

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215094	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/18/2024
NAME OF PROVIDER OR SUPPLIER  Westminster Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1234 Washington Road Westminster, MD 21157	
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>48168</p> <p>Based on record review and interview it was determined that the facility failed to treat residents with respect and dignity. This was evident for 1 facility reported incident (MD00204591) of 7 facility reported incidents reviewed during the recertification survey.</p> <p>The findings include:</p> <p>On 4/15/24 at 9:45 AM a review of the facility reported incident MD00204591 revealed an allegation that Resident #32 was treated roughly by a Geriatric Nursing Assistant (GNA #8).</p> <p>On 4/15/24 at 11:05 am an interview with Resident #32 was conducted. The resident described an incident where GNA #8 dragged the resident backwards on a shower chair through the hallway from the resident's room to the shower room and then back to the resident's room. The resident stated GNA #8 could not pull him/her forward because the resident's feet were dragging on the floor and in the way.</p> <p>On 4/15/24 at 3:54 PM during an interview with the Nursing Home Administrator (NHA), the facility's final report of the incident was reviewed. It revealed an action plan for GNA #8 to be instructed on dignity and transfers and given a written final warning. The NHA explained that meant GNA #8 had one chance for improvement.</p> <p>On 4/16/24 at 12:43 PM a telephone interview was conducted with GNA #8 regarding the allegation of pulling Resident #32 backwards on a shower chair through the hallway. GNA #8 told the surveyor that she transferred the resident to a shower chair, and that the footrest on the shower chair were broken and it did not stay in place, so she pulled the resident backwards through the hallway from the resident room to the shower room and then back to the resident's room.</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 0577</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Allow residents to easily view the nursing home's survey results and communicate with advocate agencies.</p> <p>31982</p> <p>Based on observations and interview with staff it was determined the facility staff failed to ensure the results from the last annual survey were posted in a place readily accessible to residents and visitors and failed to post accurate notice of the availability of the reports in areas of the facility that are prominent and accessible to the public. This was evident on 2 of 2 floors of the facility.</p> <p>The findings include:</p> <p>On 4/3/24 at 2:45 PM the surveyor observed a white binder labeled Annual Survey Results Book #2 on a shelf beside the receptionist desk in the front lobby. The contents of the binder were reviewed by the surveyor. The binder failed to include the results from the last annual survey conducted by the State Agency on 8/16/23 - 9/21/23.</p> <p>A tour of all common areas accessible to residents and visitors was conducted on 4/4/24 at 8:37 AM. The tour failed to reveal additional survey results. However, a sign was observed on a bulletin board in the hallway near the nurses' station on the locked Alzheimer's Care Unit (ACU). The sign indicated survey results were located in the upstairs lobby and on the wall in front of the downstairs nurses' station. The hallway in front of the downstairs nurses' station was rechecked at that time. No survey results were visible and accessible to residents/visitors in that location as indicated on the sign.</p> <p>In an interview on 4/4/24 at 8:39 AM Staff #14 a receptionist was informed that the survey results binder was labeled #2 and was asked if there was a #1 binder or any additional binders elsewhere in the facility. She indicated that there was probably one in the administrator's office.</p> <p>On 4/4/24 at 9:38 AM another surveyor indicated they observed 2 survey results binders labeled #1 and #2 inside of the nurses station on the ACU, however neither binder contained results from the 8/16/23 - 9/21/23 annual survey, and the binders were not readily accessible for review by the residents residing on the ACU without having to ask for them.</p> <p>At 2:09 PM on 4/4/24 the Administrator observed and confirmed with the surveyor, that there was one survey results book located in the lobby which did not contain the results of the last survey. The Administrator then accompanied the surveyor to the ACU. A bright pink binder labeled Survey Results Book #2 was located within the nurses' station. It was reviewed by the Administrator who stated, these are very old surveys, this shouldn't have been here. A white binder labeled Survey Results Book #1 did not contain the results from the most recent survey, the binders were within the locked nurses' station and were not accessible to the ACU residents without having to ask for them.</p> <p>The Administrator was also made aware that the surveyor was unable to locate survey results on the wall in front of the downstairs nurse's station as indicated by the sign posted on the ACU.</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>43096</p> <p>Based on a complaint, reviews of medical records, and staff interview, it was determined that facility staff failed to notify a resident's representative party and physician when a resident had a change in diet order and a new prescribed medication. This was evident for 1 (Resident #110) of 41 residents reviewed during the survey.