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	02/13/2026

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 0600 Level of Harm - Minimal harm or potential for 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. Based on administrative record review and staff interview it was determined that the facility staff failed to ensure that a resident was free of abuse while in the care of a Geriatric Nursing Assistant (GNA). This was evident for 1 (#2) of 1 residents reviewed for abuse. The findings include: On 2/11/26 at 12:06 PM, a review of facility reported incident, #2618494, revealed the facility had substantiated physical abuse based on resident and staff interviews. The facility investigation revealed on 9/11/25 after dinner & before 11:00 PM, during incontinence care, Resident #2 was slapped on his/her buttocks 2 times by Staff #1, Geriatric Nursing Assistant (GNA). The facility investigation documented the allegation of physical abuse was verified by the victim's statements, the repeated interviews that produced a consistent recounting of the incident, and the police confirmed the witness, Staff #2, GNA was involved to the extent that matched the alleged victim's consistent statements. As a result of the facility's investigation, Resident #1, GNA was terminated for his/her actions and reported to the Maryland Board of Nursing (MBON). The above findings were discussed with the Director of Nurses (DON) on 2/11/26 at 4:34 PM. The DON acknowledged the concerns and stated that once their investigation substantiated the abuse, Staff #1, GNA was terminated and reported to the board of nursing.

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

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	02/13/2026

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 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. Based on administrative record review and staff interviews, it was determined that the facility staff failed to immediately report allegations of abuse to the facility administration and the state agency and failed to report the results of their investigation of an alleged incident to the State Survey Agency within 5 working days of the incident. This was evident for 1 (#2) of 1 resident reviewed for abuse. The findings include: On 2/11/26 at 12:06 PM, a review of the facility's investigation documentation for facility reported incident, #2618494 was conducted and alleged on 9/11/25, sometime after dinner and before 11:00 PM, Resident #2 was abused by Staff #1, Geriatric Nursing Assistant (GNA), and the abuse was witnessed by GNA #2, GNA. Following the incident, GNA #1 did not report the abuse and GNA #2, failed to notify the facility's administration of the witnessed abuse. The facility's self-report documented the alleged abuse was reported by Resident #2 to GNA #6 on 9/13/25 between 2:30 PM and 3:00 PM and GNA #6 then reported the abuse allegation to the facility's administration. A written statement signed by Resident #2 on 9/15/25, documented that sometime between 9/10/25 and 9/13/25, the resident thought s/he had a bowel movement (BM) and rang the call bell. GNA #1 and GNA #2 came into the room. When GNA #1 checked him/her and found out the resident had not had a BM Staff #1 said no BM, you're just playing then slapped Resident #2's bare behind 2 times. A written statement signed by GNA #2, on 9/15/25, documented s/he remembered s/he oriented with GNA #1, GNA on Wednesday (9/10/25) during incontinence care after Resident #2 was checked and had not had a BM GNA #1 slapped Resident #2 on the buttocks and said why put your light on? You don't have a BM, The failure of GNA#2 to notify the administration of the witnessed abuse of Resident #2 by GNA #1 delayed the facility's reporting to the state agency. The incident, documented as occurring on 9/11/25, was sent to the State Survey Agency, The Office of Health Care Quality (OHCQ), on 9/13/25 6:05 PM, which was greater than 2 hours after the alleged abuse was witnessed by GNA #2. In addition, further review of the facility's documentation revealed that the facility's final self-report was submitted to the State Survey Agency on 9/22/25 at 2:57 PM, which was greater than 5 working days after the incident. On 2/11/26 at 4:34 PM, the Director of Nurses (DON) was made aware of the concern with facility staff failing to report witnessed abuse which delayed the facility's reporting to the state agency and the concern with the late submission of the facility's final self-report. The DON acknowledged the concerns and offered no further comments at that time.