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	05/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westminster Rehabilitation and Wellness 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, it was determined that the facility failed to ensure that the facility environment maintained a homelike, safe, and sanitary environment. This was evident during the initial and subsequent observations and tours during the recertification and change of ownership survey.The findings include:Gouges in countertops and walls are major infection control risks in long-term care (LTC) because they create porous and hard-to-clean surfaces that can harbor pathogens (germs). In a setting where residents often have weakened immune systems, these damaged and deteriorated surfaces act as reservoirs for microorganisms and cannot be effectively cleaned or disinfected, increasing the risk for transmission of infection.On 4/28/26 at approximately 9:30 AM, during the initial tour of the facility, the surveyor noted the following environmental concerns:Visitors enter the facility on the second floor. Upon observation, the surveyor noted that the walls throughout the floor exhibited extensive deterioration, including thinning, worn, and chipped paint, as well as multiple gouged areas. These surfaces appeared rough, uneven, and visibly damaged, preventing effective cleaning. There was a large area of peeling and missing wall material and paint outside of room [ROOM NUMBER], exposing underlying surfaces. In room [ROOM NUMBER], the countertop contained two areas with deep gouges, creating irregular, porous surfaces that cannot be properly sanitized.The surveyor noted that the walls on the first floor similarly exhibited thinning, worn, and chipped paint, as well as multiple gouges throughout the hallways and resident care areas, indicating a widespread lack of maintenance and upkeep.The bathroom in room [ROOM NUMBER] was observed to have an area of the wall with visible signs of prior water damage that had been painted over without proper repair. The surface had ridging and bubbling, indicating compromised wall integrity beneath the paint. Additionally, the ceiling tiles were observed to be bowing, misaligned, and not properly seated within the drop ceiling grid, creating a potential fall hazard. The heating vent was rusted with multiple areas of chipped paint, indicating prolonged deterioration. Numerous floor tiles were cracked, and the caulking in the corners was worn, deteriorated, and peeling away, leaving gaps that could allow moisture and debris accumulation.Additionally, there was not a chair for visitors to sit next to each bed in this room. There was also an area of the room with a partially pulled curtain enclosing a bed without a mattress, along with a wheelchair and bedside tables. This area appeared to be used for storage, contributing to a cluttered and non-homelike environment.room [ROOM NUMBER] was observed to have a gouged door with multiple wide black marks across the brown surface, giving the door a heavily worn and damaged appearance. Additionally, there were tiles missing around the pipe under the sink where it enters the wall, leaving gaps and exposed areas that cannot be properly cleaned.When making an observation in room [ROOM NUMBER], it was noted that an electrical outlet was loose and falling out of the wall while still in use with electrical plugs inserted, posing a safety hazard. The walls behind both beds had deep gouges that had been painted over without proper repair, such as spackling or sanding, leaving uneven, damaged surfaces.On 5/01/26 at 10:16 AM, the surveyor interviewed the Maintenance Director, who stated that he had started working at the facility approximately one month ago and that the position had been vacant for (continued on next page)

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	05/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westminster Rehabilitation and Wellness 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	several months prior to his employment.He stated that his general duties include plumbing, electrical work, repairs, and overall maintenance of the facility. He further explained that he is aware that there are numerous areas requiring attention but that he has needed to prioritize more urgent issues since starting. He stated that he plans to implement formal rounding logs; however, at the time of the survey, there was no formalized log or systematic process in place to ensure that all environmental issues were identified and addressed. He also explained that the facility utilizes a system called TELLS for staff to report maintenance concerns.The surveyor asked if there was a routine schedule for ongoing maintenance, such as painting and environmental updates. The Maintenance Director stated that he was too new to tackle that yet but acknowledged that he was aware the facility needed to address multiple environmental concerns.On 5/01/26 at 10:26 AM, the surveyor and the Maintenance Director toured the facility together. During this tour, he confirmed the surveyor's concerns regarding the condition of the walls throughout the facility, missing tiles, bowing ceiling tiles, gouged countertops, missing chair, cracked tiles, deteriorated caulking, and the unsafe electrical outlet. He stated that he was aware that gouged and damaged surfaces can present infection control concerns and reported that the facility is actively attempting to hire additional maintenance staff to address the backlog of needed repairs.On 5/01/26 at 11:00 AM, the surveyor reviewed the concerns with the Nursing Home Administrator, who confirmed that the facility had been without maintenance staff for a period and acknowledged awareness of the environmental concerns. The surveyor shared photographs of the identified issues. The Administrator stated that she had not realized the extent of the deterioration and that the facility would begin addressing the concerns.

