STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215094	A. Building B. Wing	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westminster Healthcare Center	1234 Washington Road Westminster, MD 21157

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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 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. 50904 Based on review of facility-reported investigation records and interview with staff, it was determined the facility staff failed to report an allegation of suspected resident abuse to the state agency in a timely manner. This was evident for 1 resident (Resident #102) out of 3 reported incidents by the facility reviewed during the survey. The findings include: A review of facility reported incident MD00207413 was started on 10/09/2024 at 12:22 PM. The facility incident report indicated the following: Alleged abuse incident occurred in the resident's room at about 11:45 AM of 07/08/24. The administrator and Law enforcement were notified on the same day and the initial report was sent to the state agency at 3:47 PM of the same day. At 2:32 PM on 10/09/2024, surveyor reviewed a copy of the facility's policies and standard procedures on reporting incidents and facility response, and it revealed that allegations involving abuse should be reported to the state agency within 2 hours, aligning with the federal requirement. On 10/10/2024 at 12:49 PM, in an interview with the Director of Nursing, she was asked about the procedure for reporting alleged abuse. She stated that as soon as the supervisor notifies either the Director of Nursing or Administrator, they both start the investigation process and notify the state agency within two hours of knowing about the alleged abuse incident. She was informed that the alleged incident had happened at 11:45 AM and was reported to the state agency at 03:37 PM and she stated that it was past the 2-hr window period for reporting an alleged abuse. At 12:53 PM on 10/10/2024, the Director of Nursing and the Administrator met with the surveyor. The Administrator confirmed the Director of Nursing's statement and agreed that this incident was reported late, 4 hours after the allegation was made.

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 42782 Based on record review and interview it was determined that the facility staff failed to complete a thorough investigation of an allegation of misappropriation of property and failed to investigation an allegation of verbal abuse. This deficient practice was evident in 2 (Resident #31 & #49) of 9 facility reported incidents reviewed during the survey. The findings include: 1. On 10/16/24 at 1:29 pm during a review the facility's investigation of MD00207401 it revealed on 05/03/24 during 7:00 am-3:00 pm shift, a blister pack of Resident #49's Oxycodone was missing from Licensed Practical Nurse (LPN) #24's medication cart located on Station #3. Further review of the investigation revealed a statement from LPN #24. Review of the staffing sheets revealed there was no copy of the staffing sheet to include the nurse who completed the narcotic count with LPN #24 and no evidence of an interview of nurse who completed the narcotic count before the medication became missing. On 10/16/24 at 2:25 pm during an interview with LPN #24 he/she confirmed the missing narcotics were taken from the medication cart assigned to them. The surveyor asked which nurse completed the narcotic count with them during the change of shift. LPN #24 verbalized the narcotic count was completed with the outgoing nurse LPN#39. A statement from LPN #39 was not included in the investigation and the nurse no longer works at the facility. 2. On 10/18/24 at 12:34 pm a review of the investigation related to facility reported incident MD00207401 revealed that Resident #31 sent an email to Administrator # 1 concerning details of an verbal encounter with a Geriatric Nursing Assistant (GNA). The resident's email was not included with the documents provided to the surveyor for review. After receiving the email sent to Administrator #1, the surveyor asked President of Operations #41 if there was an investigation of the allegation of verbal abuse related to the incident. Administrator #1 confirmed an investigation was not completed for verbal abuse related to Resident #31.

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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** 49304 Based on interviews with residents, review of medical records, and interview with facility staff, it was determined that the facility failed to provide a baseline care plan summary to residents. This was evident for 1 (#45) of 7 residents reviewed for baseline care plans during the survey. The findings include: A baseline care plan (BLCP) must be completed within 48 hours of a resident's admission to the facility and include the initial goals based on admission orders, physician orders, dietary orders, therapy services, and social services. A summary of the BLCP as well as a list of the resident's current medications must be given to each resident and his/her representative. Completion and implementation of the BLCP is intended to promote continuity of care and communication among staff, increase resident safety, and safeguard against adverse events (undesirable outcomes) that can occur right after admission. Resident #45 was interviewed on 10/08/24 at 12:44 PM. During the interview, when asked if he/she received a BLCP that included a summary of their medications within 48 hours of admission, the resident stated, no. On 10/09/24 at 9:09 AM, Resident #45's electronic medical record was reviewed. The review included an admitted [DATE]. However, no note could be found that stated the resident had received a summary of his/her BLCP. On 10/09/24 at 11:09 AM, in an interview with the Director of Nursing (DON) she confirmed there was no documentation that Resident #45 received a BLCP. On 10/11/24 at 1:38 PM in an interview with the DON, she stated the purpose of the BLCP is to indicate to the staff how to provide care safely and accurately as soon as someone is in the building. On 10/15/24 at 8:00 AM the DON provided the surveyor with Resident #45's BLCP dated 9/20/24. However, the DON was unable to provide any evidence that Resident #45 had been provided a copy of the BLCP.

