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	08/14/2025

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on medical record review, facility documentation review and interview it was determined the facility failed to maintain an effective grievance system as evidenced by the failure to resolve a complaint regarding missing clothing belonging to a resident (Resident #6). This was evident for 1 of 3 residents reviewed for grievances during this complaint survey. The findings include:Review of complaint 326588 on 8/12/25 revealed a concern related to Resident #6's missing clothes and the Resident's clothing not being returned from laundry. Medical record review on 8/12/25 revealed Resident #6 was admitted to the facility in July 2022. Further review of Resident #6's medical record revealed the facility staff assessed the Resident on 8/3/25 to have a BIMS (Brief Interview for Mental Status) of 14 out of 15, indicating the Resident's cognitive function is intact. During interview with Resident #6 on 8/12/25 at 11:22 AM, the Resident stated he/she is missing 4 pairs of sweatpants: 1 blue, 1 black and 2 grey. The Resident stated he/she has told the facility staff, and they had not done anything about it. During interview with the Director of Nursing (DON) on 8/13/25 at 8:05 AM, the DON was asked if he/she knew about Resident #6 missing sweatpants. The DON stated yes the Resident came to me about a month ago and I filled out a grievance. The DON was asked what the process is after she fills out grievance. The DON stated she gives the grievance to the Social Worker to follow-up on. The DON was asked at that time to receive a copy of the grievance. Review of the Grievance Form revealed on 6/27/25 the DON wrote under Initiation of grievance/Description of grievance: Resident #6 was missing 2 grey, 1 blue, 1 black sweatpants. Missing for 5 days and checked roommate's clothes and not there. The next section is Facility Follow up on 7/9/25 by the EVS Director that stated: we found his/her grey pants, no other clothes were found in the laundry. We will keep looking for his/her clothes. Some clothes found, some still missing. The next section on form is Resolution of Grievance which was blank. Review of the facility's Resident Grievance Policy revealed it stated: Grievances will be resolved in a reasonable time frame, generally within 5 business days, consistent with the type of grievance. During interview with the Administrator on 8/13/25 at 10:30 AM, the Administrator confirmed the grievance for Resident #6 had not been resolved and the facility was working on a process to ensure residents' grievances are resolved. During interview with the Social Worker on 8/14/25 at 9:00 AM, the Social Worker was asked what her role is in the grievance process. The Social Worker states she holds the grievance book, collects the grievance, gives to the appropriate person that would handle the grievance and then once they resolve the grievance she places back in the grievance binder. The Social Worker stated residents' missing items concerns go to the Administrator. The Director of Nursing on 8/14/25 at 9:30 AM provided the Surveyor with a copy of the facility order on 8/14/25 for four pair of sweatpants for Resident #6.

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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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Based on observation, medical record review, facility documentation review and interview, it was determined the facility staff failed to prevent intimidation of a resident after the resident alleged sexual abuse resulting in psychosocial harm (Resident #5). This was evident for 1 of 4 residents reviewed for abuse during a complaint survey.The findings include: Review of facility reported incident 326592 was conducted on 8/12/25 related to Resident #5 allegation of sexual abuse by Staff #4 on 6/4/25.Review of Resident #5's medical record on 8/12/25 revealed the facility staff assessed the Resident on 6/13/25 to have a BIMS (Brief Interview for Mental Status) of 15 out of 15, indicating the Resident's cognitive function was intact.Review of the facility reported incident documentation provided by the Administrator revealed the facility reported to OHCQ (Office of Health Care Quality) on 6/4/25 Resident #5 reported at approximately 9:00 PM Staff #4 was providing perineal care and inserted a finger into the Resident's private area and asked does it feel good. Further review of the facility documentation related to the incident revealed witness statements including from Staff #7 who was Resident #5's assigned nurse on 6/4/25. Staff #7 statement stated Resident #5 called the nurses station and said he/she wanted to talk to the nurse. Staff #7 stated she immediately went to his/her room and the Resident said he/she had been sexually assaulted by a male GNA (geriatric nursing assistant). Staff #7 stated she called assigned GNA (Staff #4) for the Resident to confirm if Staff #4 was the one. Resident stated Staff #4 put his finger into the Resident's private area during care and asked the Resident if he/she is feeling good. Staff #7 stated they left the Resident's room and she immediately called the ADON (Assistant Director of Nursing). During interview with the Director of Nursing (DON) on 8/12/25 at 9:45 AM, the DON stated she received a call from the ADON on 6/4/25 at 9:20 PM that Resident #5 reported he/she was sexually assaulted by an agency GNA (Staff #4). The DON stated she instructed the