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	05/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westminster Rehabilitation and Wellness 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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record reviews and interviews, it was determined that the facility failed to provide a transfer notice to residents. This was evident for 2 (Resident #2 and Resident #105) of 2 residents reviewed for hospitalizations.The findings include:A Transfer Notice is a legal protection for all long-term care residents. Its primary purpose is to ensure that residents are not transferred or discharged without appropriate notice, a safe plan, and information about their rights. It serves as a required safeguard that obligates the facility to provide a valid reason for the transfer, information on bed-hold status, and clear instructions on how to appeal the transfer decision, including access to an independent advocate. 1) Review of Resident #2's medical record on 4/30/26 revealed the resident was transferred to the hospital on 3/20/26. Further review of the medical record failed to reveal documentation to indicate the required transfer notice information was provided to the resident or the responsible representative. On 4/30/26 at 12:45 PM surveyor reviewed the concern with the Director of Nursing (DON) that the transfer notice was not found in the medical record for the resident's 3/20/26 hospital transfer. The DON then indicated she would check the medical record. On 4/30/26 at 1:12 PM surveyor reviewed documentation provided by the DON in regard to the 3/20/26 transfer to the hospital, which included a Hospital Transfer Form. Review of the additional documentation provided, including the Hospital Transfer Form, failed to reveal documentation to indicate the required transfer notice information was provided to either the resident or the responsible representative. On 4/30/26 at 1:24 PM the DON and Regional Nurse #9 confirmed that the transfer notification information was not being provided. 2). On 5/01/26 at 11:54 AM, the surveyor conducted a medical record review of progress notes for Resident #105 and identified documentation dated 3/27/26 indicating the resident was transferred to the emergency room for generalized weakness and a critically low sodium level based on laboratory results. A second note dated 3/27/26 indicated that the resident's family member was notified of the transfer. During this medical record review, the surveyor was unable to find evidence that a written transfer notice had been provided to the resident or representative. The surveyor requested the facility provide evidence that a written transfer notice was issued. On 5/01/26 at 12:09 PM, the Nursing Home Administrator (NHA) provided a bed-hold policy signed by a family member on 3/27/26; however, no transfer notice was included. The surveyor again requested the transfer notice documentation. On 5/01/26 at 12:15 PM, the Director of Nursing (DON) and NHA provided a transfer packet; however, review of the packet revealed that it did not contain a written transfer notice. On 5/01/26 at 12:26 PM, the DON confirmed that a written transfer notice had not been provided to the resident or representative. The DON further stated that the facility had reviewed the regulatory requirements and acknowledged that prior documentation provided to residents did not meet regulatory guidelines, and that changes were being implemented to ensure compliance going forward.

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	05/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westminster Rehabilitation and Wellness 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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, record review, and staff interview, the facility failed to ensure medications were available for administration and failed to administer medications as ordered for 3 (Resident #103, Resident #49, and Resident #32) of 4 Residents observed during a medication pass. This observation of medication administration revealed 3 errors out of 26 opportunities, for an error rate of 12%.The findings include: On 4/30/26 at 9:35 AM, a medication administration observation was initiated on the first floor with Staff #3, a Registered Nurse. Residents observed included Resident #13, Resident #32, Resident #103, and Resident #49.During the medication pass, the following medications were not administered as ordered:Resident #103:Peridex Mouth/Throat Solution 0.12% (Chlorhexidine Gluconate), 15 ml by mouth twice daily for oral hygiene. Staff #3 stated the medication was not available and that the pharmacy had been notified of the refill request.Resident #49:FLUoxetine HCl Oral Capsule 10 mg, give 3 capsules by mouth one time a day for depression.Staff #3 stated the medication was not available. Review of the medical record revealed a progress note dated 4/27/26 at 8:56 AM documenting that the medication was also not administered on that date due to being unavailable.Resident #32:Clozaril Oral Tablet 25 mg, give 1 tablet by mouth in the morning for schizoaffective disorder.Staff #3 stated the medication was not administered due to the pharmacy delivery being awaited.During the observation, Staff #3 did not attempt to escalate the unavailable resident medications, obtain the medications from the unit medication room, alternative medication storage areas, or an automated dispensing system (Pyxis). The medications were not available and were not administered during the observation period. During an interview on 4/30/26 at 12:23 PM, the Director of Nursing (DON) acknowledged concerns regarding omitted resident medications.The DON stated there is a known issue with pharmacy services delivering medications to the facility. The DON further stated that while the facility maintains a supply of certain medications, including pain medications, antibiotics, and other routine medications, the medications omitted during the observation are not commonly stocked in the automated dispensing system (Pyxis).Cross-reference also to F658, F755, and F867.