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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. 42782 Based on record review and interview it was determined that the facility staff failed to initiate person centered care plan for mobility and wound care. This deficient practice was evidenced in 1 (#67) of 4 resident records reviewed for care plans. The findings include: On 10/17/24 at 11:27 am a review of Resident #67's electronic medical record revealed the resident had two pressure ulcers and one was facility acquired. A review of the care plan revealed there were no interventions in place when the resident refused to be turned or repositioned. Further review of the resident's care plans revealed Resident #67 did not have a person-centered care plan related to skin integrity. The care plan did not include the resident's wound care and interventions specific to the resident's care. On 10/18/24 at 1:33 pm during an interview with Director of Nursing #2 he/she confirmed Resident #67 did not have patient centered care plans for mobility and skin integrity and indicated going forward the resident's care plans would have specific orders with the interventions. The staff were educated to document if a resident is refusing a treatment or task.

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F 0658

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure services provided by the nursing facility meet professional standards of quality.

30440

Based on observations and interviews with facility staff it was determined the facility failed to adhere to professional standards of practice by failing to: 1.) ensure that controlled medications (Narcotics) were signed off by the Licensed Practical Nurse upon removing the medication from the narcotic drawer for 3 residents (Residents # 41, #45, and #107) during a random narcotic reconciliation observation; and 2.) ensure the safety and integrity of narcotic medications blister packs for Resident Resident # 67 and Resident # 78; and 3.) ensure that two nurses sign the narcotic sheet during change of shift to verify the narcotic count was complete. This was found to be evident during the facility's survey.

Findings include:

1. A random narcotic medication reconciliation observation was conducted with the Licensed Practical Nurse upon (LPN) # 12 on 10/16/24 at 10:15 AM. Review of a medication blister pack for Resident # 41 was labeled Lorazepam 0.5 mg which had 10 pills in the blister pack. The corresponding narcotic control form for Resident #41 indicated Lorazepam 0.5 mg with 11 pills remaining. The nurse reviewed the electronic medication record screen for this resident, and it revealed the medication was administered at 8:00 AM by Staff #36, but it was not signed off in the narcotic book.

Another review was conducted with the nurse and 2 medication blister packs for Resident #41 was labeled Pregabalin 75 mg, one blister pack had 18 pills, and the second pack had 21 pills totaling 39 pills. The corresponding narcotic control form for the resident indicated there were 40 pills remaining. LPN #12 stated that LPN #36 was supposed to sign the narcotic book but failed to do so.

2. Observation and review of a medication blister pack for Resident #45 was labeled Lorazepam 0.5 mg which had 10 pills in the pack. The corresponding narcotic control form for the resident indicated there were 11 pills remaining. LPN #12 acknowledged that he failed to sign the narcotic book and that the narcotic was supposed to be signed at the time the medication was removed from the narcotic drawer.

3. Observation and Review of a medication blister pack for Resident #107 was labeled Oxycodone IR (5 mg) which had 24 pills in the pack. The corresponding narcotic control form indicated 25 remaining pills. LPN #12 reviewed the electronic medication administration record and stated that another nurse, LPN #36 administered the medication and did not sign the narcotic sheet. LPN #12 further stated that medications are to be signed off in the narcotic book once the medication is removed from the narcotic drawer and confirmed that it was not done.

