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

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| Westminster Healthcare Center | 1234 Washington Road<br>Westminster, MD 21157 |

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| F 0569<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42782<br><br>Based on record review and interview it was determined that the facility staff failed to notify the family of a deceased resident that money was still in their account. This deficient practice was evidenced in 1 (#113) of 2 resident accounts reviewed during the survey.<br><br>The findings include:<br><br>On [DATE] at 10:40 am the surveyor reviewed the account balances of all the residents' funds that were managed by the facility. Review of the Trial Balance sheet revealed Resident #113 expired on [DATE]. The surveyor asked Business Office Manager #33 had the family been made aware of the resident's account balance. Business Office Manager #33 verbalized a letter was sent to the family the previous day which was past the 30-day allotted timeframe for notification. |

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 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Keep residents' personal and medical records private and confidential.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49304<br><br>Based on surveyor observation and interview with staff, it was determined that the facility staff failed to protect the privacy of residents' medical information. This was found to be evident for 1 (#70) of 45 residents reviewed during the survey.<br><br>The findings include:<br><br>On 10/16/24 at 9:40 AM as the surveyor walked down the hallway (approximately 1 minute) approaching the medication cart at the end of the hallway, the surveyor did not observe a nurse by the medication cart which was across from room [ROOM NUMBER]. Furthermore, the surveyor observed a laptop computer on top of the medication cart that was unlocked and open with patient information on it. The screen displayed Resident #70's medication administration record (MAR) which displayed what medications Resident #70 was prescribed.<br><br>Approximately 1 minute later, Licensed Practical Nurse (LPN #36) exited the room (#242). She approached the cart and clicked the mouse so the laptop screen changed from having Resident #70's MAR visible on the screen to showing, This Screen is Hidden. When asked if the laptop screen was left up with resident information visible on the screen, LPN #36 stated, yes. During the interview when asked if the laptop screen should be locked so that resident information is not visible, she stated, yes.<br><br>In an interview with the Director of Nursing (DON) on 10/16/24 at 12:00 PM when asked the facility's expectation for protecting resident's information on computer screens in the facility, she stated anytime staff leaves or walks away, the computer screen should be locked. During the interview, the DON was made aware of the above findings. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>42863<br><br>Based on interviews, observations, and medical records reviews, it was determined that the facility failed to: 1.) perform and/or document that appropriate revisions to care plan goals and interventions as resident care needs changed over time. This was evident for 1 (Resident #2) of 45 resident care plans reviewed during the facility's survey.<br><br>The findings include:<br><br>A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess and evaluate the effectiveness of the resident's care.<br><br>1. On 10/09/24 at 09:41 AM a surveyor met with the resident #2 in his/her room and discussed the content of intake MD00207907 regarding basic clinical services related to activities of daily living (ADLs). 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 mobility. This resident stated that he/she was reluctant to get out bed to the chair because of the shortage of staff. This resident also stated that he/she had 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 adult 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. Review of Resident #2's record revealed the resident was a vulnerable adult that required a maximum/2-person assistance with activities of daily living. The resident also had significant behavioral problems identified by the mental health nurse practitioner and documented in the care plan on 02.24.22.<br><br>On 10.09.24 at 2:05 PM the surveyor observed the resident in bed in his/her personal clothing and with their power of attorney (POA) present. The resident was on enhanced barrier precautions secondary to an infection related to her/his suprapubic catheter acquired in August 2024 and was currently in a private room.<br><br>On 10.11.24 at 1:57 PM the surveyor requested a hard copy of the baseline care plan for Resident #2. The electronic medical review of Resident #2's revealed the facility identified the resident as having a behavior problem related to refusal of nursing interventions. The surveyor reviewed the resident behavior contract dated 06.14.2023. The behavior contract had not been revised or updated to reflect the resident's current behavior issues during 2024. Also, the care plan related to the Resident's behavioral issues related to ADLs was not changed/updated in the 08.15.2024 care plan revision. The revisions in August 2024 care plan did not address the resident's current frequency to refuse clinical interventions to achieve the goals of completing showers, out of bed activities, and/or mobility by providing new individualized staff interventions.