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	05/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westminster Rehabilitation and Wellness 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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interviews and record review, it was determined that the facility failed to ensure that the Quality Assurance and Performance Improvement (QAPI) program identified, implemented, and sustained corrective actions for a known, ongoing systemic issue involving the unavailability of ordered medications from the pharmacy provider. This failure allowed a previously identified performance deficiency to continue without the required systematic analysis or monitoring to ensure residents received medications as ordered. This was evident for 1 (Resident #11) of 2 residents reviewed for pain management and for one QAPI plan reviewed during the recertification and change of ownership survey.The findings include:QAPI is a data-driven, facility-wide system mandated to identify, monitor, and correct performance deficiencies in real time. It is not solely a periodic meeting, but an ongoing process that requires facilities to take timely, effective, and sustained systemic action when risks are identified-particularly when those risks involve essential services such as the provision of medications necessary to manage pain and other medical conditions.On 4/28/26 at 4:00 PM, the surveyor interviewed Resident #11, who reported having multiple spinal conditions that cause significant pain. When asked whether the facility effectively manages their pain, the resident stated that staff are generally timely with medication administration; however, there is an ongoing issue with the pharmacy resulting in medications not being available at times. The resident stated, I go crazy about the medications because they use a pharmacy that is always running out of medications. The resident further reported that it sometimes takes several days for medications to become available.On 4/30/26 at 1:49 PM, the surveyor interviewed the Director of Nursing (DON) and inquired whether she was aware of any issues related to medication availability. The DON confirmed that the facility has experienced ongoing issues with timely medication delivery from Pharm Script, the pharmacy provider, for at least two years. She further stated that the facility had previously been cited for this issue. According to the DON, the pharmacy had indicated plans to hire additional drivers; however, there had been little to no improvement, and the pharmacy continued to fail to fulfill resident medication orders. She stated that the facility is currently exploring transitioning to a different pharmacy provider.On 4/30/26 at approximately 2:00 PM, the Regional Nurse informed the surveyor that the facility was in the process of changing pharmacy providers to Geri Script and stated that she believed the issue had been addressed through QAPI. She further indicated that delays in implementing the change were related to a recent change in facility ownership.On 4/30/26 at 2:11 PM, the surveyor interviewed the Nursing Home Administrator (NHA) and asked whether she was aware that medications were not consistently available from the pharmacy. The NHA confirmed awareness of the issue and stated that the facility was in the process of signing a contract with a different pharmacy provider. When asked whether the issue had been investigated and monitored through the QAPI program, the NHA initially stated that she did not believe it had been addressed.At that time, the NHA independently reviewed the facility's QAPI meeting documentation and reported her findings to the surveyor. The NHA stated that the issue had been discussed in September 2025, and that in October 2025 the QAPI committee documented a plan to implement a new pharmacy provider by the end of the year.The NHA further reported that, based on her review, the issue was not carried forward for continued monitoring after October 2025, despite no evidence that the identified corrective action had been implemented or that the problem had been resolved. The NHA stated that she began working at the facility in November 2025 and confirmed that the issue was not continued under QAPI oversight following that time. She further confirmed that the transition to a new pharmacy provider had not yet occurred and confirmed that the QAPI committee failed to verify if the corrective action (changing pharmacies) was completed before removing the item from the active monitoring agenda.On 5/01/26 at 11:00 AM, the NHA informed the surveyor that the facility had initiated a contract with a new pharmacy provider, Geri Script, with an anticipated start date of July 2026.Cross-reference F755 and F759

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	05/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westminster Rehabilitation and Wellness 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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, it was determined that the facility failed to complete and submit Minimum Data Set (MDS) assessments for residents admitted to the facility. This was evident for one (Resident #110) of one Resident reviewed for Resident assessments. The findings included:The MDS is a federally mandated assessment tool that nursing home staff use to gather information on each Resident's strengths and needs. The information collected drives resident care planning decisions. Within 7 days of completing a resident's MDS assessment or tracking record, the facility must encode the MDS data (i.e., enter it into the facility's MDS software). The encoding requirements are as follows: For a comprehensive assessment (Admission, Annual, Significant Change in Status, and Significant Correction to Prior Comprehensive), encoding must occur within 7 days of the Care Plan Completion Date (V0200C2 + 7 days). For a tracking