STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215099	A. BUILDING _____ B. WING _____	03/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WILSON HEALTH CARE CENTER	301 RUSSELL AVENUE GAITHERSBURG, MD 20877

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F 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** Based on surveyor observations, resident and staff interviews, and clinical record reviews, it was determined that the facility staff failed to treat residents with respect and dignity. This finding was evident for 1 of 2 residents reviewed for the dignity care area during the survey (Resident #287). The findings include: On 03-10-2020 at 12:46 PM, surveyor observed Resident #287 had activated the call system to obtain assistance from facility staff. A visitor was present in the room at the time of surveyor's observation. Surveyor observed that RN staff #1 entered the room and asked Resident #287 how she could help. Resident #287 informed the nurse that his/her back was getting very sore and requested to be repositioned. RN staff #1 informed Resident #287 that there were no repositioning pillows available in the room at this time and she would let the wound care team know to provide repositioning pillows. The visitor asked RN staff #1 if the regular pillows which were available in the room could be used to relieve Resident #287's back pressure. Surveyor observed RN Staff #1 Responded in an argumentative tone, that she could not turn the resident by herself and needed another staff's assistance. She did not give resident #287 the opportunity to verbalize discomfort, but rather turned rapidly and exited the room with her hands in her pocket mumbling please in the presence of surveyor. Resident #287 informed surveyor that he/she felt RN staff #1's response to his/her request for repositioning observed by the surveyor was very disrespectful and stated to surveyor you see this is what happens every time I call for help. This will be my first and last stay in this facility. I will not come back! On 03-10-2020 at 4:00PM, interview with Director of Nursing (DON) revealed no additional information
F 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Reasonably accommodate the needs and preferences of each resident.** Based on surveyor observation, resident and facility staff interview, it was determined that the facility staff failed to keep residents' call lights within reach to allow residents to call for staff assistance. This finding was evident for 2 of 36 residents on the 4 North unit (Residents #77 and #103). The findings include: 1. On 03-09-2020 at 9:19 AM, observation of Resident #77's room revealed the resident's call light rolled up and pinned to the wall, not within the resident's reach. Resident #77 was alert and oriented and stated that, They (staff) always take it away from me. when asked if he/she pinned call light to the wall. The resident said, I can use the call light if they give it to me. A review of Resident #77's clinical record revealed the resident requires assistance from staff for all activities of daily living, except for eating which the resident could perform after the tray was prepared. On 03-09-2020 at 10:25 AM, surveyor reported the observation and Resident #77's response to the unit manager. The unit manager immediately secured Resident #77's call light within the resident's reach. 2. On 03/10/2020 at 2:09 PM, surveyor observed Resident #103 yelling for help. Upon entering the room, surveyor observed that Resident #103 had no access to their call light. The resident's call light was observed on the floor behind the resident dresser. When asked why he/she was yelling for help instead of using the call system, Resident #103 stated, They (staff) don't ever give me my call light. On 03-10-2020 at 2:35 PM, surveyor interview with the unit manager and the director of nursing revealed no additional information.
F 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation, clinical record review and staff interview, it was determined that the facility staff failed to develop and implement a baseline care plan for 1 of 39 residents reviewed during the survey (Resident #284). The findings include: On 03-10-2020 at 8:46 AM, surveyor observed Resident #284 with a double lumen central venous catheter on the right upper chest. Resident #284 was on Total [MEDICATION NAME] Nutrition (TPN). A central venous catheter is a thin, flexible tube that is inserted into a vein, usually below the right collarbone, and guided (threaded) into a large vein above the right side of the heart called the superior vena cava. It is used to give intravenous fluids, blood [MEDICAL CONDITIONS], and other drugs. TPN is a method of feeding that bypasses the gastrointestinal tract. Fluids are given into a vein to provide most of the nutrients the body needs. The method is used when a person cannot or should not receive feedings or fluids by mouth. On 03-11-2020, a review of Resident #284's clinical record revealed the resident was admitted to the facility with the central venous catheter and a physician's orders [REDACTED]. Further review of the resident record revealed there was no evidence that the facility staff developed and implemented a baseline care plan which included goals and interventions related to the central venous catheter for Resident #284. On 03-11-2020 at 3:00 PM, interview with the DON (Director of Nursing) revealed no additional information.