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	01/29/2025

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 40927 Based on record review and interview, it was determined the facility failed to develop and implement abuse prevention policies to ensure the safety of their residents. This was evident for 1 of 1 facility abuse prevention policies and procedures reviewed. The findings include: During the investigation of facility reported incident #MD00178929, a review of the facility abuse prevention policies and procedures were reviewed on 1/21/25 at 2:15 PM. A review of the facility's Resident Rights - Abuse and Crimes against policy dated 11/13/24, failed to reveal procedures for the implementation of training of new and existing staff, those with contractual agreements, and volunteers to include their expected roles. Further review revealed there was no policy or procedure to establish the coordination with the quality assurance performance improvement [QAPI] program. On 1/22/25 at 11:53 AM, the NHA confirmed that she had provided all the abuse prevention policies and procedures and had confirmed this with the corporate office. The concerns were reviewed with the NHA who responded by stating she needed to write down the concerns so she could let the corporate office know. She offered no rationale as to why the information had not been included.

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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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 40927 Based on record review and interview, it was determined that facility staff failed to recognize and report an injury of unknown within the required time frame. This was evident for 1 (#23) of 1 resident reviewed for injury of unknown origin. The findings include: A medical record review for Resident #23 on 1/22/25, at 2:49 PM revealed under the census tab, that the resident had been a long-term resident of the facility. The resident had a care plan initiated on 10/25/23, for the risk of falls related to dementia, lack of safety awareness, and the tendency to constantly reposition themselves to lay sideways or across in the bed. A review of the minimum data set (MDS), with an assessment reference date of 4/16/24, revealed the resident was severely cognitive (the ability to think and process information) impaired. A review of the progress notes revealed that Licensed Practical Nurse (LPN) #40 wrote a note on 6/25/24, at 11:49 AM that she found the resident lying with his/her left leg hanging on the left side of the bed, the resident was repositioned in bed and it was noted that their left lower leg was discolored with swelling, a blister on the left great toe, and was warm to touch. Further noting the resident was evaluated by the Nurse Practitioner (NP) #41and x-rays were ordered. Further review revealed on 6/25/24, at 10:17 PM LPN #25 wrote a note that the x-ray results were received and the resident had a fractured foot. On 1/22/25, at 3:39 PM, a review of the facility's investigation file for self-reported incident #MD00207069 was conducted. The initial self-report form documented the facility became aware of the injury of unknown origin on 6/25/24, at 5:30 PM upon receipt of the x-ray showing the resident had sustained a fracture. Further review revealed there was no evidence of how this injury occurred. However, a review of the email confirmation for sending the report to the State Agency revealed they failed to report the injury of unknown origin until 6/26/24, at 11:08 AM. Telephone numbers for LPN #25, who was the nurse on duty when the x-ray report was received and Unit Manager #44, who was the staff person who conducted the investigation, were requested. However, the Nursing Home Administrator (NHA) reported that both employees were out on leave and unavailable for interview. An interview with geriatric nursing assistant (GNA) #26, who was the GNA assigned to the resident on the day the incident occurred, was conducted on 1/23/25, at 10:50 AM. GNA #26 reported she remembered the resident but not the specific incident on 6/25/24. When asked about Resident #23, she stated that the resident was totally dependent on staff for care, but somehow the resident would scoot themselves around in bed to lay sideways on the bed. When asked if the resident would flail his/her arms and legs around, the GNA reported she did not recall the resident doing that. An interview with the Director of Nursing (DON) on 1/22/25 at 3:28 PM, revealed she agreed that LPN #25 should have reported this to a supervisor as an injury of unknown origin. The DON stated that LPN #25 received disciplinary action and 1:1 education regarding the expectations of reporting injuries of unknown origin. She stated she educated most of the other nurses and geriatric nursing assistance about injuries of unknown origin and reporting requirements. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/29/25, at 1:15 PM, this was reviewed with the NHA with the DON present.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 40927 Based on record review and interview, it was determined that the facility failed to ensure that an allegation of abuse was thoroughly investigated. This was evident for 1 (#8) of 21 residents reviewed for abuse. The findings include: The MDS (Minimum Data Set) is a complete assessment of the resident which provides the facility information necessary to develop a plan of care, provide the appropriate care and services to the resident, and to modify the care plan based on the resident's status. A medical record review for Resident #8, on 1/22/25 at 10:30 AM, revealed a minimum data set (MDS) with an assessment reference date of 10/3/22, revealed the resident was not cognitively impaired and relied on staff for activities of daily living (such as toileting, getting in and out of bed, dressing, bathing, and personal care). On 1/22/25 at 10:00 AM, a review of the facility's procedure titled Resident Abuse Reporting and Investigation Guidelines (there was no date on the procedure) revealed