</p> <p>The findings include:</p> <p>On 4/10/24 at 9:15 AM, a complaint MD00202974 related to Resident #110 was reviewed. The complaint alleged the staff failed to notify Resident #110's loved one about his/her diet order changes and a new prescribed medication.</p> <p>During a phone interview with Resident #110's loved one on 4/10/24 at 10:20 AM, he/she reported, when the facility staff called me on 2/21/24, they told me [Resident #110] was on puree diet. I never heard about why and when it started. Also, when [Resident #110] transferred to the hospital on 2/23/24, he/she was diagnosed with pneumonia. The facility kept saying he/she had been taking cough medication. But I never heard about coughing and medication.</p> <p>A review of Resident #110's medical record on 4/10/24 at 10:50 AM revealed that the resident's diet order changed from regular to dysphagia puree on 2/15/24. However, no additional documentation was found to explain when the resident's condition changed and/or reported to the physician and representative party.</p> <p>In an interview with a speech therapist (Staff #31) on 4/11/24 at 11:59 AM, Staff #31 stated that Resident #110 was referred to the therapist team from the nursing department about difficulty swallowing. After evaluating the resident, Staff #31 changed the diet order to puree. Staff #31 explained that therapists should change residents' diet orders based on their evaluation, and therapists needed to report the changes to the nursing, dietitian, and dietary manager.</p> <p>During an interview with a Licensed Practical Nurse (LPN #27) on 4/11/24 at 12:08 PM, LPN #27 stated that any changes in residents should be reported to all clinical teams and residents (and/or representative parties). Also, LPN #27 said, All changes should be documented in the progress note.</p> <p>On 4/11/24 at 12:10 PM, a review of Resident #110's order history revealed that the facility-attending Nurse Practitioner (NP #25) placed the order for cough medication on 2/15/24. However, there was no documentation in Resident #110's records about coughing: when it started, who was notified, what interventions were applied, etc.</p> <p>During an interview with NP #25 on 4/11/24 at 1:29 PM, NP #25 said, If I needed to order medication, I communicated with nursing staff verbally and also wrote a note. The surveyor asked about Resident #110's cough medication. NP #25 said, Per my note, I saw Resident #110 on 2/13/24 and 2/14/24. But I did not have a note regarding coughing. I'm not sure who put the order.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the Director of Nursing (DON) on 4/12/24 at noon, the surveyor shared concerns about Resident #110's cough medication, which was not documented clearly including informing the representative party. The DON said, When the provider puts in the new order for residents, whoever verified the order was supposed to document the change in condition. In this case, the process was broken to document.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>43096</p> <p>Based on review of facility records and interview with facility staff, it was determined that facility staff failed to ensure that all allegations of abuse were thoroughly investigated. This was evident for 1 (Resident #108) of 5 residents reviewed for Abuse during the survey.</p> <p>The findings include:</p> <p>On 4/08/24 at 7:41 AM, the surveyor investigated the facility-reported incident, MD00201978. The facility self-report documented that Resident #108 reported two staff members tossed him/her to bed on 1/27/24 during the evening shift (3 PM to 11 PM).</p> <p>The review of the facility's investigation revealed that they had two written statements from two Geriatric Nurse Aides' (GNAs #28 and #29), who worked on 1/26/24, and one Licensed Practical Nurse's (LPN #27) statement written on 1/29/24 (without indicating they cared the resident on 1/26/24 or not). The facility investigation packet also included an assignment sheet for the night shift on 1/26/24. However, GNA #28, #29, and LPN #27 were not listed on the sheet.</p> <p>During an interview with the Nursing Home Administrator (NHA) on 4/08/24 at 9:00 AM, the NHA recalled the incident. The NHA stated that she was not able to verify whether the incident occurred on 1/26/24 or 1/27/24. The surveyor shared the facility's self-report form, which indicated the event date was 1/27/24. However, there was no documentation to support the facility's effort to investigate the incident that was reported to have occurred on the date and to identify perpetrators. Also, there was no statement from Resident #108.</p> <p>On 4/16/24 at 9:30 AM, the surveyor shared the concern about the above with the NHA.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48168</p> <p>Based on medical record review and staff interviews, it was determined that the facility failed to: 1) revise and update a comprehensive care plan within 7 days after completing the comprehensive assessments, and 2) have care plan meetings with residents and/or their representatives. This was evident for 5 (Resident #61, #75, #87, #88, and #110) of 41 residents reviewed during the recertification survey.</p> <p>The findings include:</p> <p>A care plan is a guide that addresses each resident's unique needs. It is used to plan, assess, and evaluate the effectiveness of the resident's care. Facility staff must develop the comprehensive care plan within seven days of completing the comprehensive assessment (Admission, Annual or Significant Change in Status) and review and revise the care plan after each evaluation. After each assessment means that after each assessment, it is known as the Resident Assessment Instrument (RAI) or Minimum Data Set (MDS).