

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215146	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/07/2025
NAME OF PROVIDER OR SUPPLIER  FT Washington Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  12021 Livingston Road Fort Washington, MD 20744	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on review of facility documents and staff interview it was determined the facility failed to report an allegation of abuse immediately but not later than 2 hours after an allegation was made. This was evident for 1 (Resident #16) of 13 residents reviewed for a facility reported incident during the complaint survey. The findings include: On 8/4/25 at 2:32 PM, a review of facility reported incident 294211 alleged a male staff member had exposed himself to Resident #16. The facility's investigation documented the facility became aware of the incident on 10/20/24 at 8:00 AM. Review of facility documentation revealed an email confirmation that documented the facility's initial report was sent to the State Survey Agency on 10/20/24 at 11:21 AM. The facility failed to report the allegation of abuse immediately, but not later than 2 hours after the allegation was made. The concerns with the late reporting of an allegation of abuse was discussed with the Nursing Home Administer (NHA) on 8/5/25 at 9:45 AM. The NHA acknowledged the concerns at that time and indicated he would look into the concern.</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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on medical record review and staff interview, it was determined that the facility staff failed to ensure that each resident received treatment and care in accordance with professional standards of practice by 1) failing to ensure orders for the resident's immediate care were confirmed with the physician and documented in the medical record, 2) failing to reconcile a resident's medications on admission, 3) failing to ensure medication was available in a timely manner for the facility to administer, and 4) failing to notify the physician when a resident was not given medication as prescribed. This was evident for 1 (Resident #20) of 16 residents reviewed for a complaint. The findings include: Respite care is either planned care or temporary emergency healthcare that is provided to the caregiver of a child patient or adult patient. Medication Reconciliation is the process of identifying the most accurate list of all medications that the patient is taking by comparing the medical record to an external list of medications obtained from a patient, hospital, or other provider. Medication reconciliation is required for patients transitioning into a new care setting or being transferred to another provider. On 7/30/25 at 12:55 PM, a review of complaint #294208 alleged that when Resident #20 resided in the facility for respite care in August 2024, the resident was not given all his/her medications, specifically his/her medication prescribed for Leukemia. During an interview on 8/6/25 at 3:40 PM, the complainant reported that s/he brought Resident #20's medication into the facility, went over the medication with the staff, and gave the staff the resident's medication. On 8/6/25, at 3:00 PM, a review of Resident #20's electronic medical record) (EMR) and closed paper medical record was conducted and revealed Resident #20 was admitted to the facility on [DATE] for respite care and was discharged from the facility on 8/26/24. The medical record documented Resident #20 had multiple diagnoses which included dementia, atrial fibrillation (irregular heartbeat), primary aldosteronism (adrenal gland disorder), allergies, hypertension (high blood pressure), benign prostatic hyperplasia with lower urinary tract symptoms, type 2 Diabetes, and chronic lymphocytic Leukemia. A review of a physician's Order Summary Report for active orders as of 8/24/24 for Resident #20 revealed admission orders including dietary orders, treatment orders, and 24 medication orders. Continued review of Resident #20's medical record failed to reveal documentation that when Resident #20 was admitted to the facility, the physician was notified and orders for the resident's immediate care were confirmed with the physician. Further review of the EMR and paper medical record failed to reveal evidence of physician signed admission orders for Resident #20, and there were no physician progress notes were found in the resident's electronic and paper medical record. The medical record review failed to reveal documentation of the sources used to identify the medication prescribed for Resident #20 upon admission to the facility and there was no evidence that a medication reconciliation of Resident #20's admission medications had been conducted. A review of Resident #20's August 2024 electronic Medication Administration Record (eMAR) included 8 orders for medication (Donepezil by mouth for dementia, Eplerenone by mouth for primary aldosteronism (hormonal disorder), Lotrel by mouth for hypertension, Montelukast by mouth for breathing, Oxybutynin by mouth for overactive bladder, Sitagliptin-Metformin (Janumet) by mouth for Diabetes, Fexofenadine by mouth for allergies, and Fluticasone nasal suspension, 1 inhalation in each nostril for nasal allergies) to be given every day at AM that were signed off with the code 9 (other/see nurses notes) on 8/24/25 AM, indicating Resident #20 was not given the medication as