

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215304	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2026
NAME OF PROVIDER OR SUPPLIER Asbury Solomons		STREET ADDRESS, CITY, STATE, ZIP CODE 11750 Asbury Circle Solomons, MD 20688	
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 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 a review of facility investigation documents, medical records, and staff interviews, it was determined that the facility failed to provide adequate supervision to a resident identified as a wandering risk. This was evident in 1 (Resident #17) out of 1 resident reviewed for supervision during the recertification and complaint survey. The Findings include: A Wander Guard system is an electronic security solution used in long term care facilities to prevent at-risk residents from wandering off-site or into unsafe areas. During an interview with the ADON on 07/16/2026 the wander guard system was explained as a two step process. The sensor will give an audible alarm sound when warning that a resident wearing a wander guard sensor has approached an exit door or the elevator. If the resident crosses through the threshold of the door or the elevator, the alarm will be triggered and will give both an audible alarm sound along with flashing lights at the nurses station. The wander guard sensor activation location can also be mapped visually on a computer screen at the nurse's station where it provides further details as to which resident set off the alarm as well as the time and location. The wander guard system has to be manually turned off by staff at the pin pad by the door or elevator that was triggered by entering the pin. On 07/15/2026 at 11:58 AM, a review of the facility incident report revealed Resident #17 was able to leave off the second-floor Health Care (HC) unit via the elevator and made their way down to the first-floor lobby on 6/7/2026. Resident #17 had a documented wander guard in place, and it was confirmed it was working at the time of incident. It was determined Resident #17 was able to enter the elevator when a visitor to the HC floor exited. On 07/15/2026 at 12:55 PM, a review of the facility's incident report for alarm notifications, indicated that a warning was set off by Resident #17's wander guard upon approaching the HC elevator lobby at 8:28:04 AM. An alarm activation was triggered at 8:28:13 AM when the HC elevator doors opened to the second floor lobby. According to the report there was a warning triggered at 8:28:57 AM in the HC second floor lobby and again at 08:29:57 AM at the first floor lobby exit door that led outside. The alarm was cleared at HC elevator lobby pin pad at 8:30:19 AM manually by a staff member. The alarm was reactivated at 08:32:07 AM when the HC elevator doors opened to the HC second floor elevator lobby as Resident #17 returned to the unit escorted by facility staff. MDS (Minimum Data Set) is a complete assessment of the resident which provides the facility information necessary to develop a plan of care, provide the appropriate care and services to the resident, and to modify the care plan based on the resident's condition. Brief Interview of Mental Status (BIMS) is a standardized test used to get a quick snapshot of the cognitive function of a resident and is a required screening tool used in long term care facilities to assess cognition. A score of 13-15 points indicates intact cognition, 8-12 points indicates moderately impaired cognition, and 0-7 points indicates severely impaired cognition. On 07/15/2026 at 12:24 PM, a review of Resident #17's medical record confirmed a Minimum Data Set Assessment (MDS) was completed on 6/3/26. The MDS assessment showed (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #17 was documented for daily use of a wander / elopement alarm. The MDS assessment also revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 3, indicating severe cognitive impairment. On 07/16/2026 at 9:01 AM, an interview with Certified Nursing Assistant (CNA) #7 confirmed the wander guard alarm is a different sound than the call bell system. The call bell system alarms on cell phones the CNAs carry with them. CNA #7 stated there are 2 wander guard sensors she is aware of, one by the elevator and the other by the kitchen door. When asked what the process was if she heard the alarm, she stated she would go to the area and assist if needed, when asked how she would know which area, she reported that there is a light that would indicate which sensor was triggered. On 07/16/2026 at 12:16 PM, an interview with the Assistant Director of Nursing (ADON) and the Director of Nursing (DON) confirmed wander guard alarms are tested monthly. The facility tests the door sensors and the sensors worn by the residents. The ADON and DON confirmed the wander guard placement on the resident is checked every shift and documented on the resident's Treatment Record (TAR). When the ADON was asked what is the expectation of staff when they hear the alarm she stated they are to report to the area and if it's by the elevator and no resident is observed in the immediate area then they are to do a head count of all residents and 1 staff member will take the elevator down to the lobby to ensure no residents have left the secured area. She reports they just had an In-service last month on facility expectation and process for how to respond to the wander guard alarm. On 07/16/2026 at 12:27 PM, an interview with the Nursing Home Administrator (NHA) was completed to discuss the facility incident report findings. This surveyor informed the NHA there is a deficiency due to Resident #17 being able to leave the secure HC area. Discussed with the NHA the concern that the alarm was manually turned off by a staff member without following the expected facility process for performing a head count of all residents. NHA acknowledged that the process was not followed and that they re-trained all staff on responding to wander guard alarms after the incident.		