</p> <p>Minimum Data Set: The Minimum Data Set (MDS) is part of the federally mandated process for clinical assessment of all residents in Medicare or Medicaid-certified nursing homes. It is a core set of screening, clinical, and functional status elements, including common definitions and coding categories, forming the foundation of a comprehensive assessment.</p> <p>1) During the entrance conference on 4/01/24 the Nursing Home Administrator (NHA) stated that the facility was a smoke-free facility, and that no residents smoke.</p> <p>On 4/03/24 at 11:08 AM in an interview with Resident #88, the resident stated that he stopped smoking a year ago.</p> <p>On 4/08/24 at 11:07 AM a review of Resident #88's care plan revealed a problem titled [Resident #88] utilizes nicotine products due [to] Lifestyle, with the initiation date of 12/30/23. The corresponding care plan interventions included in part, Educate resident to designated smoking areas. A review of the resident's medication list revealed no active order for any nicotine products. A previous order for a nicotine patch was discontinued on 7/31/23.</p> <p>On 4/08/24 at 12:42 PM an interview with the NHA was conducted to review Resident #88's care plan for the use of nicotine products and smoking. The NHA again stated that the facility was a smoke-free facility. When the care plan and orders were reviewed with her, the NHA indicated that the care plan had not been revised and was inaccurate.</p> <p>15701</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2) Resident #87's medical record was reviewed on 4/3/24 in relation to complain intake MD00203943. Review of the medical record revealed that the most recent MDS (Minimum data set) quarterly assessment was dated 2/26/24. Review of the medical record did not reveal documentation to indicate that a care plan meeting was held within 7 days of the quarterly MDS assessment. Review of the paper chart and the miscellaneous tab in the electronic record did not reveal any care plan signature sheets since the quarterly MDS assessment.</p> <p>An interview was conducted with the director of the unit (Staff#2) that Resident #87 resided on 4/3/24 at 12:45 PM. She was informed that upon surveyor review of Resident #87's medical record care plan conference/meeting documentation was not found. She reviewed the resident's medical record and confirmed that a quarterly care plan meeting was not documented since the last quarterly assessment of 2/26/24.</p> <p>3) On 4/3/24 at 10:55 AM, Resident #61's medical record was reviewed. Resident #61 was admitted to the facility on [DATE] and the 1st quarterly MDS assessment was dated 2/28/24. Review of the progress notes in the electronic health record (EHR) did not reveal that a quarterly care plan meeting was conducted after the MDS assessment of 2/28/24.</p> <p>An interview with the Unit director (staff #2) was conducted on 4/3/24 at 12:45 PM. She revealed that the facility did not have a social worker and she took over as a social services liaison in November of 2023 to coordinate care plan meetings. She indicated the best way to read her notes was to use a custom search for her name in the EHR progress notes.</p> <p>A follow-up meeting was conducted with the Unit Director #2 on 4/4/24 at 9:24 AM. She was informed that documentation of a care plan meeting/conference was not found in Resident #61's medical record related to the quarterly MDS assessment of 2/28/24. At 10 AM the Unit Director #2 provided a document signed by her and a nurse dated 3/14/24. The Unit Manager was asked to provide the letter that was provided to the responsible party/guardian of Resident #61. The letter was addressed to the cognitively impaired resident who based on medical record review on 4/3/24 had documented certifications of incapacity and an undated handwritten note at the bottom of the form Called mother [name of Resident #61's mother and telephone #]. It was reviewed with the Unit Director #2 that the facility had provided a document to a cognitively impaired individual, and there was no documentation in the record to indicate the lack of participation of resident and the resident's responsible party and the alleged date of the care conference was greater than 7 days after the quarterly assessment.</p> <p>43096</p> <p>4) On 4/08/24 at 12:27 PM, a review of Resident #75's medical record revealed that the resident's quarterly MDS assessments were completed on 11/16/23, 2/16/24, and 4/08/24. The resident's progress note contained care conference notes dated 12/01/23, which was 15 days later than the comprehensive assessment completed. Additionally, care conference notes dated 3/06/24 showed Resident #75 had a care plan meeting. However, this was 19 days later than the MDS assessment was completed.</p> <p>In an interview with the Nursing Home Administrator (NHA) on 4/03/24 at 2:06 PM, the NHA confirmed that the facility had a regional social worker (Staff #11) who covered this facility. The NHA explained that Staff #11 comes to the facility 2-3 times weekly to manage residents' issues like guardianships, surrogates, and other concerns. The NHA also stated that Staff #2 (activities director and Alzheimer care unit manager) coordinated care plan meetings for residents.