record, encoding should occur within 7 days of the Event Date (A1600 + 7 days for Entry records and A2000 + 7 days for Death in Facility records). Assessment Transmission: Comprehensive assessments must be transmitted electronically within 14 days of the Care Plan Completion Date (V0200C2 + 14 days). All other MDS assessments must be submitted within 14 days of the MDS Completion Date (Z0500B + 14 days)Tracking Information Transmission: For Entry and Death in Facility tracking records, information must be transmitted within 14 days of the Event Date (A1600 + 14 days for Entry records and A2000 + 14 days for Death in Facility records). A record review on 4/28/26 at 3:23 PM for Resident #110 showed that the Resident was admitted to the facility on [DATE]. The continued review failed to show a completed entry tracking and an admission MDS record for Resident #110 in the facility's electronic health record.A follow-up review on 5/4/26 at 8:47 AM contained an Entry tracking dated 4/3/26, completed and transmitted on 4/30/26, which was 20 days late for encoding and 13 days for transmission. Further review revealed an admission MDS for Resident #110, dated 4/7/26 and signed as completed on 4/8/26, in Section V0200C2. The MDS should have been encoded by 4/15/26, and the data transmitted electronically on 4/22/26. However, continued review showed that the MDS data was entered by staff #8, an MDS Coordinator, into the facility's MDS software on 4/30/36, 22 days after V0200C2 was completed and 8 days late for transmission.During an interview on 5/4/26 at 10:10 AM, staff #8 stated that the facility was undergoing a change of ownership and, as a result, did not have access to the facility's MDS software from April 1-10. Staff #8 said she completed the Entry tracking on paper on 4/4/26 and the admission MDS on 4/8/26. However, she did not enter the data into the facility's MDS software on April 11, when access became available. Staff #8 confirmed that both Resident #110's Entry tracking and admission MDS were encoded and transmitted late.

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	05/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westminster Rehabilitation and Wellness 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 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. Based on record review and interviews, it was determined that the facility failed to ensure that a resident had a personalized, resident-specific care plan. This was evident for 1 (Resident #78) of 1 resident reviewed during a communication and sensory investigation.The findings include:Personalized care plans in long-term care are essential to ensure that each resident's unique physical, emotional, cognitive, and communication needs are identified and addressed. Individualized care planning promotes safety, dignity, and effective communication, particularly for residents with cognitive impairment, behavioral concerns, and language barriers.On 4/28/26 at 10:40 AM, during the initial screening process, the surveyor attempted to interview Resident #78. The resident was observed speaking a language that appeared to be a mix of Italian and Spanish, which made it difficult for the surveyor to effectively communicate with the resident. The surveyor also observed that there was no call bell present in the resident's room, limiting the resident's ability to independently request assistance.On 4/28/26 at 3:23 PM, the surveyor conducted a review of Resident #78's care plan. The care plan failed to identify the resident's primary language and did not include individualized interventions to guide staff on how to effectively communicate with the resident. There was no documentation explaining the resident's communication needs or preferences.Additionally, the care plan failed to address the absence of a call bell in the resident's room. There were no interventions, rationale, or alternative measures documented to ensure the resident's safety and ability to summon assistance despite the lack of a call bell.The care plan did include a general intervention related to use of a language line; however, this intervention was not individualized to the resident, as it failed to identify the resident's language. It read in part:[Resident #78] has a communication problem Date Initiated: 08/14/24 Revision on: 09/02/24Press 1 - FOR SPANISH,Press 2 - FOR ALL OTHERS AND CLEARLY STATE THE LANGUAGEPress 0 - IF YOU DON'T KNOW THE LANGUAGEThis intervention lacked resident-specific direction and did not provide staff with clear guidance on how to effectively communicate with Resident #78.On 4/30/26 at 10:56 AM, the surveyor conducted an interview with the Director of Nursing (DON). The DON stated that Resident #78 has dementia and a history of behavioral concerns, including self-inflicting behaviors (banging head) and expressed suicidal ideation without a specific plan. The DON further stated that the resident speaks Spanish and very little English. She indicated that staff utilize a language line, Google Translator, and Spanish-speaking staff to communicate with the resident.When asked about the absence of a call bell, the DON stated that it had been removed due to the resident's behavioral concerns and suicidal ideation.The surveyor asked whether these communication needs, behavioral risks, and the removal of the call bell were reflected in the care plan. Upon review, the DON acknowledged that the care plan did not include the resident's primary language, did not reflect the removal of the call bell, and did not include interventions for increased monitoring or alternative methods for the resident to request assistance. The DON further acknowledged that care plans are expected to be resident-specific and individualized.On 4/30/26 at 11:15 AM, the surveyor discussed these concerns with the Nursing Home Administrator, who confirmed that care plans are required to be individualized and resident specific.