An interview was conducted with LPN # 36 on 10/16/24 at 10:45 AM and she was asked about Resident #41 and Resident #107 who had medications that were removed from the narcotic drawer that were not signed off. She stated that she did not have access to the narcotic book at the time the narcotic medications were administered. She further stated the nurse who was leaving, and the oncoming nurse were doing a narcotic count with the book and that she did not have access to it.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON was made aware of the above concerns on 10/16/24 at 11:30 AM and she stated that education would be done with all staff and that the LPN #36 is an agency nurse who will not be returning. She further stated that it is the facility policy that narcotics are to be signed off immediately when removed from the narcotic drawer. 42782 4. On 10/16/24 at 10:12 am the surveyor and Licensed Practical Nurse #30 completed the narcotic count on Cart B located on Unit #3. During the count the surveyor observed Resident #67 blister pack of Tramadol 50 mg 1/2 tablet pill #15 was sealed inside with tape on the blister packet. LPN #30 confirmed the surveyor's observation. 5. Further review of the narcotics revealed Resident #78 was prescribed Acetaminophen Codeine 300 mg-30 mg tablets. Pill #9 & Pill #10 in the blister packs were damaged. LPN #30 confirmed the surveyor's observation and verbalized the medication should have been wasted. Review of the Shift Count sheets revealed there was only one nurse signature to verify the narcotic count was completed on the following dates: 08/08/24 7 am - 3 pm shift 08/11/24 11pm - 7 am shift 08/14/24 7 am- 3 pm shift 08/30/24 11 pm- 7 am shift 08/31/24 7 am - 3 pm shift 09/03/24 7 am - 3 pm shift and 09/04/24 7 am- 3 pm shift On 10/16/24 12:01 PM During an interview with Director of Nursing (DON) #2 revealed that the nurse who is handing over the keys to the cart and the nurse who is receiving the keys are supposed to do the narcotic count together and sign the book. Typically, the supervisors check between the nurses coming on and off. DON also revealed there should not be medication taped inside the blister pack; it should have been wasted. 50904 6. During a narcotic observation review and reconciliation on 10/16/2024 at 09:45 AM on the first floor, surveyor observed LPN# 24 during a medication administration pass. The surveyor reviewed the Controlled Substance Shift Inventory Sheet with LPN # 24 and it revealed the following; On 10/14/24 at 3pm-11pm change of shift, there was no nurse signature for the nurse going off duty, but there was a nurse signature for the nurse coming on duty. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/14/2024 11pm-7am change of shift, there was no signature for the nurse coming on duty but there was a signature for the nurse going off duty. On 10/15/24 during the 7am-3pm change of shift, there was a signature for the nurse coming on duty but there was no signature for the nurse going off duty. When LPN #24 was asked what the process was for the controlled substance shift count, she stated that there should be two signatures, one for the nurse coming on duty and the other for the nurse going off duty. At 10:31 AM on 10/16/2024, in an interview with the nurse manager for unit 3, Registered Nurse (RN) #17, she was asked who was responsible for the shift count of narcotics on the unit and she stated that two nurses were responsible for counting the narcotics and signing off, one signature for the incoming nurse and the other signature for the outgoing nurse, and she added that nurses were supposed to sign in and out of the log book at the beginning and end of each shift. When she was asked why there were missing signatures, she was unable to provide any further explanation but stated that she audits the narcotic log whenever she gets to work but must have missed the signature part during that period. She stated that she would start educating staff members in regard to counting the narcotics and signing the logbook at the end of the count during shift change. At 12:38 PM on 10/16/2024, in an interview with the Director of Nursing (DON), she was asked what the process was for controlled substance audits and she stated that the in-coming nurse and the out-going were supposed to do the counts together making sure that there were no discrepancies. After the counting they both sign on the appropriate portion of the log sheets and then the outgoing nurse hands over the keys to the in-coming nurse. When she was informed of the missing signatures, she stated that she would assume that the nurses forgot and she added that not signing on and off the narcotic logbook was an unacceptable practice. She also added that she was putting plans in place for audit sheets to be signed and checked by the supervisors.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 42863 Based on medical record reviews and interviews it was determined that the facility failed to ensure that a dependent resident's personal hygiene needs were adequately met. This was evident for 1 (Resident #2) of 23 residents reviewed during the survey process. The findings include: Activities of daily living is a term used collectively to describe fundamental skills required to independently care for oneself, such as eating, bathing, and mobility. The task assessment record (TAR) is a electronic form utilized by nursing staff to document the activities of daily living of the residents. On 10.10.24 at 10:30 AM review of the MD00207907 and medical records involving Resident #2's Activities of daily living revealed the resident is a vulnerable adult that required maximum 2-person assistance with activities of daily living based on the care plan initiated 03.02.22 secondary to trauma to below the knee amputation, morbid obesity, and impaired mobility. Continued review revealed that on 08.14.24 the facility failed to document that staff provided assistance with the resident's personal hygiene during the night shift. On the following dates the facility failed to document that staff provided the resident with assistance with showering and bathing on: 08.15, 08.17, 08.18, 08.19, 08.21, 08.22, 08.24, 08.25, 08.26, 08.28, 08.29, and 08.31.24. On 10/09/24 at 09:41 AM the surveyor met with the resident in his/her room and discussed the content of the MD00207907. Resident #2 stated that the staff took away his/her commode chair because she/he fell on ce while trying to get back in bed after using the commode chair. The resident stated he/she would like to be able to use the commode chair in order to decrease the chances of sacral wounds and to increase his/her mobility. This resident stated that he/she is reluctant to get out bed to the chair because of the shortage of staff. This resident also stated that he/she has observed evidence that the GNA's do not clean his/her buttock thoroughly when she/he has a bowel movement. The resident stated that she/he is not able to wear diapers because they cause blisters on his/her skin. The resident stated that his/ her dignity was negatively impacted by the staff not responding to his/her requests in timely fashion. On 10.17.24 at 2:00 PM the surveyor interviewed the unit manager, RN # 17 who stated that the resident can be demanding with clinical staff regarding when certain activities of daily living are completed. RN #17 stated that the resident frequently refused to shower on the scheduled days of Tuesday and Thursday. RN #17 stated that however, when the resident asks to be showered on a particular day then the staff will try to accommodate the resident's needs. The unit manager failed to provide any specific individualized interventions the clinical staff utilize to assist resident #2 with accomplishing their ADL goals consistently. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10.18.24 at 1:37 PM the surveyor interviewed the director of nursing (DON). The surveyor asked what the documentation and performance expectations of the geriatric nursing assistants, (GNAs) were, and the charge nurses related to ensuring residents are assisted with ADL's including showering, out of bed activities, and mobility. Also, the DON stated that geriatric nursing assistants (GNAs) and nurses should use clinical interventions to address residents who have a history of refusing clinical interventions related to ADL assistance including mobility. The identified deficient practices were discussed with DON during the survey as well as during the exit conference on 10.18.24.