

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215228	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/02/2024
NAME OF PROVIDER OR SUPPLIER Althea Woodland Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 Daleview Drive Silver Spring, MD 20901	

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 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>42886</p> <p>Based on medical record review and interview, the facility failed to provide written notice to the resident or resident representative of the facility's bed hold policy. (Resident # 2). This was evident in 1 of 5 residents reviewed during a complaint survey.</p> <p>Findings includes:</p> <p>Review of resident #2's medical records on 7/30/24 at 11:12am revealed the resident was transferred from the facility after exhibiting behavioral issues that put the resident and other residents at risk. The resident was transferred to a local hospital for emergency psychiatric evaluation on 8/28/21 and did not return to the facility. Continued review of resident #2's medical records revealed no evidence that the facility provided the resident or his/her representative with a bed hold policy. Also, there was no evidence of a provider discharge summary on the resident's medical record 30 days after the resident transferred to the local hospital.</p> <p>Interview with the Social Worker Director #3 on 7/31/24 at 12:00pm revealed the facility failed provide a bed hold policy to the resident or the resident representative at or after the resident was transferred to the local hospital.</p> <p>Surveyor interview with the Administrator on 7/31/24 at 1:30pm provided no additional information.</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 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42886</p> <p>Based on medical record review and interview, the facility failed to allow a resident (resident #2) to return to the facility after transfer for emergency treatment. This was evident for 1 of 5 residents reviewed during a complaint survey.</p> <p>Findings include:</p> <p>Review of resident #2's medical records on 7/30/24 at 11:12am revealed the resident was transferred from the facility after exhibiting behavioral issues that put the resident and other residents at risk. The resident was transferred to a local hospital for emergency psychiatric evaluation on 8/28/21 and did not return to the facility. Continued review of resident #2's medical records revealed no evidence that the facility provided the resident or his/her representative with a bed hold policy. Also, there was no evidence of a provider discharge summary on the resident's medical record 30 days after the resident transferred to the local hospital.</p> <p>Interview with the complainant on 7/31/24 at 12:24pm. The complainant revealed that he/she was the Director of Behavioral Health for the local hospital to which resident #2 was sent for emergency psychiatric evaluation on 8/28/21. The complainant stated the resident was cleared for transfer back to the facility on [DATE]. When the local hospital called to arrange for transportation to the facility, the facility told the local hospital that the resident's bed was no longer available, and the facility had no other beds available for the resident. The complainant further stated that the local hospital had to place the resident on the observation unit until the he/she could be transferred to other long-term care facility. The local hospital was able to have the resident sent to another long-term care facility on 9/10/21.</p> <p>Interview with the Administrator on 7/31/24 at 1:29pm confirmed that the facility failed to allow resident #2 to return to the facility after emergency treatment. The Administrator admitted that as of 9/2/21, the facility had one bed that could have been assigned the resident, but the facility did not believe the room assignment would have been an appropriate placement due to the room's occupant would not tolerate residents with any behavioral issues.</p>		

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<p>F 0661</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge.</p> <p>42886</p> <p>Based on record review and interview, it was determined that the facility failed to place a discharge summary on a resident's (resident #2) medical record after discharge. This was evident for 1 of 5 residents reviewed in a complaint survey.</p> <p>Findings includes:</p> <p>Review of resident #2's medical records on 7/30/24 at 11:12am revealed the resident was transferred from the facility after exhibiting behavioral issues that put the resident and other residents at risk. The resident was transferred to a local hospital for emergency psychiatric evaluation on 8/28/21 and did not return to the facility. Continued review of resident #2's medical records revealed no evidence that the facility provided the resident or his/her representative with a bed hold policy. Also, there was no evidence of a provider discharge summary on the resident's medical record 30 days after the resident transferred to the local hospital.</p> <p>Interview with the Administrator on 7/31/24 at 1:29pm confirmed that the facility failed to place a provider discharge summary on resident #2's medical record after discharge.</p>		