

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215099	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/10/2025
NAME OF PROVIDER OR SUPPLIER  Wilson Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>50457</p> <p>Based on record reviews and interviews, it was determined that facility staff failed to ensure that a resident's Advance Directive (AD) was completed. This deficient practice was evident for 1 (#121) of 3 residents reviewed for AD during the survey.</p> <p>The findings include:</p> <p>Advance Directive is a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated.</p> <p>On 04/08/25 at 10:43 AM, a review of Resident #121's AD in the paper chart revealed several oversights. There was no indication of when the designated health agent's power would become effective--immediately or whenever the resident was unable to make informed healthcare decisions. The resident did sign the AD, but the form was not dated, and the signature and date for two witnesses were left blank. Additionally, part one of the organ donation section was incomplete, and the witness signature and dates were left blank.</p> <p>On 04/09/25 at 10:39 AM, the surveyor presented a copy of Resident #121's AD and informed the Administrator #1 that the documents were missing dates and witness signatures. The Administrator #1 stated that she expects all AD to be fully completed and noted that the resident's medical orders for life sustaining treatment (MOLST) form are used in the event of a code.</p> <p>During an interview with the Social Worker (SW) #19 on 04/09/25 10:44 AM, the surveyor presented Resident #121's AD. The SW #19 acknowledged that the document was incomplete.</p> <p>On 04/10/25 at 09:38 AM, a review SW #19 progress note dated 04/09/25 at 2:17 PM, revealed that she met with Resident #121 to review their AD. The resident's AD was missing a date and witness signatures. The SW provided the resident with a copy to review and requested that they sign and have the AD witnessed. The social worker also offered assistance in finding two witnesses should they need it. The resident agreed to review the documents and follow-up with the social worker.</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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>49148</p> <p>Based on record review and interview with staff, it was determined that the facility failed to ensure a resident was free from misappropriation of resident property. This was evident for 1 facility reported incident (MD00214164) out of 5 facility reported incidents reviewed during the survey.</p> <p>The findings include:</p> <p>On 4/10/2025 at 7:30AM, a review of Resident #19's investigative file for the facility reported incident (FRI) MD00214164 revealed that on 1/24/2025 at 8:10AM, the resident notified the Nursing Home Administrator (NHA) that his/her credit card was missing, and that his/her credit card had been used four times on the evening of 1/23/2025 between 6:46PM and 8:41PM.</p> <p>An additional review of the investigative file revealed that after a thorough investigation, the facility was able to verify the allegation of misappropriation of resident property due to theft and use of the resident's credit card at various stores.</p> <p>On 4/10/2025 at approximately 1:20PM, the Surveyor conducted an interview with the NHA which confirmed the allegation of misappropriation of Resident #19's credit card.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>50457</p> <p>Based on record reviews and interviews, it was determined that facility staff failed to update a resident's care plan to address falls involving equipment. This deficient practice was evident for 1 (#121) of resident review for care plan revision during the survey.</p> <p>The findings include:</p> <p>During an interview with Resident #121 on 04/08/25 at 10:15 AM, they reported that the break lever on their wheelchair was broken. As a result of the broken lever, they had multiple falls while attempting to stand up or sit down using the wheelchair.</p> <p>Review of communication form and progress note revealed that Resident #121 had a fall on 10/07/24, 12/12/24, 12/27/24, 03/19/25, 04/09/25.</p> <p>On 04/09/25 at 1:05 PM, a review of the residents' post fall evaluation progress note dated 10/07/24 indicates that Resident #121 had an unwitnessed fall in their room while attempting to get into bed, and the wheelchair was involved in the fall.</p> <p>A review of physical therapy treatment note dated 12/30/24 revealed that physical therapy was informed of a fall the resident had in the bathroom. The resident reported that they did not lock the wheelchair brake and when they reached back to sit down the wheelchair moved.</p> <p>Review of Resident #121 care plan on 04/09/25 at 2:07 PM, revealed that on 09/17/24 the resident was identified as a high fall risk due to balance issues and a history of falls. Further review indicates that the resident's care plan was not updated to address the residents use of a wheelchair and compliance with locking the wheelchair brake until 3/19/25.