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/08/24 at 1:30 PM, the surveyor requested Resident #75's care plan meeting documentation from Staff #2. The staff provided a copy of the care conference notes in progress dated 12/01/23 and 3/06/24, the same notes the surveyor had already verified. No additional documentation was submitted to the surveyor.</p> <p>5) On 4/10/24 at 10:20 AM, the surveyor interviewed Resident #110's loved one while investigating a complaint. The resident's loved one reported that he/she received no update regarding the care plan except the initial one upon Resident #110's admission.</p> <p>Resident #110's medical record review on 4/10/24 at 11:00 AM revealed that the resident's quarterly MDS assessments were completed on 9/09/23 and 12/10/23. Resident #110's progress note contained a care plan note on 9/14/23. However, there was no supportive documentation that the resident's representative party attended and/or was notified about the care plan meeting. Additionally, the progress note date 12/27/23 documented the care plan meeting. However, it was 17 days later that the comprehensive assessment (MDS) was completed.</p> <p>During an interview with the Director of Nursing (DON) on 4/12/24 at 11:40 AM, the surveyor shared the above concerns about Resident #110's care plan meeting documentation.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47200</p> <p>Based on medical record review, staff interviews and a complaint, it was determined that the facility failed to:</p> <p>1) have a process in place to address and review medical orders pending provider signature; 2) provide timely care for residents who experienced a change in condition; and 3) timely arrange for a resident to go for their 2-weeks follow up (F/u) post op visit. This was evident for 4 of 41 residents (Resident #46, #109 and #110, #107) reviewed during recertification survey</p> <p>The findings include:</p> <p>1) On 4/4/24 at 10:02AM the surveyor conducted a review of the medications for Resident #46. Upon review of the resident's April 2024 Medication Administration Record (MAR) it was revealed that on 4/1/24 the following medication had been documented as administered: methylprednisolone sodium succinate injection. Review of the medical order dated 4/1/24 indicated the medication was a one-time dose. Further review of the April 2024 MAR revealed a second order dated 3/31/24 for the one-time dose of the medication, which had not yet been administered, and the following was notated on the order: pending order signature.</p> <p>On 4/5/24 at 10:15 AM the surveyor conducted an interview with Staff #35, Licensed Practical Nurse, who reported that if an order is pending signature, it is waiting for the doctor to approve it to be given. Staff #35 further reported that if they saw two of the same orders and one was still pending signature, they would tell their supervisor.</p> <p>On 4/5/24 at 11:10 AM the surveyor conducted an interview with Staff #4, Registered Nurse, Infection Control Preventionist and Educator, reported to the surveyor that they rely on nurse to nurse verbal report to make them aware of situations like this, but there is no process in place to ensure the resident would not receive the duplicate dose if the provider ends up signing off on it later on. They further reported that if the medication having been administered was not communicated during the nurse to nurse verbal report and the provider signed the second duplicate order, the resident could end up getting the medication a second time.</p> <p>On 4/5/24 at 11:20 AM the surveyor conducted an interview with Staff #23, Registered Nurse, Acting Unit Manager, Regional Mobile Director of Nursing. When the surveyor inquired as to the duplicate orders they stated: that's the telehealth people. When asked if they review provider's pending orders that have not been signed yet, they reported no. At this time, the surveyor shared their concern with Staff #23, who acknowledged and confirmed understanding of the concern.</p> <p>15701</p> <p>2) Resident #109's medical record was reviewed in relation to complaint MD00202250. Initial review of resident #109's medical record on 4/8/24 at 1:11 PM revealed the resident was admitted to the facility on [DATE] and was transferred to a hospital on 2/3/24.</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 - Some</p>	<p>Review of a nursing progress note dated 1/31/24 at 1:43 PM indicated that Resident #109 had a decline in functioning, difficulty chewing, and had difficulty sitting up unassisted. The nurse documented that Resident #109 stated I don't feel like my normal self. The nurse had contacted a physician (not the residents attending) and had received new orders for laboratory blood work, urinalysis with culture and sensitivity, and the resident's diet was downgraded to puree.</p> <p>Review of a nurse's progress note of 2/1/24 at 5:49 AM revealed the collection of the urinalysis and the urine culture and sensitivity with indication that 1200 ml (milliliters) of output from urinary straight catheterization. Review of the blood laboratory results revealed that the laboratory received the blood specimen on 2/1/24 at 10:45 am and reported the results at 2:36 PM.</p> <p>There was a late entry Acute Visit note by a certified registered nurse practitioner (CRNP Staff #25) time stamped for 1 AM on 2/1/24 and signed on 2/4/24. The note documented Patient seen today for lab review. The note reflected abnormal values for BUN (Blood urea nitrogen) and GFR (glomerular filtration rate) as both of these test measures how well the kidneys' function. The CRNP documented that he discussed with MD and per his recommendation, no IV hydration. Will order nephrology consult for patient.