in #9 the individual conducting the investigation should: #9a review all the documentation and evidence, #9e interview all witnesses, and #9h interview all staff members (on all shifts) who may have had contact with the resident during the period of the alleged event. A review of the facility's investigation file for the facility reported incident #MD00178929 on 1/21/25, at 2:41 PM revealed an email sent from Resident #8's family on 5/13/22, at 4:13 PM reporting that a staff member came into the resident's room around 5:00 AM on 5/13/22, slapped the resident's hand, took the call bell from them, placing it out of reach, and left the room. Another staff member came in later that morning with medications and gave the call bell back to the resident. A review of the call bell response time audit revealed the resident had not used the call bell between 4:30 AM and 8:46 AM. Further, review failed to reveal that the facility conducted the investigation to verify with the nursing staff who had brought medications to the resident that morning. A review of the staffing schedules revealed Licensed Practical Nursing (LPN) #45 was assigned to the resident on night shift 7/12/22 going into 7/13/22. Review of LPN #45's interview questions and answers with Unit Manager #44 revealed she was not asked if she had went into the room with medications that morning and if so, was the call light within the resident's reach or not. Furthermore, there was no interview with the nurse who was assigned to the resident on 5/13/22, dayshift, as they would have given the resident medications that morning. An interview with LPN #45 on 1/23/25 at 7:30 AM revealed she could not recall the incident or the interview that was conducted by Unit Manager #44. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Nursing Home Administrator (NHA) was interviewed on 1/22/25 at 12:18 PM. She reviewed the self-report form. When asked what she does to investigate an allegation of abuse, she stated that she would interview the alleged perpetrator to establish if they were in the room, provided care, and anything unusual or complain about abuse. She would interview all staff who were working around the time of the incident. When asked why staff were asked specific questions during this investigation and not asked about the events that were reported, she stated that she had not conducted the interviews. They were conducted by Unit Manager #44 who was out on leave and unavailable for an interview. She stated that she would review the investigation and report back with additional information. However, there was no additional information provided by the end of the survey.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 43648 Based on record review, interview, and facility policy review, the facility failed to administer a physician ordered medication for 1 (Resident #22) of 3 residents reviewed for medication administration. Specifically, the facility failed to administer a Rocephin (an antibiotic medication) injection to Resident #22 on 02/28/2024. Findings included: A facility policy titled, Medication Administration-General Guideline, revised 12/09/2024, indicated, Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after the have been properly oriented to the facility's medication distribution system (procurement, storage, handling and administration). The facility has sufficient staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions. The policy revealed, B. Administration 2. Medications are administered in accordance with written orders of the prescriber. Per the policy, D. Documentation (including electronic) 1. The individual who administers the medication dose records the administration on the resident's MAR/eMAR [Medication Administration Record/electronic Medication Administration Record] directly after the medication is given. Resident #22's Face Sheet indicated the facility admitted the resident on 02/19/2024. According to the Face Sheet, the resident had a medical history that included diagnoses of sepsis, urinary tract infection (UTI), and metabolic encephalopathy. A hospital Discharge/Transfer Summary, dated 02/19/2024, revealed Resident #22 came to the hospital from home for altered mental status and acute encephalopathy, and was found to have sepsis secondary to a UTI. The Discharge/Transfer Summary revealed the hospital treated the resident for the UTI and sepsis, which was resolved at the time of discharge after four doses of intravenous (IV) Rocephin. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/21/2024, revealed Resident #22 had a Brief Interview for Mental Status (BIMS) score of 2, which indicated the resident had severe cognitive impairment. The MDS revealed that Resident #22 had a UTI in the last 30 days and had not received any IV antibiotic medications during the last three days of the assessment look-back period. Resident #22's Care Plan Report, included a problem statement created on 02/28/2024, that indicated Resident #22 had an IV line for antibiotics. Interventions directed staff to administer antibiotics as ordered (effective 02/28/2024 through 03/06/2024). Resident #22's Telephone Orders, dated 02/27/2024 revealed an order for a urinalysis with a culture and sensitivity test. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #22's urinalysis laboratory report dated 02/28/2024 revealed the resident's urine contained a moderate amount of blood (reference range was negative amount), a large number of leukocytes (reference range was negative amount), red and white blood cells were too numerous to count per high power field (HPF) (reference range was zero to two), Many bacteria (reference range was none), and a moderate amount of crystals (reference range was none). Resident #22's Telephone Orders, dated 02/28/2024 revealed an order for Rocephin 1 gram IV every 24 hours for seven days for a diagnosis of UTI. Per the order, the first dose was required to be given STAT [immediately]. Resident #22's Telephone Orders dated 02/28/2024 revealed an order for one dose of Rocephin 1 gram to be administered intramuscular (IM) today for a UTI. Resident #22's February 2024 Medications record revealed a transcription of the order for Rocephin 1 gram IM with an order date of 02/28/2024. However, the medication record revealed the order was not assigned administration times in the date range and there was no documented evidence the medication was administered as ordered by the provider. The February 2024 Medication record revealed that staff documented that the first dose of IV Rocephin was administered on 02/29/2024. Resident #22's laboratory report dated 03/01/2024 revealed there was no bacterial growth on the resident's final urine culture. During an interview on 01/27/2025 at 11:23 AM, Licensed Practical Nurse (LPN) #21 stated he was the nurse who took the physician's order for an IV line for Resident #22 because the nurse practitioner's first order for Rocephin was for the medication to be administered IV. He stated the resident required a PICC (peripherally inserted central catheter) line to give the medication, which was why the order was re-written for the first dose of Rocephin to be given IM. LPN #21 stated if the nurse practitioner wrote an order for IM Rocephin, it should have been administered as ordered. During a telephone interview on 01/27/2025 at 11:14 AM, Pharmacist #34 stated there were no charges for Rocephin for Resident #22 on 02/28/2024 from the facility's Pyxis system (a computerized system that stored and dispensed medications). He stated there would have been a charge had the medication been removed from the system. He stated that no charge indicated Rocephin was not dispensed. During an interview on 01/27/2025 at 3:04 PM, LPN #24 stated she gave the IM mediation to Resident #22 on the day she took off the order. She stated she got the medication out of the Pyxis system, mixed it, and gave the medication. She stated she did not know why the resident's medication administration record did not reflect that the medication was administered. After notification that the pharmacy had no record that the medication was taken out of the Pyxis system, LPN #24 again stated that she took the medication out of the Pyxis system, reconstituted the medication, and gave the medication. During an interview on 01/27/2025 at 5:05 PM, the Director of Nursing (DON) stated she had spoken with LPN #24, and LPN #24 stated she did not give Resident #22's IM Rocephin. The DON stated she did not know why LPN #24 stated that she removed the medication from the Pyxis system because it was not given. The DON then stated her expectation was for any medication ordered by the physician or nurse practitioner to be given as ordered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/24/2025 at 2:41 PM, Nurse Practitioner (NP) #38 stated if she wrote an order for Rocephin IM, she intended for the medication to be given. Per NP #38, the resident received a PICC line and then received six days of IV Rocephin. The Physician was interviewed on 01/23/2025 at 3:55 PM. Per the Physician, Resident #22 received six days of antibiotics. According to the Physician, six versus seven days of the medication would not have made any difference as the resident's prognosis was poor. The Physician stated they treated the resident's dehydration and infection, and the resident continued to decline. During an interview on 01/28/2025 at 1:49 PM, the Administrator stated any medication ordered by the physician or nurse practitioner was expected to be given as ordered.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40927 Based on observation, record review, and interview, it was determined that the facility failed to ensure that all staff were wearing mask during a COVID 19 outbreak. This was evident on 1 of 4 floors in the facility. The findings include: Upon entry to the facility on [DATE] at the receptionist reported the facility had an outbreak of COVID 19 and masks were required. On 2/24/25, at 6:25 AM, an observation on the transitional care unit [TCU] revealed Geriatric Nursing Assistant (GNA) #7 sitting at a table in an open dining area with no mask on. An interview was conducted with the GNA for approximately 15 minutes, and he failed to put a mask on during this time. In addition, during the interview GNA #42 came over, removed her mask, and sat at the same table. She put her mask back on, left the dining room area, and then came back and removed the mask again. A second observation on 1/24/25, at 6:47 AM revealed Housekeeping Aid (HA) #43 sitting in the common area on the 1st floor with no mask on. The Director of Nursing (DON) walked into the area at the time of the observation. When asked why staff were not wearing their mask, she stated she was not sure and approached HA #43 to ask why she did not have her mask on. HA #43 shrugged her shoulder and stated that she had it with her and patted the mask laying on the seat beside her. The DON asked her to put on her mask. An observation with the DON present of GNA #7 and GNA #42 was made 1/24/25, at 6:49 AM and she observed both of them not wearing their mask while in the opening dining area. She asked them why they were not wearing their mask and neither one of them gave a rationale. An interview was conducted with the DON during the time of the observations, and she confirmed that all staff were expected to wear a mask at all times while in the resident care areas. She was informed that this was not the case for these observations. She stated that staff have been educated. An interview with Operations Manager on 1/24/25, at 9:24 AM revealed he supervised HA #43. He stated that housekeeping staff had received education when the outbreak started and each week during a huddle. He stated that his staff were aware that once they passed through the glass door (entry/exit to the lobby area) they were to wear their mask at all times unless eating or drinking. He was made aware of the observation concerns. On 1/24/25 at 10:16 AM, the Operations Manager provided a copy of the education being provided to the staff and the huddle education. Reviewed with no concerns.