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** Based on surveyor review of the clinical records and facility staff interview, it was determined that the facility staff failed to develop a comprehensive resident centered care plan for 1 of 39 residents selected for review during the survey (Resident #77). The findings include: On 03-11-2020 at 11:10 AM surveyor review of the clinical records revealed that on 02-03-2020 Resident #77 was started on antibiotic therapy. Further review of the clinical record revealed that the most recent quarterly Minimum Data Set assessment (MDS) with an assessment reference date (ARD) of 03-02-2020 documented Resident #77 received antibiotics. There was no evidence in the clinical record that the facility staff developed a person-centered plan of care that addressed Resident #77's antibiotic use as referenced in the quarterly MDS . On 03-11-2020 at 11:40 AM interview with the Director of nursing (DON) revealed no additional information.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** Based on review of the clinical record and interviews with residents and facility staff, it was determined that the facility failed to ensure residents and /or representatives participated in care plan meetings and to review and revise care plans as necessary. This was evident for 5of 39 residents (Residents #35, #24, #31, #18, and #118) selected for this

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) survey. The findings include: 1. On 03-10-2020 at 11:05 AM, surveyor interview with Resident #35 revealed the facility had not held a care plan meeting since admission on 12-11-2019. On 03-11-2020 at 1:00 PM, surveyor review of Resident #35's clinical record revealed a comprehensive admission MDS assessment was completed for Resident #35 on 12-23-2019. There was no documented evidence that a care plan meeting was held with the resident as required. The MDS is part of the U.S. federally mandated process for clinical assessment of all residents in Medicare or Medicaid certified nursing homes. On 03-11-2020 at 1:38 PM, surveyor interview with the Administrator revealed that no care plan meeting had been held with Resident #35. 2. On 03-11-2020 at 8:20 AM, surveyor interview with Resident #24 revealed he did not recall his last care plan meeting. Further review of Resident #24's record revealed that the resident had a comprehensive MDS assessment completed on 12-12-2019. The last documented care plan meeting was held on 10-01-2019. There was no documented evidence that a care plan meeting was held with the resident as required. On 03-11-2020 at 1:38 PM, surveyor interview with the Administrator revealed that no care plan meeting had been held since 10-01-2019. 3. On 03-11-2020 at 1:00 PM, surveyor review of Resident #31's clinical record revealed a comprehensive MDS assessment was completed for Resident #31 on 12-20-2019. There was no documented evidence that a care plan meeting was held with the resident as required. On 03-11-2020 at 1:38 PM, surveyor interview with the Administrator revealed that no care plan meeting had been held since the last assessment on 12-20-2019. 4. On 03-10-2020 at 1:30 PM, surveyor interview with Resident #18's responsible party revealed the resident was not given showers but get received bed bath twice weekly per request. On 03-10-2020 a review of Resident#18's plan of care, initiated on 09-11-19, revealed a focus area Use shower stretcher for showers. DO NOT use shower chair with adjustable leg rests and backrest - it does not accommodate the resident's body and it's NOT safe. Additional record review revealed nursing documentation on 09-23-19 indicated that Resident #18 became very agitated and combative during a transfer from the bed to the shower gurney. The resident almost fell from the Hoyer lift. The resident daughter was present during the transfer and the shower process and told the charge nurse not to give the resident a shower since it was not safe. The resident's daughter agreed for the resident to receive twice weekly bed baths. The facility staff failed to update Resident #18's plan of care to indicate that only bed baths should be given to Resident #18. On 03-11-2020 at 4:30 PM, surveyor interviewed the Director of Nursing who stated that Resident #18's care plan should have been updated. 5. On 03-12-2020, a review of the clinical record for Resident #118 revealed that resident was receiving an antipsychotic medication. A review of the care plan revealed no evidence that the facility staff revised the care plan to reflect the need to monitor Resident #118 for side effects related to the use of the antipsychotic medication.
F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough food/fluids to maintain a resident's health.** Based on surveyor observation, review of the clinical record, and staff interviews, it was determined that the facility staff failed to weigh 1 of 6 residents reviewed for the nutrition care area (Resident #285). The findings include: On 03-09-2020 review of Resident #285 clinical record revealed an admission weight on 02-29-2020 of 110.4 pounds. On 03-13-2020 further review of the clinical record revealed no other weights had been obtained since admission. On 03-13-2020 at 11:00 AM, interview with the TCU unit manager revealed that the facility protocol is to obtain weights weekly for a total of four (4) weeks post admission. The unit manager stated all weights on the TCU are conducted on Wednesdays, and that Resident #285 should have been weighed on 03-04-2020 and 03-11-2020. On 03-13-2020 at 11:15 AM Resident #285 was weighed by facility staff. The current weight was documented as 107.4 pounds, a 3 pound weight loss since admission on 02-29-2020. The unit manager notified the facility dietitian of the weight loss.