</p> <p>Nursing note of 2/1/24 at 9:15 PM indicated that Resident #109 had a PIV line placed in the right forearm. (Peripheral Intravenous Line. It's a small, short plastic catheter commonly used to deliver fluids or medications.)</p> <p>Nursing note of 2/1/24 at 10:04 PM revealed that the resident had poor intake (eating decline) and a continued decline in baseline. A PIV line placed in the right forearm. The note indicated that the pharmacy was called for a stat delivery of intravenous fluid to be administered to the resident upon delivery. There was not a note to indicate when the resident was started on intravenous fluids. Review of the medication administration record for February 2024 revealed that the administration of sodium chloride intravenous fluids was provided on the day shift of 2/1/24.</p> <p>Review of a nursing note written by the facility's infection control preventionist at 2:35 PM on 2/2/24 revealed the interdisciplinary team met reviewed lab results and the medical director provided orders to discontinue IV fluids for elevated BUN and new order for nephrology consult. The only other note written on 2/2/24 revealed that the patient's IV and IV fluids were discontinued.</p> <p>Review of the medication administration record for February 2024 revealed that an appointment was made for the resident to be seen by nephrology on 2/29/24.</p> <p>Interviews were conducted with the CRNP (staff #25) on 4/10/24 and on 4/11/24 at 11:55 AM. He explained the significance of the resident with identified chronic kidney disease and the abnormal blood work and that IV fluids would be invaluable to the resident. He indicated the resident did not receive intravenous fluids. It was explained that per the physician's order sheet it was he that ordered intravenous fluids. He was asked about the staff removing 1200 ml of urine per note. He was unaware of the note indicating the removal of 1200 ml in the AM hours of 2/1/24, and he seemed unaware of the resident receiving IV fluids.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Westminster Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1234 Washington Road Westminster, MD 21157	
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A meeting/interview was held with the director of nursing, the Divisional VP of clinical services, Division VP of Clinical Assessment and Reimbursement, the CRNP, and at least for a time the nursing home administrator. Questions and concerns were shared related to the resident being provided with IV fluids without documentation of the decision as the CRNP was unaware that the resident was placed on IV fluids. The director of nursing began to express her thoughts as to how the orders were obtained but stopped short of her explanation. There was not any indication that the CRNP or the interdisciplinary team had discussed that Resident #109 was retaining fluids and that the resident was administered additional fluids. The Divisional VP of clinical services acknowledged that the CRNP's late note would not have been in the resident's chart for review on 2/2/24 and 2/3/24. Questions went unanswered as to why or what the facility would be waiting for prior to the resident being transferred to the hospital per family request on 2/3/24.</p> <p>43096</p> <p>3) On 4/10/24 at 9:15 AM, as part of a review of complaint MD00202974, the surveyor reviewed Resident #110's medical records which revealed that Resident #110 had a change in condition on 2/22/24 which consisted of lethargy, slow response, and elevated pulse rate. However, the medical record revealed that the resident did not receive any interventions until he/she was transferred to a hospital on 2/23/24.</p> <p>Further review of Resident #110's medical record on 4/10/24 at 9:40 AM revealed a progress note dated 2/22/24 at 3:11 PM, written by the mobile Director of Nursing (Staff #33) that described Resident #110's change in condition: upon entering room. [Resident #110] lying in bed with eyes closed, slow to respond to stimuli, v/s obtained. In house NP (Nurse Practitioner) notified and will assess and call family to discuss. The same document also noted that the resident has abnormal vital signs such as blood pressure 143/84, pulse 108, respiration rate 22, temperature 97.5, and pulse oximetry O2 91%.</p> <p>Further review of the medical records revealed that a progress note dated 2/23/24 written by a Registered Nurse (RN #36) documented that Resident has altered mental status. Vital signs: temperature 100.2, pulse 130 per minute, respiration 40 per minute, oxygen 61% on room air, after 15% with non-rebreather applied, O2 saturation recorded 85%. NP notified. New order to transfer patient to the ED for evaluation. Resident transferred to [hospital name] for evaluation.</p> <p>Resident #110's medical record lacked any documentation that described any interventions for the resident's change in condition on 2/22/24 until the transfer to the hospital on 2/23/24.</p> <p>The surveyor reviewed Resident #110's historical vital signs records on 4/10/24 at 10:30 AM. The records revealed that the resident's average pulse was 60s-70s since his/her admission in July 2023. Based on comparing Resident #110's average pulse rate, the resident's pulse rate on 2/22/24 (108 per minute) was elevated.