ordered at the scheduled administration time on 8/24/25. In addition, on 8/25/24, the order for Fexofenadine by mouth was signed off with the code 9, and the order for Fluticasone nasal suspension, to be given every day at AM was signed off with the code 9. When the medication administration is coded 9, the medication order populates in a medication administration note in the EMR for the practitioner to document pertinent information when medication was not given. Review of Resident #20's eMar Medication Administration Notes revealed:- An eMar administration note on 8/24/25 at 3:34 PM documented, Awaiting pharmacy delivery, N/A. MD (medical doctor) /RP (representative) aware. The eMar note indicated the facility was waiting for the pharmacy to deliver a medication for Resident #20. There was no documentation to indicate the name of the medication awaiting delivery from the pharmacy and there was no documentation in the eMar note to indicate what was reported to the MD or the response of the MD. Continued review of Resident #20's eMar administration notes, found no other eMar notes in that addressed the reason the medications, Donepezil, Eplerenone, Lotrel, Montelukast, Oxybutynin, Sitagliptin, Fexofenadine, and Fluticasone nasal spray, were not administered to Resident #20 on 8/24/25 at AM as prescribed, and no documentation was found to</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observation, medical record review, and staff interview, it was determined that prior to the installation of bed rails, the facility 1) failed to identify and use appropriate alternatives prior to installing or using bed rails, 2) failed to ensure the risks and benefits of bed rails were reviewed with the resident or resident representative and obtain informed consent for use of the bed rails, 3) failed to obtain a physician's order for the use of the bed rails and 4) failed develop a care plan with specific interventions for use of the bed rail. This was evident for 3 (Resident #8, #11, #28) of 3 residents reviewed for bed rails during the complaint survey. The findings include: Bed rails (side rails) are adjustable bars that attach to the bed and available in a variety of types, shapes, and sizes. As enablers, bedrails facilitate movement and may promote independence. Entrapment is an event in which a resident is caught, trapped, or entangled in the space in or about the bed rail. A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care 1) On 7/31/25 at 11:34 AM, a review of Complaint #294227 alleged the complainant was told the facility could not provide bed rails to Resident #8's bed due to a state regulation. On 7/31/25 at approximately 2:00 PM, Resident #8 was observed lying in bed. Observation of the resident's bed revealed an enabler side rail was attached to each side of the resident's bed. At that time, Resident #8 indicated that the bed rails were installed on the bed shortly after his/her admission to the facility, that s/he used the bed rails to help with positioning and pull him/herself up, and the resident had no concerns related to the use of the bed rails. On 8/7/25 at 1:05 PM, a review of Resident #8's medical record revealed a Bed Safety Evaluation on 6/14/25, however there was no documentation on form to indicate bed rails were attached to the resident's bed or an assessment of the resident's for risk of entrapment from bed rails had been conducted. Continued review of Resident #8's medical record failed to reveal a physician's order for the resident's use of the bed rails and there was no documentation in the medical record to indicate the risks and benefits of bed rails were reviewed with the resident and/or resident representative, and informed consent had been obtained prior to the installation of the bed rails. In addition, no documentation was found to indicate appropriate alternatives were attempted prior to the installing or using the bed rails, and there was no documentation of any ongoing direct monitoring and supervision provided during the use of the bed rail. Review of Resident #8's care plans failed to reveal a care plan had been developed with specific interventions for use of the bed rail. 2) On 7/31/25 at 2:15 PM, an observation of Resident #11 found the resident lying in bed. Observation of Resident #11's bed revealed a bed rail was attached to each side of the resident's bed. On 8/6/25 at 1:15 PM, a review of Resident #11's medical record revealed a 4/29/25 order for 1/4 siderails to bed to promote independence with ADL's. Indicated right and left bed rail. A review of a Bed Safety Evaluation for Resident #11, dated 7/29/25, revealed there was no documentation on the form to indicate bed rails were attached to the resident's bed or that an assessment of the resident for risk of entrapment from bed rails had been conducted prior to the installation of the bed rails. Continued review of Resident #11's medical record failed to reveal documentation to indicate the risks and benefits of bed rails were reviewed with the resident and/or resident representative, and informed consent had been obtained prior to the installation of the bed rails. In addition, no documentation found to indicate appropriate alternatives were attempted prior to the installing or using the bed rails, and there was no documentation of any ongoing direct monitoring and supervision provided during the use of the bed rail. Review of Resident #11's care plans failed to