</p> <p>During an interview with the Director of Nursing (DON) #2 on 04/09/25 at 11:00 AM the surveyor informed the DON #2 of the above findings. The DON #2 stated that the wheelchair involved was the resident's personal equipment. She further stated that the resident should have behavioral care plan addressing noncompliance with locking the wheelchair breaks. When asked why the resident's care plan was not updated following the resident's fall on 10/07/24 and 12/27/24, the DON #2 was unable to provide an explanation.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>50457</p> <p>Based on interviews, observations, and record reviews, it was determined that facility staff failed to ensure that a resident's wheelchair was safe for use. This deficient practice was evident for 1 (#121) resident review safety hazards during the survey.</p> <p>The findings include:</p> <p>During an interview with Resident #121 on 04/08/25 at 10:15 AM, they reported that the break lever on their wheelchair was broken. As a result of the broken break lever, they had multiple falls while attempting to stand up or sit down using the wheelchair.</p> <p>Review of communication form and progress note revealed that Resident #121 had a fall on 10/07/24, 12/12/24, 12/27/24, 03/19/25, and 04/09/25.</p> <p>On 04/09/25 at 8:57AM, the surveyor observed Resident #121 sitting in a wheelchair in their room, watching television. With permission from the resident, the surveyor assessed the wheelchair's brakes. Upon unlocking and locking the right break lever, it was noted that the lever did not fully lock the wheel, allowing movement with activity. The left brake lever locked the wheel preventing movement.</p> <p>After exiting the resident's room, the surveyor observed an unoccupied wheelchair in the seating area in front of the nurse's station. While assessing this wheelchair break levers, it was noted that the right brake lever did not fully lock the wheel, allowing for movement. The left break lever locked the wheel preventing movement. There were no tickets or signs indicating that the wheelchair needed repairing.</p> <p>On 04/09/25 at 9:18 AM, the surveyor informed nurse unit manager #5 about the malfunctioning brake levers on both wheelchairs and inquired about the process of addressing faulty resident equipment. The nurse UM #5 stated that nursing staff are responsible for reporting equipment concerns to the front desk secretary who will submit a work order through a platform called TELS.</p> <p>On 04/09/25 at 9:36 AM, during an interview with maintenance tech #25, he stated that nursing staff is responsible for immediately reporting equipment concerns. The surveyor asked if he regularly checks equipment including wheelchairs on the units to ensure they are functioning properly. Maintenance Tech #25 explained that he is the only technician for the building, and he does not proactively check equipment, but instead addresses issues based on reports submitted through the TELS system. The surveyor asked if a work order was submitted for Resident #121 in October and December 2024, and he stated that he was uncertain about gathering records from those months.</p> <p>During an interview with the Director of Nursing (DON) #2 on 04/09/25 at 11:00 AM the surveyor shared findings regarding Resident #121's wheelchair. The DON #2 reports that the wheelchair was the resident's personal property. When asked whether the wheelchair had been assessed for safety hazards upon the resident's admission or prior to its use within the facility, the DON #2 was unable to provide documentation confirming that an assessment had been conducted prior to use in the facility.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>30440</p> <p>Based on medical record review and interviews with facility staff, it was determined the facility failed to ensure that: 1) staff accurately documented if a resident exhibited side effects while receiving anti anxiety medications; 2) staff accurately documented a resident's Treatment Administration Record; 3) staff accurately documented side effects of antipsychotic and anticoagulant medications; 4) antipsychotic medication monitoring on the treatment administration record (TAR) was documented to reflect resident status; 5) resident medical records accurately reflect a resident's status; and 6) resident's medical records were complete and accurately reflects the residents advance directive status. This was found to be evident for 5 (Resident #7, # 27, #55, #91, and #367) of 6 residents reviewed for unnecessary medications, 1 (Resident #49) of 3 residents reviewed for hospitalization , and 1 (Resident #121) of 4 residents reviewed for advance directives.</p> <p>The findings include:</p> <p>1) Resident #7's medical record was reviewed on 4/10/25 at 10:58 AM and it revealed the resident had the following but not limited diagnosis: Dementia, Anxiety, and Depressive Disorder.