</p> <p>During an interview with the facility attending Nurse Practitioner (NP #25) on 4/11/24 at 1:29 PM, NP #25 insisted that he did not see Resident #110 on 2/22/24. The surveyor shared Resident #110's progress note dated 2/22/24 at 3:11 PM, documenting, in-house NP [Name of NP #25] notified and will assess. NP #25 said, I don't know when they contacted me. If it were here, I would evaluate the resident. I saw him/her on 2/23/24 and ordered to send him/her out for further evaluation.</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 - Some</p>	<p>On 4/12/24 at 1:38 PM, the Director of Nursing (DON), NP #25, and Staff #33 requested a meeting with the surveyor. They stated that Resident #110's condition change occurred on 2/23/24, not 2/22/24. Staff #33 insisted that she made a mistake in not changing the event date when she put the late entry note under the progress note. She said, condition changed reported on 2/23/24 NOT 2/22/24. The surveyor questioned how she could explain the vital signs (blood pressure 143/84, pulse 108, respiration rate 22, temperature 97.5, and pulse oximetry O2 91% on 2/22/24 at 3:12 PM) documented in Staff #33's note on 2/22/24. Staff #33 did not answer the surveyor's question.</p> <p>On 4/16/24 at 9:30 AM, the surveyor shared the concern with the Nursing Home Administrator (NHA) about delayed care when Resident #110 had a condition change reported on 2/22/24. The NHA validated the concern.</p> <p>44441</p> <p>4) On 4/10/24 at 9:45 AM review of a complaint MD00197991 alleged that Resident #107 who had surgery and was admitted on [DATE] to the facility was supposed to have a 2-weeks post op visit but was unable to have the f/u appointment for 6 weeks because the facility was unable to make the appointment for the resident.</p> <p>Review of the nurse's progress note dated 8/22/23 on 4/10/24 at 11:25 AM documented a first follow up appointment/visit on 8/22/23 to the orthopedic surgeon's office accompanied by family members. A second visit was documented on 9/12/23.</p> <p>On 4/10/24 at 12:39 PM the Director of Nursing (DON) was asked in an interview who schedules doctor's appointment for residents. She stated that Staff #24, a scheduler, does scheduling for all residents. She was made aware of the concerns and said she will check with the scheduler. She came back to report that she spoke with Staff #24 and was told that when they tried to make the appointment for Resident #107, staff #24 was told that the earliest available date was 8/22/23. The DON was asked if they made the surgeon or residents family aware, and she said no. She was asked if this was documented anywhere in the medical records, and she said no.</p> <p>Staff #24 the scheduler in an interview on 4/11/24 at 10:45 AM was asked about the process for scheduling post op doctors' appointments. She stated that it was dependent on whether the resident was going to see a specialist, the slot availability, type of surgery and the urgency of the appointment. She was asked why the 2-weeks F/u post op appointment was not scheduled as instructed by the surgeon. She stated that when she called the office to schedule the f/u with the specialist, she was told that the next available opening was in August 2023. She was asked if she notified the surgeon or the residents' families or documented her responses. She stated that she did not notify the surgeon or residents family and did not document regarding the appointments unless it was canceled.</p> <p>On 4/11/24 at 11:27 AM: The surgeon's office was called, and an office scheduler was asked in an interview the process for when a surgeon requests to see a resident 2 weeks post op, if they get the appointments. The scheduler said they will. She was asked if the appointment was dependent on the type of surgery, and she said no. She was asked what date the resident was seen post op. She said the resident was first seen post-op on 8/22/23 and subsequently on 9/12/23. She was asked if their office gave preferences to first time post op patients, and she said yes.</p> <p>On 4/11/24 at 3:15 PM- The Administrator was made aware that this was a concern.</p>		

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<p>F 0711</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47200</b></p> <p>Based on medical record review and staff interview it was determined that the physician/Certified Registered Nurse Practitioner (CRNP) progress notes were not written, signed and timely present in the resident medical records. This was evident for 2 (Residents #46, and #106) of 41 residents reviewed during the survey.</p> <p>The findings include.</p> <p>1) On 4/4/24 at 10:02AM the surveyor conducted a review of the medication orders for Resident #46. During this review, it was noted the resident was currently receiving 15mg of the following psychiatric medication: escitalopram.</p> <p>On 4/4/24 at 10:02AM the surveyor reviewed the most recent psychiatric note present in the resident's medical record which was dated 3/15/24. The surveyor noted that the visit date was 3/15/24, however, the note had not been uploaded to the resident's medical record until 3/21/24, approximately, seven days after the visit was dated as having occurred. Review of this note indicated a recommendation made by Staff #38, Psychiatric Certified Registered Nurse Practitioner, on 3/15/24 for the resident to receive 10mg of the medication: escitalopram.</p> <p>On 4/4/24 at 1:50PM the surveyor conducted an interview with Staff #38, inquiring as to the dosage amount. The surveyor noted the information Staff #38 provided during the interview did not correlate with the information the surveyor reviewed in the medical record. During the interview Staff #38 reported they were seeing the resident weekly. At this time, the surveyor noted the last visits made according to the medical record documentation, were on 3/13/24 and 3/15/24. When the surveyor inquired as to where the documentation was for the weekly visits, Staff #38 reported they would need to be uploaded to the medical record.