STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215007	A. Building B. Wing	03/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wicomico Nursing Home	900 Booth Street Salisbury, MD 21801

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 18819 Based on surveyor reviews of a facility reported incident and facility staff interview, it was determined that the facility failed to report the final investigation of an incident of alleged abuse reported by a resident's family member to the Office of Health Care Quality. This finding was evident for 1 (Resident #3) of 4 residents reviewed during a complaint survey. This finding is related to the facility reported incident #MD00212903. The findings include: On 03/06/2025, an on-site review of the facility reported incident for Resident #3 revealed that, on 12/19/24, Resident #3 was observed by a staff member and the resident's family member with discoloration to her bilateral hands and left forearm. Resident #3 was unable to describe how the discoloration happened. Further review of the facility investigation revealed that the facility submitted the initial report to OHCQ (Office of Health Care Quality) on 12/19/24, within 24 hours of the allegation as required. However, the final investigation report was not submitted to OHCQ. The facility is required to complete the investigation and submit the final investigation report within 5 working days. On 03/10/25 at 11:40 AM, the nurse surveyor interviewed the Assistant Director of Nursing (ADON) who was unable to provide any additional information. The facility ADON confirmed that the staff were unable to locate any documentation that a 5 day conclusion was reported to the State Survey Agency for facility reported incident MD00212903.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 18819 Based on reviews of a complaint, interviews with staff, and reviews of a closed record, it was determined that the facility failed to ensure that a resident's medications were administered as ordered. This was evident for 1 (Resident #1) of 4 residents reviewed during a complaint survey. The findings include: Documentation is an integral part of medication administration. Documentation communicates the timing, dosing, and effect of any medications received by a patient. In the setting of skilled nursing care, residents are often prescribed multiple medications for significant medical conditions. They are also often more vulnerable to medication errors and more prone to changes in condition that require review and adjustment of their medication regimen. Inaccurate medication documentation has the potential to place residents at significant risk of medication error, provide incomplete or inaccurate information for providers and care givers to evaluate, and represents a failure of basic medication administration principles. Review of complaint MD00215237 on 03/06/25 revealed an allegation Resident #1 was administered the wrong dosage of medication that caused his/her death. The complaint allegation indicated Resident #1 was only to receive one dose of the medication daily but instead received the medication twice daily. A review of Resident #1's closed medical record on 03/06/25 revealed a physician's order, dated 01/30/25, instructing the nursing staff to insert a peripherally inserted central catheter (PICC) line and administer the antibiotic, Cefepime, 1 gram, intravenously, every 24 hours, for 7 days. A review of Resident #1's January 2025 and February 2025 medication administration records revealed that on January 31st, February 1st and 2nd, the nursing staff administered the antibiotic Cefepime, 1 gram, intravenously, twice on these days. In an interview with Resident #1's physician on 03/06/25 at 4:40 PM, Resident #1's physician stated that he was made aware of the medication error by the nurse regarding Resident #1. Resident #1's physician confirmed that Resident #1 was to receive a 1 gram dose of Cefepime daily. In an interview with the facility pharmacy on 03/10/25 at 1:33 PM, the facility pharmacy manager confirmed the facility pharmacy received a new order for the antibiotic Cefepime, 1 gram, IV, to be administered every 24 hours, for 7 days. The facility pharmacy manager stated the physician order was signed by Resident #1 physician on 01/30/25 at 3:45 PM.

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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 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. 18819 Based on medical record review and staff interview, it was determined the facility staff failed to maintain a medical record in the most accurate form. This was evident for 1 of (Resident #1) of 4 residents reviewed during a complaint survey in relation to advanced directives. The findings include: A medical record is the official documentation for a healthcare organization. As such, it must be maintained in a manner that follows applicable regulations, accreditation standards, professional practice standards, and legal standards. All entries to the record should be legible and accurate. resident records. A review of Resident #1's closed medical record revealed a completed physician certification related to medical condition, decision making, and treatment limitations form dated 03/29/24. The facility nurse practitioner completed the form, signed the form, that was found in Resident #1's closed medical record on 03/06/25. In an interview with the facility CRNP#1 on 03/06/25 at 5:23 PM, CRNP#1 stated that she did not know why the signed certification form found in Resident #1's closed medical record did not have Resident #1's printed on the form. CRNP#1 stated that she receives a new binder full of documents to be completed for all newly admitted residents. These findings were shared with the Administrator and Assistant Director of Nursing on 03/10/25 at 3:20 PM.