</p> <p>The resident medication administration record for March 2025 and April 2025 was reviewed on the same date and indicated to observe the residents closely for significant side effects of anti-anxiety medication; including drowsiness, slurred speech, dizziness, nausea, aggressive or impulsive behavior every shift and document (Y) if monitored and none of the above is observed, and (N) if monitored and any of the above was observed.</p> <p>Documentation by staff revealed a check mark above the staff initials for each shift. During a meeting with the DON on the same date she was asked to explain how she would verify if the resident had any of the above side effects and she stated that</p> <p>staff should document a yes (Y) when side effects are present with a note and no (N) when there are no side effects observed. She stated that re-education will be provided for her staff.</p> <p>All concerns were discussed with the Administration team at the exit conference on 4/10/25 at 2:00 PM.</p> <p>48167</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2) Review of Resident #27's medical record on 04/09/2025 at 09:38 AM the Treatment Administration Record (TAR) for the month of April 2025 revealed a physician order dated 08/01/2024 at 2300 PM, states Observe closely for side effects of Antipsychotic medication including dry mouth, constipation, blurred vision, disorientation or confusion, difficulty urinating, hypotension, dark urine, yellow skin, nausea or vomiting, lethargy, drooling, EPS symptoms (tremors, disturbed gait, increased agitation, restlessness, involuntary movement of mouth or tongue) every shift Document: 'Y' if monitored and none of the above observed. 'N' if monitored and any of the above was observed, select chart code 'Other/ See Nurses Notes' and progress note findings. Further review of the TAR revealed that Staff #23 documented No on 4/2/25 and N on 4/3/25-Night shift; Staff #24 documented N on 4/4/25-Day shift; and Staff #22 documented N on 4/3/25 and 4/8/25-Day shift and no progress note findings were found.</p> <p>During an interview on 04/09/2025 at 09:43 AM the Surveyor conducted a staff interview with Nurse Manager, staff #5 while reviewing Resident #27's April 2025 TAR. The surveyor asked Staff #5 are progress notes required when indicated. Staff #5 stated, yes progress notes are needed if staff members answer No or N. Staff #5 stated there were no progress notes completed for staff members who documented No or N and staff should have completed a progress note.</p> <p>3) Review of resident #367 medical record on 04/09/2025 at 09:40 AM the Treatment Administration Record (TAR) for the month April 2025 revealed a physician order dated 08/01/2024 at 2300 PM, states Observe closely for significant side effects of Antidepressant medication including drowsiness, blurred vision, dizziness, nausea, fatigue, trouble sleeping, dry mouth, hallucinations, other unusual changes in mood or behavior every shift for Monitoring Document: 'Y' if monitored and none of the above observed. 'N' if monitored and any of the above was observed, select chart code 'Other/ See Nurses Notes' and progress note findings. Staff #23 documented No on 4/1/25, 4/2/25 and documented N on 4/3/25-Night shift; staff #22 documented N on 4/3/25 and 4/8/25-Day Shift, and no progress note findings were found.</p> <p>During an interview on 04/09/2025 at 09:45 AM the Surveyor conducted a staff interview with Nurse Manager, staff #5 while reviewing resident #367 April 2025 TAR. The surveyor asked staff #5 are progress notes required when indicated. Staff #5 stated yes progress notes are needed if a staff member answers No or N. Staff #5 stated there were no progress notes completed for staff members who documented No or N and staff should have completed a progress note.</p> <p>49148</p> <p>4) Antipsychotic drugs are prescription medications used to treat symptoms of psychotic disorders.</p> <p>Anticoagulants drugs are prescription medications that increase the time it takes the blot to clot.</p> <p>On 4/9/2025 at 9:15AM during a review of Resident #91's electronic medical record, the Surveyor discovered an order for Eliquis oral tablet 2.5MG, an anticoagulant, and Quetiapine Fumarate oral tablet 25MG, an antipsychotic. An additional review of the resident's electronic medical record revealed that the medications had been received according to the Medication Administration Record (MAR).</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Further review revealed orders located in the Treatment Administration Record (TAR) for the months of March 2025 and April 2025 to Observe closely for side effects of Antipsychotic medication including dry mouth, constipation, blurred vision, disorientation, or confusion, difficulty urinating, hypotension, dark urine, yellow skin, nausea or vomiting, lethargy, drooling, EPS symptoms (tremors, disturbed gait, increased agitation, restlessness, involuntary movement of mouth or tongue) every shift. Document: 'Y' if monitored and none of the above was observed. 