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	02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westminster Healthcare Center	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 43648 Based on record review, interview, and facility policy review, the facility failed to follow the physician's orders for 1 (Resident #1) of 3 residents reviewed for medications. Specifically, the facility failed to discontinue Resident #1's tramadol, (pain medication) as ordered by the physician, on 12/13/2024 when oxycodone (opioid pain medication) arrived at the facility. The facility administered both medications to Resident #1 on the morning of 12/14/2024. Findings included: A facility policy titled, Medication Administration, dated 12/02/2024, indicated, 1. General Procedures: a. Administer medication only as prescribed by the provider. An Admission Record revealed the facility admitted the resident with diagnoses that included acute embolism and thrombosis of the left femoral vein, neurofibromatosis, unspecified intellectual disabilities, pain in the right and left foot, and polyneuropathy. A 5-day Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/11/2024, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 7, which indicated the resident had severe cognitive impairment. The MDS revealed the resident had mild, occasional pain during the previous five-day look-back period. According to the MDS, Resident #1 received scheduled pain medications and as-needed pain medications during the five-day look-back period. Resident #1's Care Plan included a focus area, initiated on 12/10/2024, that indicated the resident had complaints of acute/chronic pain. Interventions directed staff to follow the physician's orders for complaints of pain (initiated 12/09/2024). Resident #1's Progress Notes, dated 12/11/2024, indicated a medical doctor saw the resident for a follow-up visit and for pain management. The notes revealed on physical examination, Resident #1 had no acute distress, was calm and cooperative, and had a left lower extremity DVT (deep vein thrombosis), for which the resident was complaining about pain that was not controlled. According to the notes, tramadol had been started recently, 50 milligrams (mg), one tablet by mouth three times a day for moderate to severe pain and the resident had an order for oxycodone 5 mg by mouth every six hours as needed for a pain rating of 4 to 10 on a pain scale (0 being no pain and 10 being the worst pain imaginable). According to the Progress Notes, tramadol was to be discontinued when the pharmacy delivered oxycodone. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1's December 2024 Medication Administration Record [MAR] also revealed an order started on 12/11/2024 at 9:00 PM to discontinue tramadol when oxycodone was received from the pharmacy. A pharmacy Delivery Manifest, dated 12/13/2024 at 8:11 PM, revealed Registered Nurse (RN) #13 signed the document indicating that 30 capsules of oxycodone IR (immediate release) 5 mg capsules had been delivered to the facility for Resident #1. Resident #1's December 2024 MAR revealed no documented evidence that the facility discontinued tramadol when oxycodone was delivered to the facility. The MAR revealed RN #12 administered tramadol on 12/14/2024, during the morning medication pass when the resident's pain score was 8, on a scale of 0 to 10. The MAR revealed RN #13 also administered oxycodone 5 mg at 8:11 AM on 12/14/2024, due to a pain score of 8, on a scale of 0 to 10. Resident #1's Progress Notes, dated 12/14/2024 at 10:14 AM, revealed the resident had a change in condition that included a new onset of pocketing food and stroke like symptoms, which included eye fixated/staring left, no response to commands, and being nonverbal. The physician ordered the resident be sent to the hospital for evaluation. During an interview on 02/12/2025 at 4:53 PM, RN #13 stated she worked with Resident #1 on the evening of 12/13/2024 and gave the resident tramadol at 8:00 PM. She stated at 8:11 PM, the pharmacy delivered the resident's oxycodone, and she did not think to go back and discontinue the tramadol. She stated it was overlooked on her part. During a phone interview on 02/12/2025 at 9:13 AM, RN #12 stated she worked with Resident #1 on 12/14/2024. She stated the resident received their morning medications and always yelled and complained of leg pain. RN #12 stated she had overlooked the order to discontinue tramadol when the oxycodone arrived and administered both medications. The nurse stated had she known, she would not have administered both medications. During an interview on 02/11/2025 at 12:38 PM, RN #2, the Clinical Manager, stated in reviewing Resident #1's orders, the tramadol should have been discontinued when the facility received oxycodone from the pharmacy. During an interview on 02/11/2024 at 12:54 PM, the Director of Nursing (DON) stated the agency nurse overlooked the order and Resident #1 received tramadol and oxycodone on the morning of 12/14/2024. The DON stated the tramadol medication should have been discontinued when the oxycodone arrived in the facility. The DON stated her expectation was that all medications be given as ordered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/11/2025 at 1:50 PM, the Medical Director stated Resident #1 was admitted following a re-hospitalization from home for DVT. He stated the resident was primarily at the facility for pain management, from pain the resident had prior to entering the facility. The Medical Director stated he did a thorough chart review following this event. The Medical Doctor stated the facility was treating the DVT, and while there, the resident received the appropriate medications for their diagnoses. He stated that on 12/14/2024, the resident had stroke-like symptoms that included a left-sided gaze, left-sided facial drooping, and left-leaning. According to the Medical Director, the resident was not completely unresponsive or flaccid, which may be seen in someone who had overdosed. He stated the resident was on the lowest dose of tramadol, and oxycodone, and given the resident was almost two hundred pounds, it was not an overdose. He also stated that the pain medications the resident received would not have contributed to the stroke-like symptoms. The Medical Director stated tramadol and oxycodone together must have been needed to control the resident's pain; however, he stated if he wrote an order to discontinue the tramadol when the oxycodone arrived, the tramadol should have been discontinued.