F 0757 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and surveyor interview, it was determined that the facility staff failed to adequately monitor residents receiving antipsychotic medications for side effects, and failed to attempt a gradual dose reduction of [MEDICAL CONDITION] medication. This finding was evident for 2 of 5 residents reviewed for unnecessary drugs (Residents #9 and #118). The findings include: 1. On 03-12-2020 review of the clinical record for Resident #9 revealed that the resident received antipsychotic medication with no evidence in the clinical record that facility staff were monitoring the resident for side effects associated with use of the medication. In addition, a review of the clinical record revealed that on 10-23-2019, the psychiatrist documented a plan to delay the gradual dose reduction (GDR) for one of Resident #9's [MEDICAL CONDITION] medications due to an upcoming surgery. The psychiatrist assessed Resident #9 on 12-04-2019 (after the surgical procedure had been completed); however, there was no evidence that the resident was re-evaluated for a GDR after the surgery. On 03-12-20 at 01:47 PM interview with the Director of Nursing provided no additional information. 2. On 03-12-2020, a review of the clinical record for Resident #118 revealed that on 02-26-2020 the nurse practitioner discontinued the antipsychotic medication that was currently being administered to the resident, and ordered the initiation of a different antipsychotic medication. The nurse practitioner also documented instructions for facility staff to monitor sleep/wake cycle, for Resident #118 on the new antipsychotic medication; however, there was no evidence that monitoring was implemented. In addition, there was no evidence of side effect or behavior monitoring in the clinical record specific to the use of the antipsychotic drug. On 03-13-2020 at 1:00 PM, interview with the 3rd floor unit manager revealed no additional information.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on surveyor observation and staff interviews, it was determined that the facility staff failed to serve food under sanitary conditions. This finding was evident in the facility's dining room on the second floor north dining room, and on the fourth-floor during the lunch observation. The findings include: 1. On 03-09-2020 at 12:20 PM surveyor observed Staff #10 in the dining room when lunch was being served. Staff #10 was observed pushing residents in wheelchairs to position them at their respective dining tables. Staff #10 was observed moving from table to table assisting with positioning the residents. Continued observation revealed Staff #10 delivered and set up the residents' meals without washing their hands or using hand sanitizer. Staff #10 sat down and was observed assisting the residents with their meal. Surveyor observation of the dining room revealed a hand sanitizer mounted on the wall at the entrance of each doorway into the dining room opposite the kitchenette. However, Staff #10 washing hands or applying hand sanitizer at any time while repositioning residents or assisting residents with their meal. On 03-09-2020 at 12:45 PM, surveyor interview with Staff #10 revealed that she forgot to wash her or sanitize her hands between residents. On 03-09-2020 at 1:40 PM, surveyor interview with the Director of Nursing revealed that an infection control in-service had been conducted with facility staff one week prior to surveyor's observation. The director of nursing provided no additional information. 2. On 03-10-2020 at 12:28 PM, surveyor observed Staff #2 touch Resident #38 then touched Resident #194 without washing her hands. Staff #2 was also observed in use of her personal cell phone during the residents' meal. Staff then immediately continued assisting a resident with the meal without washing her hands after using her personal cell phone. On 03-10-2020 at 12: 30 PM, surveyor interviewed Staff #2 revealed the employee stated she had forgotten to wash her hands between residents. On 03-13-2020 at 1:30 PM,an interview with the Director of Nursing revealed no additional information.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** Based on surveyor observations, clinical record review and staff interview, it was determined that the facility staff failed to follow standard and transmission-based precautions to prevent spread of infection while providing care. This finding was evident for 1 of 7 units in the facility. The findings include: 1. On 03-09-2020 at 8:37 AM, surveyor observed GNA staff #4 was in Resident #436's room with a nursing student. GNA staff #4 pulled the resident up on bed with help of the nursing student. She then helped the resident to set up the breakfast tray. Both GNA staff #4 and the nursing student did not wash their hands prior to leaving the room. On 03-09-2020 at 9:40 AM, surveyor observed GNA staff #4 pushing

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) Resident #218 in a wheelchair in the hallway. While passing by in the hallway, GNA staff #4 entered Resident #211's room and assisted Resident #211 with items on his/her overbed table. Upon completing the task, GNA staff #4 left the room without washing her hands and continued pushing Resident #218's wheelchair to their room. Upon arrival in Resident #218's room, GNA staff #4 placed the water cup and television remote control within the resident's reach and left the room again without washing her hands. On 03-09-2020 at 2:01 PM interview with DON (director of nursing) revealed no additional information. 2. On 03-09-2020 at 12:30 PM surveyor observed as GNA staff #3 walked into Resident #287's room. Surveyor observed a sign on their entrance door for contact isolation. GNA staff #3 assisted the resident with the water cup and call light placing them within reach. GNA staff #3 pushed the bedside table close to the resident and left the room without washing her hands. On 03-09-2020 at 2:01 PM interview with DON (director of nursing) revealed no additional information.