ADON to go to the facility and the ADON lives within 5 minutes from the facility. The DON stated she then left for the facility and while driving to the facility the DON called 911. The DON stated 911 told her to ensure the alleged perpetrator remained at the facility. The DON then called Staff #7 and told her to not allow Staff #4 into any resident rooms, have Staff #4 stay at the nurse's station and to keep an eye on him. The DON stated when she arrived she immediately went to check on Resident #5 to make sure he/she was okay and shortly after that the police arrived. The DON stated she went with the police when they interviewed Staff #4. The DON stated when the police were questioning Staff #4 he initially denied the allegation but refused to answer any questions, refused to write a statement and requested a lawyer. The DON stated the police then left the facility with Staff #4. The DON stated Staff #4 was an agency GNA working 3-11 PM on 6/4/25 and this was his first shift in the facility. The DON stated after the incident Staff #7 was written up for bringing Staff #4 back into Resident #5's room after an allegation of sexual abuse. The Surveyor requested the write-up of Staff #7.During interview with Staff #7 on 8/12/25 at 11:45 AM, Staff #7 stated Resident #5 called the nurse's station and asked to speak to the nurse. Staff #7 stated she went immediately to the Resident's room and the Resident alleged he/she was sexually abused by a male GNA but did not know the GNA's name. Staff #7 stated at that time Staff #4 was at doorway, so she brought Staff #4 into room for the Resident to identify if Staff #4 was the perpetrator. She asked Resident #5 if Staff #4 was the one and the Resident confirmed. Staff #4 said what? and Staff #7 told Staff #4 in front of Resident #5 that the Resident said you sexually assaulted him/her. Staff #7 stated she called and reported the incident to the ADON. Staff #7 stated she was written up for allowing Staff #4 back into Resident #5's room after the allegation.During interview with the DON on 8/12/25 at 12:17 PM the DON stated the ADON was currently out on leave and unavailable for interview. During interview with Resident #5 on 8/12/25 at 1:09 PM, Resident #5 stated he/she put on his/her call bell to be changed and when the GNA came in room he got a washcloth and was cleaning him/her up. The Resident stated he was taking a long time and said he/she never had someone wash me up like that before. The Resident stated I could feel him put a finger inside of me and he pushed my leg up and asked me if it felt good. I didn't know what to say or do. He eventually left and I immediately called the desk and asked for someone to come to my room. When the nurse (Staff #7) came in, I told her what happened. She brought in the GNA (Staff #4) and had me identify him and tell the whole thing over in front of him. Resident #5 said when he/she saw him (Staff #4) come in the room he/she said why is he here, I don't want him here, I covered my eyes, I did not want to see him again. At that time the Surveyor observed the Resident place both his/her hands over his/her eyes. The Resident stated Staff #4 was crying and telling Resident #5 he was going to lose his job. After the incident Resident #5 stated he/she was afraid he was

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on review of facility reported incidents and staff interview, it was determined the facility failed to provide documentation that allegations of misappropriation of property were thoroughly investigated. This was evident for 1 (#2) of 3 residents reviewed for facility reported incidents during a complaint survey.The findings include:On 8/13/25 at 7:37 AM a review of facility reported incident 326591 was conducted and revealed Resident #2 alleged that on 6/5/25 someone broke into Resident #2's locked nightstand drawer and stole ninety dollars. The facility report documented that Resident #2 stated, I think it happened last night, 6/1/25, unsure of time, did not notice the money missing and drawer broken until this morning. Review of the facility's investigation revealed a written statement from the Director of Nursing (DON) that documented Resident #2 thought that it happened the previous night as the resident was up late watching TV in the dining room, however there was not an exact time. The facility investigation revealed that (5) staff members worked the night shift, 11:00 PM to 7:00 AM, and (8) staff members worked the evening shift, 3:00 PM to 11:00 PM. There were written statements from (4) of the (5) night shift staff, however only (3) of the (8) evening shift staff were interviewed or had written statements. There were no interviews or statements provided from the 6/2/25 day shift staff. On 8/13/25 at 9:12 AM an interview was conducted with the DON. The DON stated that she did the investigation. The DON stated that the resident came to her office to report the missing money. The DON stated that the resident said someone in the middle of the night had broken into the bedside drawer and money was missing. The DON stated the resident's account of the story changed and was inconsistent. The nursing schedule was reviewed with the DON at that time, and the DON was asked if the resident stated it happened at night and the resident was down watching tv, why wasn't the evening shift staff interviewed about the nightstand drawer. The DON stated that she should have gotten statements from that staff as well and confirmed that the investigation was not complete.