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 10.14.24, at 2:45 PM the surveyor reviewed the care plan and documentation survey report and task documentation of activities of daily living (ADLs) report for the month of August and September 2024, and did not find any updates or revisions related to interventions by clinical staff to address the resident's consistent frequency to refuse showers, to get out of bed, or to utilize the motorized wheelchair.<br><br>The identified deficient practices were discussed with DON during the survey as well as during the exit conference on 10.18.24. |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>30440<br><br>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.<br><br>Findings include:<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>42782<br><br>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.<br><br>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.<br><br>Review of the Shift Count sheets revealed there was only one nurse signature to verify the narcotic count was completed on the following dates:<br><br>08/08/24 7 am - 3 pm shift<br><br>08/11/24 11pm - 7 am shift<br><br>08/14/24 7 am- 3 pm shift<br><br>08/30/24 11 pm- 7 am shift<br><br>08/31/24 7 am - 3 pm shift<br><br>09/03/24 7 am - 3 pm shift and<br><br>09/04/24 7 am- 3 pm shift<br><br>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.<br><br>50904<br><br>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;<br><br>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.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49304<br><br>Based on surveyor observation and interview with staff, it was determined the facility staff failed to ensure medications were secured as evidenced by an unlocked and unattended medication cart. This was found to be evident for 1 of 7 medication carts reviewed during the survey.<br><br>The findings include:<br><br>On 10/16/24 at 9:40 AM as the surveyor walked down the hallway (approximately 1 minute) approaching the medication cart at the end of the hallway, the surveyor did not observe a nurse by the medication cart which was across from room [ROOM NUMBER]. The surveyor approached and stopped next to the medication cart and noted the silver button that locks the medication cart was protruding out, in the unlocked position.<br><br>Approximately 1 minute later, Licensed Practical Nurse (LPN #36) exited the room (#242). She approached the cart and pushed the silver button on the top right hand side of the medication cart which depressed it into the locked position. When asked if the medication cart was left unattended and unlocked, LPN #36 stated, yes. During the interview she stated yes, the medication cart is supposed to be locked at all times.<br><br>A review of the facility Medication Administration policy on 10/10/24 revealed on page 2 of 7, Do not leave medication cart unlocked.<br><br>In an interview with the Director of Nursing (DON) on 10/16/24 at 12:00 PM when asked the facility's expectation for staff locking medication carts, she stated they are to be locked immediately anytime you leave, walk away, or turn around. During the interview, the DON was made aware of the above findings. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42782<br><br>Based on observation and interviews it was determined that the facility staff failed to maintain infection control practices as evidenced by an uncapped foley catheter drainage bag in a resident bathroom, two unlabeled urinals without lids were in a shared bathroom along with a brown matter on the commode of a shared bathroom. This deficient practice was discovered during the survey.<br><br>The findings include:<br><br>On 10/08/24 at 7:47 am during observation rounds on Unit 3 the surveyor observed an uncapped foley catheter drainage bag hanging on the handle of the commode in room [ROOM NUMBER]. Geriatric Nursing Assistant #14 confirmed the surveyor's findings.<br><br>At 7:56 am the surveyor observed two unlabeled urinals without lids hanging over the commode in the shared bathroom between Rooms 105-106.<br><br>At 8:04 am the surveyor observed brown matter on the shared bathroom commode located between Rooms 107-108.<br><br>On 10/15/24 at 1:53 pm during an interview with Infection Prevention Nurse #7 he/she verbalized the urinals are not supposed to be in the bathroom; they go into a plastic bag and into their residents' drawers. She also verbalized that the urinals are supposed to be labeled. When the urinary drainage bag is changed, the drainage bag should be discarded and a new drainage bag is used.<br><br>On 10/17/24 at 11:36 am during an interview with Environmental Service Manager #15 he/she verbalized they do rounds all the time to be certain the facility is clean. Their shifts are 6am- 2:30 pm, and 7am - 3:30 pm and someone works in the laundry but is trained to clean the rooms and works from 4 pm - 12 am. There are always four housekeepers rounding on the rooms. Environmental Services Manager #15 was made aware of the brown matter that was on the commode of the shared bathroom.<br><br>On 10/18/24 at 1:30 pm during an interview with Director of Nursing (DON) #2 the surveyor asked if the nursing staff have supplies to clean a resident's room or bathroom if needed. DON #2 verbalized yes and since he/she has been working there they have access to the janitor closet if there is a need to be addressed and a Mop & bucket, Clorox wipes, broom dustpan etc. are available on each floor/unit. |