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	05/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westminster Rehabilitation and Wellness 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 0657 Level of Harm - Minimal harm or potential for actual harm 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. Based on medical record review and interviews, it was determined that the facility failed to hold care plan meetings. This was evident for 1 (Resident #37) of 3 residents reviewed for care planning.The findings include:Care plan meetings are required to be held at least quarterly following the completion of a Comprehensive or Quarterly Minimum Data Set (MDS) Assessment.An MDS assessment is a federally mandated, standardized clinical tool used in Medicare/Medicaid-certified nursing homes to assess a resident's functional, cognitive, and physical health status. It serves as the foundation for comprehensive, person-centered care planning by identifying clinical conditions and risk factors (such as pain, falls, or decline in function) that must be addressed through individualized interventions.On 4/28/26 at 2:25 PM, the surveyor interviewed Resident #37 regarding participation in care plan meetings. Resident #37 stated that they might attend care plan meetings. When asked if meetings were held to discuss their preferences and overall care, the resident stated that discussions sometimes occur regarding medications but not regarding their preferences.On 4/30/26 at 9:59 AM, the surveyor conducted a record review of Resident #37's care plan documentation. Review of the care plan meeting sign-in sheets revealed that the most recent documented care plan meeting occurred on 12/4/25. No additional documentation was identified to evidence that a care plan meeting had been conducted since that date. Further review revealed that an MDS assessment was completed and submitted in February 2026; however, there was no evidence that a care plan meeting was conducted within the required timeframe following completion of this assessment.On 4/30/26 at 10:29 AM, the surveyor conducted an interview with the facility Social Worker, who stated that she has worked in the facility since May of 2024 and is responsible for scheduling all care plan meetings. When asked if she was familiar with Resident #37, she confirmed that she was and stated that the resident and the resident's sister typically attend care plan meetings. At the request of the surveyor, the Social Worker reviewed the resident's care plan meeting notes and associated documentation due to the surveyor's inability to locate evidence of a recent meeting.Upon review, the Social Worker confirmed that a care plan meeting had not been conducted since 12/4/25. She stated that it appeared that the February 2026 MDS assessment had been completed earlier than expected and, as a result, was not captured on her scheduling calendar, leading to the failure to schedule and conduct the required care plan meeting. She further stated that a meeting would be scheduled immediately.

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	05/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westminster Rehabilitation and Wellness 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 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 observation, record review, and staff interview, the facility failed to provide necessary care and services in accordance with professional standards of practice by failing to administer medications as ordered for 3 (Resident #103, Resident #49, and Resident #32) of 4 residents observed for medication administration during the annual recertification survey. The findings include: On 4/30/26 at 9:35 AM, a medication administration observation was initiated on the first floor with Staff #3, a Registered Nurse. Residents observed included Resident #13, Resident #32, Resident #103, and Resident #49.During the medication pass, the following medications were not administered as ordered:Resident #103:Peridex Mouth/Throat Solution 0.12% (Chlorhexidine Gluconate), 15 ml by mouth twice daily for oral hygiene. Staff #3 stated the medication was not available and that the pharmacy had been notified of the refill request.Resident #49:FLUoxetine HCl Oral Capsule 10 mg, give 3 capsules by mouth one time a day for depression. Staff #3 stated the medication was not available. Review of the medical record revealed a progress note dated 4/27/26 at 8:56 AM documenting that the medication was also not administered due to being unavailable on that date. Resident #32:Clozaril Oral Tablet 25 mg, give 1 tablet by mouth in the morning for schizoaffective disorder.Staff #3 stated the medication was not administered due to awaiting pharmacy delivery.During the observation, Staff #3 did not attempt to obtain the medications from the unit medication room, alternative medication storage areas, or an automated dispensing system (Pyxis). The medications were not available and were not administered during the observation period.On 4/30/26 at 12:23 PM, during an interview with the Director of Nursing (DON), they acknowledged concerns regarding omitted resident medications.The DON stated that this was a known issue with pharmacy services delivering medications in a timely manner to the facility. The DON further stated that while the facility maintains a supply of certain medications, including pain medications, antibiotics, and other routine medications, the medications omitted during the observation are not commonly stocked in the automated dispensing system (Pyxis). On 4/30/26 at 12:30 PM, there was no evidence that the facility implemented alternative measures to ensure residents received prescribed medications as ordered.Cross-reference also to F755, F759, and F867.