</p> <p>Further review of the medical record on 4/4/24 at 2:48PM revealed the following visit dates and upload dates:</p> <p>On 12/22/23 Resident #46's psychotherapy visit note was not uploaded to the medical record until 12/26/23.</p> <p>On 1/13/24 Resident #46's x-ray report was not uploaded until 1/16/24.</p> <p>On 1/24/24 Resident #46's psychotherapy note was not uploaded until 2/1/24.</p> <p>On 1/22/24 Resident #46's orthopedic consult was not uploaded until 2/6/24.</p> <p>On 2/1/24 Resident #46's psychotherapy note was not uploaded until 2/13/24.</p> <p>On 2/7/24 Resident #46's psychotherapy note was not uploaded until 2/14/24.</p> <p>On 2/14/24 Resident #46's psychotherapy note was not uploaded until 2/27/24.</p> <p>(continued on next page)</p>		

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<p>F 0711</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 2/21/24 Resident #46's psychotherapy note was not uploaded until 2/28/24.</p> <p>On 2/27/24 Resident #46's facility requested consult was not uploaded until 2/29/24.</p> <p>On 1/6/24 Resident #46's follow up mental health visit was not uploaded until 3/9/24.</p> <p>On 2/28/24 Resident #46's psychotherapy note was not uploaded until 3/11/24.</p> <p>On 3/6/24 Resident #46's psychotherapy note was not uploaded until 3/11/24.</p> <p>On 3/10/24 Resident #46's follow up mental health visit was not uploaded until 3/21/24.</p> <p>On 3/15/24 Resident #46's facility requested consult was not uploaded until 3/21/24.</p> <p>On 3/13/24 Resident #46's psychotherapy note was not uploaded until 3/25/24.</p> <p>On 3/28/24 Resident #46's psychotherapy note was not uploaded until 4/5/24.</p> <p>On 3/21/24 resident #46's psychotherapy note was not uploaded until 4/5/24.</p> <p>On 4/3/24 resident #46's psychotherapy note was not uploaded until 4/7/24.</p> <p>On 4/11/24 resident #46's psychotherapy note was not uploaded until 4/15/24.</p> <p>On 4/5/24 at 2:27PM the surveyor conducted an interview with the Director of Nursing (DON) who reported that the facility expects providers to document and upload their medical notes within 72 hours of their visit with the resident. At this time, the surveyor shared their concern, and the DON stated the provider was not in compliance, and acknowledged and confirmed the surveyor's concern.</p> <p>15701</p> <p>2) Resident #109's closed medical record was reviewed on 4/8/24 in relation to complaint MD00202250. Resident #109 was admitted to the facility on [DATE] and was transferred to a hospital on 2/3/24. Review of a nurse practitioner's (CRNP staff #25) Acute Visit note revealed the date of service as 2/1/24 and an effective date as 2/1/24 at 1:00 AM. The CRNP's note was signed on 2/4/24 at 3:37 PM. By the time the CRNP's note was uploaded to the electronic medical record the resident no longer remained in the facility.</p> <p>A meeting was held on 4/15/24 at 2:21 PM with the director of nursing, Divisional VP of clinical services (staff#6), Division VP of Clinical Assessment and Reimbursement (staff #7), CRNP (Staff#25) and eventually the nursing home administrator. There was a discussion related to resident #109's transfer to the hospital on 2/3/24. The Divisional VP of clinical services acknowledged that the CRNP's late note would not have been in the resident's chart for review on 2/2/24 and 2/3/24.</p>

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain dental services for each resident.</p> <p>48168</p> <p>Based on observation, interview and record review it was determined that the facility failed to provide dental services to meet residents' needs. This was evident for 1 of 2 (Resident #17) reviewed for dental during the survey.</p> <p>The findings include:</p> <p>On 4/01/24 at 10:08 AM an observation and interview with Resident #17 was conducted. The resident was observed to have only bottom dentures and had no natural upper teeth. Resident #17 explained that his/her upper dentures had been lost a few months ago and had not been replaced, and although a care plan meeting was held last week when he/she was told a dentist would come to the facility to do the needed impressions, there had been no follow up to date.</p> <p>On 4/04/24 at 1:38 PM a review of Resident #17's medical record revealed a care plan problem for poor fitting dentures. No dental care notes were found in the resident's record. The surveyor requested all documentation related to the resident's dental care.</p> <p>On 4/05/24 at 1:55 PM another review of Resident #17's record was conducted, and no dental notes were found in the clinical progress notes or in the record where outside service notes were scanned and uploaded. Additionally, there was no response to the surveyor's request for dental services documentation made on 04/04/24.</p> <p>On 4/05/24 at 2:59 PM an interview with the Director of Nursing (DON) and the Nursing Home Administrator (NHA) was conducted. The DON stated that Resident #17 went to the dentist in September or October 2023 and recommendations were made to the resident's family, but the facility was unaware of the recommendations. When asked how the facility ensured this resident's dental needs were being met, they were unable to provide an answer.