reveal a care plan had been developed with specific interventions for use of the bed rail. 3) On 8/6/25 at 1:00 PM, Resident #28 was observed lying in bed. An observation of the resident's bed revealed a bed rail was attached. A review of the Resident #28's medical record on 8/6/25 at 1:30 PM, revealed a 4/22/25 physician's order for 1/4 siderails to bed to promote independence with ADL's. A review of a Bed Safety Evaluation for Resident #28 on 7/29/25, revealed no documentation to indicate bed rails were attached to the resident's bed or that an assessment of the resident for risk of entrapment from bed rails had been conducted prior to the installation of the bed rails. Continued review of Resident #28's medical record failed to reveal documentation to indicate the risks and benefits of bed rails were reviewed with the resident and/or resident representative, and informed consent had been obtained prior to the installation of the bed rails. In addition, no documentation found to indicate appropriate alternatives were attempted prior to the installing or using the bed rails, and there was no documentation of any ongoing direct monitoring and supervision provided during the use of the bed rail. Review of Resident #28's care plans failed to reveal a care plan had been developed with specific interventions for use of the</p>		

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<p>F 0713</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or arrange emergency care by a doctor 24 hours a day.</p> <p>Based on medical record review and staff interview, it was determined the facility failed to ensure the provision of physician services 24 hours a day, in case of emergency. This was evident for 1 (Resident #14) of 16 residents reviewed for a complaint during the complaint survey. The findings include: Telehealth is the delivery of health services remotely, using technology to connect patients and providers who are not in the same physical location. On 7/31/25 at 12:08 PM, complaint #294220 reviewed alleged that on 2/9/25 the resident's representative received a call from Resident #14 complaining of continued severe stomach pain and the resident had requested to go to the emergency room (ER). The complaint alleged the resident's representative received a call from the facility informing him/her that the staff could not get in touch with the on-call doctor, and the resident wasn't in distress, therefore, if the representative wanted Resident #14 transported to the hospital ER, then then s/he would have to transport the resident to the ER. On 8/6/25 at 12:00 PM, a review of Resident #14's electronic medical record (EMR) was conducted. In a nurses note on 2/9/25 at 8:30 PM, the nurse (Staff #11, Licensed Practical Nurse (LPN)), documented Resident #14 complained of abdominal pain and emesis (vomit) one time. The nurse wrote that Resident #14 was assessed and not in distress at that time, and the [the resident's representative] insisted on taking the resident to the ER. The nurse further wrote that the Convergence (telehealth on-call service) was called twice, with no response. In a Telehealth Notification Note, on 2/10/25 at 12:44 AM, the Clinical Nurse Practitioner documented that the nurse reported that Resident #14 had an episode of emesis and abdominal pain earlier, and [the resident's representative] took him/her to the ER just after 9:00 PM. In a nurses note on 2/10/25 at 7:33 AM, the nurse wrote that Resident #14 was being admitted to the hospital for a bowel obstruction, and hypotension (low blood pressure). On 8/6/25 at 4:38 PM, during an interview, Staff #11, LPN stated that the evening Resident #14 was transported to the hospital by his/her representative, she had worked the 3 pm to 11 pm shift. Staff #11 stated that Resident #14 complained that his/her stomach hurt and s/he took Resident #14's complaint seriously, because the resident rarely complained. Staff #11 stated s/he called the physician's on-call service, and it took a while for the doctor to call back. Staff #11 stated that while s/he was waiting for the doctor to call back, s/he received a call from the resident's representative who stated s/he was going to the hospital to meet the resident. Staff #11 stated that s/he told the resident's representative that s/he was waiting for the doctor to call back and, since the representative was going to the hospital, it would be easier for the representative to transport Resident #14 to the ER. Staff #11 stated s/he did not call 911 because Resident #14 was not in distress at the time and indicated s/he was waiting to speak to the on-call practitioner to obtain treatment orders. Staff #11 stated that s/he was no longer at the facility when the practitioner called back, and that s/he thought it was the next morning. On 8/7/25 at 6:50 PM, NHA was made aware of the above concern that the on-call practitioner failed to respond timely when called by facility nursing staff about a resident with a change in condition and that when the nursing staff were unable to reach the on-call practitioner for emergency treatment orders, the nursing staff transferred the resident for emergency treatment without a physician's order was discussed with the Nursing Home Administrator (NHA) on 8/7/25 at 6:50 PM. At that time, the NHA acknowledged the concerns and stated that the practitioner on-call should be available and respond back to the facility in a reasonable time.</p>		