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	05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wilson Health Care Center	301 Russell Avenue Gaithersburg, MD 20877

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)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, facility investigative materials, and staff interview, the facility failed to ensure the confidentiality and protection of a resident's medical record from unauthorized disclosure. This deficient practice was identified for 1 of 2 residents (Resident #138) reviewed as part of facility-reported incident investigations during the recertification/complaint survey.The facility implemented corrective actions prior to the start of the survey. Surveyor verification of the facility's corrective measures determined that the deficient practice had been corrected. Therefore, this deficiency is cited as past noncompliance with a compliance date of 07/03/2025. The findings include:HIPAA stands for the Health Insurance Portability and Accountability Act of 1996, a U.S. federal law designed to protect sensitive patient health information from being disclosed without consent. It establishes national standards for privacy, security, and electronic transactions of, or related to, Protected Health Information.On 04/29/2026 at 7:29 AM, review of facility investigation report #2692537 revealed that on 12/12/2025 at 9:16 AM, the facility Social Worker (Staff #31) received an email from the daughter of Resident #138 alleging a potential HIPAA violation, indicating that another resident's medical record had been provided during a medical appointment.On 04/29/2026 at 7:35 AM, review of Resident #138's electronic health record revealed that the resident's Minimum Data Set (MDS), dated [DATE], Section C, reflected a Brief Interview for Mental Status (BIMS) score of 0 out of 15, indicating severe cognitive impairment at the time of the incident.On 04/29/2026 at 8:04 AM, further review of the facility's investigative documentation revealed the followingA concern and resolution tracking form dated 07/02/2025, which indicated that Resident #138's daughter reported receiving an incorrect medical chart during a dental appointment. Documentation indicated that Licensed Practical Nurse (LPN #4) inadvertently provided another resident's chart, reportedly due to being rushed.Additional documentation indicated that Nurse Supervisor/Manager (Staff #5) confirmed that on 07/02/2025, during an in-house dental consultation with Staff #30, the incorrect chart was provided in error.In a written statement dated 07/04/2025, LPN #4 acknowledged that she mistakenly handed another resident's chart to Resident #138's daughter while the resident was being transported to an in-house dental appointment. The statement indicated that the daughter later returned the chart after identifying it as incorrect, and LPN #4 apologized for the error.04/29/2026 9:11 AM, The investigation packet also included an in-service education given to the staff members on 07/03/2025 stating the necessary actions to be taken by staff members during dental consultations.On 04/29/2026 at 9:54 AM, In an interview with the Director of Nursing (DON), when asked about the incident, she stated that Resident #138's documents had been prepared for the appointment and that the resident's daughter arrived early to accompany the resident. The DON stated that a nurse inadvertently selected and provided the incorrect chart to the daughter. The DON further stated that upon return from the appointment, the daughter reported noticing that the chart did not belong to her family member and expressed concern that treatment may have been based on incorrect information. The DON confirmed that the incorrect chart had been issued.The DON reported that the consulting dentist (Staff #30) did not rely on the paper chart during the visit, as electronic access to the resident's medical record was available. The DON further (continued on next page)

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated that, at the time of the incident, it was the facility's practice to send paper charts with residents to appointments.The DON added that, following the incident, the facility provided in-service education to nursing staff, including charge nurses, geriatric nursing assistants (GNAs), and unit clerks, regarding verification of resident identity and medical records during transfers. The DON also reported that the facility revised its process and discontinued the use of paper charts for appointments, transitioning to a fully electronic system.Based on the facility's investigation, staff statements, and corrective actions, the facility failed to ensure the confidentiality and protection of a resident's medical record. Surveyor verification confirmed that the facility implemented corrective measures, including staff education and process changes, which prevented recurrence. Therefore, this deficiency is cited as past noncompliance with a compliance date of 07/03/2025.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on interviews and record reviews, it was determined that the facility failed to provide dependent residents with showers. This was evident for 1 (Resident #18) out of 11 reviewed for activities of daily living during the recertification survey.The findings include:On 04/27/2026 at 1:58 PM, an interview with Resident #18's representative was conducted. They reported that Resident #18 preferred showers over bed baths, but the facility had not showered the resident in a long time.On 04/29/2026 at 11:54 AM, a review of Resident #18's medical record was conducted. The review revealed that the resident was scheduled to be showered every Mondays and Thursdays 3pm-11pm shift.Review of the Resident #18's preference evaluation indicated that the resident preferred showers in the morning.Review of the care plan and progress notes, failed to indicate that the resident refused showers.On 04/29/2026 at 1:05 PM, further review of the records revealed that Staff #9 had showered Resident #18 on 4/6/26, 4/10/26, 4/13/26, 4/16/26 and 4/20/26. No showers were documented for 4/2/26, 4/3/26, 4/9/26, 4/17/26, 4/23/26, 4/24/26 and 4/27/26.On 04/29/2026 at 2:55 PM, an interview with Staff #9 was conducted. She reported that she had not showered Resident #18 the entire month of April. She further clarified that she had provided the resident with bed baths only and documented the task under showers.On 04/29/2026 at 4:30 PM, an interview with the Director of Nursing (DON) was conducted. She confirmed that residents should receive showers twice a week unless the resident refused, and that the staff were expected to document refusals. On 04/30/2026 at 9:23 AM, a brief follow up interview with the DON was conducted. She reported that she had followed up with Resident #18 and staff and had identified that Resident #18 had not been showered as records indicated. She confirmed that the documentation was for bed baths and not showers. At this time DON was notified of the concerns.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations and interviews, it was determined that the facility failed to ensure that residents had call bells within reach. This was evident for 2 residents (Resident #122 and #181) out of 10 randomly selected residents observed on the unit during the recertification survey. The findings include:On 04/29/2026 at 3:05 PM, Surveyor observed Resident #122's call bell on the floor. When asked where the call bell was, Resident #122 looked around their bed and reported they didn't see it.On 04/29/2026 at 3:07 PM, an interview was conducted with Staff #14. Staff #14 stated that it is the facility staff's responsibility to ensure that resident call bells are within reach at all times. During an observation of the resident's room with Staff #14, she indicated that the call bell should have been clipped to the resident's bed to ensure accessibility. On 04/29/2026 at 3:15 PM, Surveyor observed Resident #181's call bell on the floor. On 04/29/2026 at 3:20 PM, an interview was conducted with Staff #15. Staff #15 stated that the resident was in therapy and reported that she was unsure why the call bell had not been returned to within the resident's reach.On 04/29/2026 at 3:30 PM, the Director of Nursing was made aware of the observations and concerns.