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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. Based on record review and staff interview it was determined that the facility failed to meet professional standards of practice as evidenced by licensed nursing staff signing off that a medication was administered when the medication had not yet been delivered to the facility. This was evident for 1 (#1) of 3 residents reviewed for pharmacy services. The findings include:According to the National Library of Medicine, the sixth right of medication administration, correct documentation, should be done immediately after the medication is administered. Signing off on a medication that was not given is a violation of the principle as the documentation does not reflect the actual care provided.On 8/12/25 at 11:34 AM a review of Resident #1's medical record revealed Resident #1 was admitted to the facility in May 2024 with diagnoses that included, but were not limited to, cerebral infarction with hemiplegia and hemiparesis, aphasia, generalized anxiety disorder, bipolar disorder, and major depressive disorder.Review of a 7/17/25 at 15:20 (3:20 PM) SBAR (change in condition) note documented that Resident #1's left eye was noted with redness, like a blood vessel had broken. A new order was given to start the resident on an eye drop, Polyethylene glycol.A 7/17/25 at 21:09 (9:09 PM) eMar (electronic Medication Administration Record note) documented, Polyethyl Glycol-Propyl Glycol Gel 0.4-0.3%; Instill 1 drop in left eye two times a day for protection for bloodshot/dry OS (left eye) until 7/27/22; new medication order. Waiting pharmacy delivery.A 7/19/25 at 22:31 (10:30 PM) eMar note documented, OTC (over the counter) form faxed to pharmacy. Waiting delivery.A 7/20/25 at 5:54 AM nurse's note documented a note about the Polyethyl Glycol that stated, redness noted left eye sclera. Waiting delivery.Review of Resident #1's July 2025 MAR documented on 7/17/25 the PM dose of the eye drop was not given as evidenced by a 9 and the nurse's initials. The 9 indicated that the medication was not given and there was a corresponding nurse's note to explain why it was not given. On 7/18/25 the AM and PM doses and the 7/19/25 AM dose were signed off as given as indicated by a check mark and the nurse's initials. The 7/19/25 PM dose had the nurse's initials and the number 9. The 7/20/25 AM dose was signed off as given.On 8/13/25 at 12:25 PM an interview was conducted with Licensed Practical Nurse (LPN) #13 as she signed off the drops were administered on 7/18/25 in the PM. The progress notes related to the eye drops were reviewed with LPN #13. LPN #13 was asked if she administered the eye drops. LPN #13 stated that she signed off that she did. LPN #13 was able to pull up the audit details of the order in the electronic medical record. Review of the audit details revealed the medication was ordered on 7/17/25, however was not dispensed to the facility until 7/20/25. LPN #13 was asked how she was able to give the drops to Resident #1 when the drops had not been received at the facility until 7/20/25. LPN #13 stated that she could not remember, she could have documented that she gave the drops in error. On 8/13/25 at 12:34 PM an interview was conducted with the Director of Nursing (DON). The July 2025 MAR was reviewed with the DON and the progress notes along with the medication audit sheet. The DON stated, so 3 nurses signed off that the drops were given and they were not yet delivered to the building. The DON confirmed the findings. On 8/13/25 at 1:51 PM an interview was conducted with the Nursing Home Administrator (NHA). The NHA stated she was made aware of the concern from the DON, and she acknowledged the concern.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interviews, it was determined that the medical provider failed to review the pain medication orders for a resident (Resident #4). This was evident for 1 out of 3 residents selected for review during a complaint survey. The findings include: A review of a complaint was conducted on [DATE] regarding the facility stopping Resident #4's Oxycodone in [DATE]. Oxycodone is a narcotic medication used to treat moderate to severe pain. Review of Resident #4's medical record on [DATE] revealed the Resident was admitted to the facility in [DATE] with a diagnosis of chronic pain due to trauma. Review of the Resident's physician orders on admission revealed the Resident was ordered Oxycodone 15 mg every 4 hours as needed for pain. Further review of the Resident's medical record revealed the Resident was followed by the Physical Medicine and Rehabilitation Nurse Practitioner (Staff #15) for pain management. Review of