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

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on record review, staff interview, and facility policy review, it was determined that the facility failed to ensure that a resident's right to formulate an advance directive and to have a properly identified and authorized representative make healthcare decisions was maintained for 1 (Resident #15) of 4 residents reviewed for advanced directives during the annual survey. Findings include: On 04/28/2026 at 9:32 AM, an initial review of Resident #15's medical record revealed the resident had two incapacity certifications dated 6/28/24 and 7/10/24. There were 2 individuals noted to be making decisions for the resident, one was a niece of the resident, and the other was a friend who had Financial Power of Attorney. The medical record failed to contain documentation identifying a legally authorized representative or copies of a financial power of attorney (POA) documentation. On 04/29/2026 at 12:50 PM, further review of the Resident's medical records revealed multiple consent forms, including vaccine consents dated 8/7/24 and 7/7/25, that identified an individual as POA; however, no supporting legal documentation was present in the medical record to verify this authority. Additionally, a telephone consent for psychoactive medication dated 5/23/24 identified a different individual as POA, further contributing to inconsistency regarding the resident's decision-maker. On 04/29/2026 at 12:55PM, review of the social worker progress notes failed to reveal documented evidence that the resident or representative was offered the opportunity to complete an advance directive upon admission, nor was there social services documentation to support that education regarding advance directives was provided. During interview on 04/29/2026 at 1:46 PM, the Social Work Director confirmed that the facility did not have a copy of the Financial POA documentation on file, had not verified the scope of authority, and acknowledged that the individual signing consents should not have been permitted to do so without such verification. She further stated that neither the niece or the resident's friend have a legal surrogate decision maker form filled out, as required by the state of Maryland Surrogate Decision hierarchy, to make medical decisions on behalf of the resident. At this time the Social Work Director was made aware of the concerns. On 04/29/2026 at 2:04 PM, a review of the facility policy titled Health Care Decision Making - Advanced Directives - Maryland stated that residents will be informed of their rights regarding advance directives and that the facility will ensure a healthcare decision-maker is identified in the absence of an advance directive. It also stated that an existing advanced directive will be reviewed by the Social Worker and special care should be taken to clearly understand what rights are conferred by an advance directive that establishes health care agent (scope of decision making authority) and when the advanced directive becomes effective.

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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on resident interview, record review, and staff interview, the facility failed to ensure that a resident received necessary services and equipment to maintain or enhance independence in activities of daily living, specifically related to bed mobility. This deficient practice was identified for 1 (Resident #65) of 2 residents reviewed for accommodation of needs. The findings include: On 4/27/2026 at 11:31 AM, an interview was conducted with Resident #65, who reported that the facility removed the bed rails from their bed due to concerns regarding entrapment risk. The resident expressed that without the bed rails, they experienced decreased independence with repositioning in bed and voiced fear of rolling out of bed during care. On 4/28/2026 at 12:36 PM, a review of physician orders revealed an order dated 9/27/2024 for Bilateral upper bedrails for bed mobility and promotion of independence per resident request, which was discontinued on 3/31/2026. On 4/28/2026 at 12:38 PM, Resident #65's Health Status Note from 3/31/2026 was reviewed. The note stated the resident was notified again that due to the risk of entrapment, the facility has decided to remove all bedside rails. He expressed understanding and his bedrails were removed. On 4/28/2026 at 12:43 PM, review of the most recent Bed Rail Evaluation dated 1/7/2026 indicated that bilateral side rails/assist bars were assessed as appropriate and necessary, serving as an enabler to promote independence. On 4/28/2026 at 1:25 PM, an interview was conducted with the Rehabilitation Director (Staff #32) and Director of Nursing (DON). Staff #32 stated that the resident's need or preference for bed rails had not been brought to the attention of the rehabilitation team prior to that day. The DON stated that the facility implemented a house-wide removal of bed rails due to entrapment risk, regardless of individual resident need. The DON confirmed that no individualized reassessment was completed prior to removal but stated that residents and their representatives were notified. The DON further stated that wider beds were provided as an alternative intervention. On 4/29/2026 at 8:52 AM, Resident #65 stated that they had informed the Nurse Manager (Staff #5) and other management staff of their desire to have bed rails reinstated. On 4/29/2026 at 9:47 AM, an interview with Staff #5 revealed that reevaluation of bed rail use should occur when there is a decline in ADLs and therapy should be involved to assess risks versus benefits. Staff #5 confirmed that they were not aware of Resident #65's concerns and could not recall whether a reevaluation was conducted prior to removal of the bed rails.

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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.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and interview, it was determined that the facility failed to maintain the accuracy of the content of R14's EMR (electronic medical record). This was evident for three residents (R14, R179, and R180) as R14's EMR contained medical documents for R179 and R180. The findings include:A review of R14's EMR was performed on 4/28/26 at 11:30 AM. During the review, it was found that medical documents for two other residents had been added to R14's EMR. The surveyor note that on 4/22/26 at 1:45 AM, RN33 uploaded into R14's EMR under the Documents tab, a hospital discharge summary for R179 and the baseline care plan for R180.During an interview on 4/30/26 at 8:35 AM, DON2 stated, Anyone can upload documents into the resident's EMR under the Documents tab but usually the clerks do it. DON2 also confirmed that RN33 was a staff nurse at the facility. During an interview on 5/1/26 at 10:54 AM, NHA1 confirmed that there were two wrong documents uploaded into R14's EMR.