'N' if monitored and any of the above was observed, select chart code 'Other/ See Nurses Notes' and progress note findings and Observe closely for significant side effects of Anticoagulant medication including discolored urine, bleeding, bleeding gums, black tarry stools, sudden severe headache, nausea or vomiting, diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status or vital signs, shortness of breath, nosebleeds every shift for Bleeding Precautions Document: 'Y' if monitored and none of the above was observed. 'N' if monitored and any of the above was observed, select chart code 'Other/ See Nurses Notes' and progress note findings. According to the residents' TAR, the nursing staff was documenting 'N' for the antipsychotic and anticoagulant observation of side effects. A review of Resident #91's nursing progress notes for March 2025 and April 2025 failed to reveal a nurses note to coincide with all 'N' documented in the resident's TAR.</p> <p>50573</p> <p>5) On 04/09/25 at 07:34 AM, review of Resident #49's medical record revealed an active order for antipsychotic medication monitoring that indicated for staff to document Y as the resident was observed with no side effects, and N as the resident was observed with side effects. Antipsychotic medications are used to treat psychological (mental) signs and symptoms.</p> <p>Further review of the order revealed the indication that if staff were to document an N, then an additional step would be indicated on the resident's medical record about the observation.</p> <p>On 04/09/25 at 12:51 PM, review of Resident #49's TAR in March and April 2025 revealed a check mark for each shift but failed to reveal indication that Y or N was documented to reflect the observation based on the orders indication.</p> <p>6) On 04/08/25 at 11:05 AM, review of Resident #55's medical record revealed a progress note titled, Fall Risk Evaluation dated 3/29/25 at 10:48 PM completed by Unit Coordinator (Staff 15), that indicated the resident had been hospitalized in the last 30 days of the progress note date.</p> <p>On 04/09/25 at 12:51 PM, the Director of Nursing informed the surveyor with Resident #55's last hospitalization date, which was 4/19/24.</p> <p>On 04/09/25 at 07:22 AM, the surveyor reviewed the concern with the Director of Nursing regarding the progress note dated 3/29/25 versus the last hospitalization date provided. She indicated that it was an error.</p> <p>50457</p> <p>7) Review of Resident #121's advance directive (AD) in the paper medical chart on 04/08/25 at 10:43 AM, revealed that the documents were missing dates, witness signatures, and other information.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Social Worker (SW) #19 progress note for Resident #121 dated 08/15/24 at 12:55 PM, revealed a note; Resident provided completed AD. Documents uploaded to the electronic medical records, and a copy was placed in the resident's chart.</p> <p>During an interview with SW #19 on 04/09/25 at 10:44 AM, the surveyor presented Resident #121's AD and informed SW #19 that the documents were missing dates and witness signatures. SW #19 acknowledged that the document was incomplete.</p> <p>On 04/10/25 at 09:38 AM, a review SW #19 progress note dated 04/09/25 at 2:17pm, revealed that she met with Resident #121 to review their AD. The social worker mentioned that the resident's AD was missing a date and witness signatures. The SW provided the residents with a copy and requested that they sign and have the AD witnessed. The social worker also helped in finding two witnesses.</p>

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>51712</p> <p>Based on observations and interviews with the facility staff, it was determined that the facility staff failed to ensure that a resident's call bell was within reach. This was evident for 1 resident (Resident #1) out of 4 residents observed during the survey.</p> <p>The findings include:</p> <p>On 4/08/25 at 10:24 AM, the resident was observed lying in bed comfortably. The call bell was noted to be hanging behind the bookcase at the foot of the resident's bed against the wall. The surveyor interviewed the resident and asked he/r, how they would call for assistance. They stated that they uses the call bell. The resident started to look for the call bell and then said, I don't know what I did with it. Then the surveyor asked, How would you ask for assistance if you can't find the call bell? The resident responded that s/he would wait until someone came to check in on them.</p> <p>On 4/09/25 at 1:17 PM, the resident was observed lying in bed, watching TV. The call bell was hanging from the wall on the left side of the bed on the floor. The surveyor went to the nursing station and to interview the Charge Nurse (CN) #15. The surveyor asked the CN #15 to walk with them to see a resident. After entering the resident's room, and the surveyor asked him where the call bell was. CN #15 stated that he had observed the call bell behind the bookcase the day before and had given it back to the resident. The CN #15 continued to say that he had started to educate his employees on the policy for call bells on the evening of 4/8/2025. Then, the CN #15 picked the call bell up off the floor and handed it to the resident.</p>