Staff #15's medication orders revealed Staff #15 decreased the Oxycodone to 10 mg every 4 hours as needed for pain on [DATE]. On [DATE] Staff #15 decreased the Oxycodone to 5 mg every 6 hours as needed for pain for 21 days. Review of Staff #15's [DATE] progress note revealed it stated: Plan at this time is keep the patient on his/her extended release morphine sulfate 15 mg twice daily and keep his/her as needed Oxycodone 5 mg at every 6 (hours). Review of Resident #4's physician orders revealed the Oxycodone was discontinued on [DATE] since the order on [DATE] expired after 21 days. Review of Resident #4's [DATE] Medication Administration Record revealed the Resident had not taken the as needed Oxycodone since [DATE]. Review of Staff #15's [DATE] progress note revealed it stated: Patient not currently on services and is only being seen for pain management. Currently taking Morphine ER (extended release) 15 mg 2 times a day. His/her as needed oxycodone was discontinued for unknown reasons. Patient states today that he/she is in pain in his/her lower extremities and that the as needed medication helped control this pain which he/she is no longer receiving. Review of Resident #4's physician orders revealed the Oxycodone was reordered on [DATE] for 5 mg every 8 hours as needed for pain. During interview with Resident #4 on [DATE] at 7:45 AM, the Resident was asked if his/her pain is under control and is he/she receiving his/her pain medication as he/she would like. The Resident stated yes he/she has no issues with his/her pain medication. The Resident was asked if he/she could remember in [DATE] when his/her Oxycodone was discontinued and he/she put in a complaint with the Office of Health Care Quality. The Resident stated no. During interview with Staff #15 on [DATE] at 8:50 AM, Staff #15 stated he shouldn't have put Resident #4's [DATE] Oxycodone order for 21 days and that was an error. Staff #15 also stated he should have ordered Oxycodone indefinitely until he had reevaluated the Resident. Interview with the Director of Nursing on [DATE] at 10:00 AM confirmed Staff #15 failed to review Resident #4's medication orders on [DATE].

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on medical record review and staff interview, it was determined the facility failed to provide physician ordered medications timely to meet the needs of the residents. This was evident for 1 (#1) of 3 residents reviewed for facility reported incidents during a complaint survey.The findings include:On 8/12/25 at 11:34 AM a review of Resident #1's medical record revealed Resident #1 was admitted to the facility in May 2024 with diagnoses that included, but were not limited to, cerebral infarction with hemiplegia and hemiparesis, aphasia, generalized anxiety disorder, bipolar disorder, and major depressive disorder.Review of a 7/17/25 at 15:20 (3:20 PM) SBAR (change in condition) note documented that Resident #1's left eye was noted with redness, like a blood vessel had broken. A new order was given to start the resident on an eye drop, Polyethylene glycol.A 7/17/25 at 21:09 (9:09 PM) eMar (electronic Medication Administration Record note) documented, Polyethyl Glycol-Propyl Glycol Gel 0.4-0.3%; Instill 1 drop in left eye two times a day for protection for bloodshot/dry OS (left eye) until 7/27/22; new medication order. Waiting pharmacy delivery.A 7/19/25 at 22:31 (10:30 PM) eMar note documented, OTC (over the counter) form faxed to pharmacy. Waiting delivery.A 7/20/25 at 5:54 AM nurse's note documented a note about the Polyethyl Glycol that stated, redness noted left eye sclera. Waiting delivery.On 8/13/25 at 12:23 PM an interview was conducted with the Director of Nursing (DON), and she was asked if the facility had issues with the pharmacy and timely medication delivery. The DON stated, the pharmacy is awful, and we have had to escalate the issues to corporate. The DON stated, there are weekends when I am at home, and I have gone back and forth with the pharmacy to get new patient meds in here timely. The DON stated that they were in the process of switching pharmacy providers next month.On 8/13/25 at 1:30 PM an interview was conducted with Registered Nurse (RN) #10 who stated they do have an issue with the pharmacy delivering medications timely and there are times when she has to repeatedly call the pharmacy to ask where the medication is and then will have to order the medication STAT (immediately) because the resident really needed the medication.On 8/13/25 at 1:51 PM an interview was conducted with the Nursing Home Administrator (NHA). The NHA was informed of the concern with timely delivery of medications to the facility and she stated that the DON had made her aware.

