordance with accepted professional standards of practice as evidenced by staff inaccurately documented a resident's wanderguard placement and functionality. This was found to be evident for 1 (resident #1) out 1 resident reviewed for elopement.</p> <p>The findings include:</p> <p>A Wanderguard is a bracelet that a resident wear that has a sensor. When the sensor comes in range of a door with a sensor, the sensor will trigger an audible alarm to alert the caregiver that a wanderer is in range of a door with a sensor.</p> <p>During a review of Resident #1's progress note conducted on 05/09/2024 at 11:32 AM, the surveyor read a note dated 04/11/2024 that stated Resident was seen and evaluated by medical director today and deemed competent to make own decisions. Wonderguard [Wander Guard] order has been discontinued.</p> <p>A review of the physician orders conducted on 05/09/2024 at 11:35 AM did not reveal an order to discontinue Resident #1's wanderguard until 04/23/2024.</p> <p>On 05/09/2024 at 11:45 AM a review of Resident #1's Treatment Administration Record (TAR) was conducted. The review revealed an order for a Wander Guard/ Wander Elopement service due to poor safety awareness. Check function and document in supplemental documentation expiration date every night shift.</p> <p>Further review of the TAR revealed a second order for a Wander Guard/ Wander Elopement service due to poor safety awareness. Check function and document in supplemental documentation expiration date. Every shift check the placement of the service and in supplemental documentation document the location.</p> <p>On 05/09/2024 at 11:50 AM a review of Resident #1's TAR revealed License Practical Nurses (LPN) # 3, #5, #8, #9, #10, #11, #12, #13, & #14 documented that the Resident's [NAME] Guard was functional and documented its placement from 04/12/2024 - 04/22/2024 although the resident's wanderguard was removed and the order discontinued as of 04/11/2024.</p> <p>During an interview conducted on 05/09/2024 at 12:00 PM, the Director of Nursing (DON) stated Resident #1's wander guard was removed, and the order was discontinued on 04/11/2024 by the physician. The DON further stated that an error was made when the order to discontinue the wanderguard was not entered into the Resident's medical record. She also acknowledged that LPNs # 3, #5, #8, #9, #10, #11, #12, #13, & #14 inaccurately documented that the Resident had a wander guard in place and that it was functional.</p>		