</p> <p>On 4/09/24 at 11:13 AM in an interview with Unit Manager (Staff #1), and Licensed Practical Nurses (LPN#35), the Unit Manager stated the family was going to pay for the resident's missing dentures and were taking care of it. When asked if there was a grievance form or any documentation in the medical record about the missing dentures, they both said yes. When asked for the documentation, they could not provide any.</p> <p>On 4/10/24 at 2:32 PM in an interview with the NHA, the surveyor reviewed with her that the resident did not receive timely care for dental needs and the NHA verbalized understanding.</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>47200</p> <p>Based on record review and interviews, it was determined the facility failed to: 1) adequately document certifications of incapacity and ensure accuracy of the Maryland Medical orders for life sustaining treatment (MOLST) form (Resident #15), and 2) ensure pertinent information regarding surrogacy/guardianship disputes were documented in the medical records (Resident #101). This was evident for 2 of 41 residents reviewed during the recertification survey.</p> <p>The findings include</p> <p>1. On 4/2/24 at 10:00AM the surveyor reviewed Resident #15's advanced directives document in which they had identified their selection of a primary health care agent.</p> <p>On 4/2/24 at 10:00AM the surveyor reviewed Resident #15's MOLST form dated 2/19/24 which indicated the patient had a guardian. No documentation could be found in the medical record regarding a guardian for the resident.</p> <p>On 4/2/24 at 10:00 AM the surveyor reviewed a Certification of Incapacity form dated 11/11/22 located on Resident #15's paper medical record, and noted Part 1 of the form requiring identifying information was left blank. The following items from Part 1 were left incomplete: 1.) Identification of the patient in which the information was being certified about, 2.) Identification of the certifying practitioner's credentials, and 3.) Documentation certifying the time frame in which the resident was examined within two hours of the certification. At this time, no second Certification of Incapacity could be found on the paper medical record. At this time, the surveyor inquired to Staff #23, Registered Nurse, Acting Unit Manager, Regional Mobile Director of Nursing, regarding documentation of the second Certification of Incapacity.</p> <p>On 4/2/24 at 10:07 AM Staff #23 provided the surveyor with the 2nd Certification of Incapacity form dated 1/28/24. Upon surveyors review of the documentation the following was noted: 1.) Part 1 identification of the certifying practitioners' credentials was left blank, 2.) Certifications under Part 2 of the form, (Section A) were left blank although the certification dated 11/11/22 certified both an end stage condition and terminal condition, and 3.) Section C was incomplete and failed to include a diagnosis or reason for incapacity. From this documentation, no information could be identified as to why the resident was being certified as lacking adequate decision-making capacity.</p> <p>On 4/2/24 at 10:10AM the surveyor shared their concern with Staff #23 who acknowledged understanding of the concern.</p> <p>After surveyor intervention, on 4/2/24 at 10:42AM Staff #23 was interviewed and informed the surveyor that the facility had corrected the MOLST form to reflect the resident's health care agent per their advanced directive and provided a copy of this dated 4/2/24 to the surveyor.</p> <p>On 4/3/24 at 12:41PM the surveyor shared their concerns with the facility Administrator who acknowledged understanding of the concerns.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>31982</p> <p>2) Resident #101's medical record was reviewed on 4/3/24 at 10:12 AM. The record revealed a certificate dated 12/23/23 signed by the resident's attending physician and another dated 12/28/23 signed by the medical director which indicated the resident lacked adequate decision-making capacity due to a brain injury. The residents face sheet indicated the resident's mother was his/her representative and healthcare surrogate. Social History Assessments dated 6/14/23 and 10/3/23 Advance Directives section C. 2. indicated Resident #101's father was his/her health care proxy/agent. C.5. indicated if resident lacks decision making capacity and does not have an advance directive in place who is the decision maker based on state statute? Father. The Assessment also indicated the resident had no power of attorney, conservatorship, or court appointed guardianship.</p> <p>Review of the resident's closed medical record on 4/10/24 at 2:17 PM revealed a paper dated December 21, 2023, that stated Attention: Staff Family is undergoing Guardianship proceedings. Until this becomes official, and we have the papers in (his/her) chart, (he/she) is not to leave the building with anyone, except for medical appointments. **If you have any questions about this, notify the Executive Director (Administrator). Bandage tape was folded over all 4 edges of the paper. No documentation was found in the record related to an interested family member seeking guardianship.</p> <p>In an interview on 4/10/24 at 2:45 PM the Administrator was asked about the notice. She indicated that there was an ongoing dispute between the resident's family and significant other. She was asked if there was any documentation in the resident's medical record regarding this issue. She indicated that the dispute involved protective orders between the parties, and it was not documented in the resident's record because it was all between family members.</p>		