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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. Based on medical record review and interview, it was determined the facility failed to maintain complete and accurate medical records in accordance with accepted professional standards. This was evident for 1 (#1) of 3 residents reviewed for facility reported incidents during a complaint survey. The findings include:A medical record is the official documentation of 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.On 8/12/25 at 11:34 AM a review of Resident #1's medical record revealed Resident #1 was admitted to the facility in May 2024 with diagnoses that included, but were not limited to, cerebral infarction with hemiplegia and hemiparesis, aphasia, generalized anxiety disorder, bipolar disorder, and major depressive disorder.Review of a 7/17/25 at 15:20 (3:20 PM) SBAR (change in condition) note documented that Resident #1's left eye was noted with redness, like a blood vessel had broken. A new order was given to start the resident on an eye drop, Polyethylene glycol.A 7/17/25 at 21:09 (9:09 PM) eMar (electronic Medication Administration Record note) documented, Polyethyl Glycol-Propyl Glycol Gel 0.4-0.3%; Instill 1 drop in left eye two times a day for protection for bloodshot/dry OS (left eye) until 7/27/22; new medication order. Waiting pharmacy delivery.A 7/19/25 at 22:31 (10:30 PM) eMar note documented, OTC (over the counter) form faxed to pharmacy. Waiting delivery. A 7/20/25 at 5:54 AM nurse's note documented a note about the Polyethyl Glycol that stated, redness noted left eye sclera. Waiting delivery.Review of Resident #1's July 2025 MAR documented on 7/17/25 the PM dose of the eye drop was not given as evidenced by a 9 and the nurse's initials. The 9 indicated that the medication was not given and there was a corresponding nurse's note to explain why it was not given. On 7/18/25 the AM and PM doses and the 7/19/25 AM dose were signed off as given as indicated by a check mark and the nurse's initials. The 7/19/25 PM dose had the nurse's initials and the number 9. The 7/20/25 AM dose was signed off as given.On 8/13/25 at 12:25 PM an interview was conducted with Licensed Practical Nurse (LPN) #13 as she signed off the drops were administered on 7/18/25 in the PM. The progress notes related to the eye drops were reviewed with LPN #13. LPN #13 was asked if she administered the eye drops. LPN #13 stated that she signed off that she did. LPN #13 was able to pull up the audit details of the order in the electronic medical record. Review of the audit details revealed the medication was ordered on 7/17/25, however was not dispensed to the facility until 7/20/25. LPN #13 was asked how she was able to give the drops to Resident #1 when the drops had not been received at the facility until 7/20/25. LPN #13 stated that she could not remember, she could have documented that she gave the drops in error. On 8/13/25 at 12:34 PM an interview was conducted with the Director of Nursing (DON). The July 2025 MAR was reviewed with the DON and the progress notes along with the medication audit sheet. The DON stated, so 3 nurses signed off that the drops were given and they were not yet delivered to the building. The DON confirmed the findings.On 8/13/25 at 1:51 PM an interview was conducted with the Nursing Home Administrator (NHA). The NHA stated she was made aware of the concern from the DON, and she acknowledged the concern.