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	05/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westminster Rehabilitation and Wellness 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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, it was determined that the facility failed to ensure that residents who required assistance with Activities of Daily Living (ADLs) received showers. This was evident for one (Resident #23) of five residents reviewed for ADL. The findings include:The Minimum Data Set (MDS) is a federally mandated assessment tool used by nursing home staff to gather information on each Resident's strengths and needs. Information collected drives resident care planning decisions.An interview with Resident #23 on 4/30/26 at 10:45 AM indicated that he/she had not received a shower in 2 years and wanted to shower regularly. A record review for Resident #23 on 4/30/26 at 10:47 AM included an MDS assessment dated [DATE], which indicated that Resident #23 did not walk and relied on staff for most of his/her self-care needs.A review of the shower schedule for the nursing unit where Resident #23 resided showed that the Resident was scheduled for showers on Wednesdays and Saturday evenings, totaling 8 showers per month.A follow-up review of the GNA (geriatric nursing assistant) shower documentation for Resident #23 from December 2025 to April 30, 2026, was completed. The review documented one RR (Resident refused shower) and four bed baths (washing the Resident in bed) in December; four bed baths in January; five bed baths in February; seven bed baths in March; and five bed baths in April. The review did not indicate that Resident #23 was consistently offered 2 showers per week.During an interview on 5/1/26 at 11:00 AM, the director of nursing (DON) reported that Resident #23 was to be offered showers twice a week by the staff. If the Resident refused the showers, the nursing assistant was to notify the nurse, and the Resident's refusal was to be documented. The DON further stated that Resident #23 consistently refused his/her showers. However, the interview provided no evidence that the Resident consistently refused his/her showers.In a subsequent interview on 5/1/26 at 11:24 AM, the DON said she would provide education to staff if needed to ensure that Resident #23 received his/her showers.

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	05/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westminster Rehabilitation and Wellness 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and medical record reviews, it was determined that the facility failed to ensure that residents received medications and treatments as ordered. This was evident for one (Resident #11) out of two residents reviewed for pain management and for 1 (Resident #37) of 1 resident reviewed for dialysis.The findings include:1). On 4/28/26 at 4:00 PM, the surveyor interviewed Resident #11, who reported having multiple spinal conditions that cause significant, ongoing pain. When asked if the facility effectively managed their pain, the resident stated that they do not always receive their medications as ordered.On 4/30/26 at 1:37 PM, the surveyor reviewed Resident #11's March 2026 Medication Administration Record (MAR) and Treatment Administration Record (TAR). The review revealed multiple dates where there was no documentation to indicate that ordered medications and treatments were administered, including the following:3/5/26:Vital signs monitoring3/12/26:AspirinLidocaine patches (four separate orders)MirtazapineTizanidine3/13/26:Voltaren3/22/26:VoltarenBiofreezeLidocaine patches (four separate orders)GabapentinMonitoring for painScreening for respiratory or COVID-19 illness signs and symptomsOxycodone3/23/26:Screening for respiratory or COVID-19 illness signs and symptoms3/28/26:Oxycodone3/31/26:AtorvastatinVoltarenLidocaine patches (four separate orders)MultivitaminPantoprazoleSenokotVitamin CFerrous sulfateFluticasone propionateMonitoring for signs and symptoms of anxietyMonitoring for signs and symptoms of side effects of anticoagulant therapyMonitoring for side effects of antidepressant therapyMonitoring for painWear back brace when out of [NAME] 4/30/26 at 1:49 PM, the surveyor interviewed the Director of Nursing (DON), who confirmed awareness of gaps in documentation and stated that when documentation is absent, it indicates that the medications or treatments were not provided. The DON reported that agency staff are often responsible for these occurrences, stating that efforts are made to contact them for clarification or late documentation; however, most do not return her call, and they are subsequently placed on a do not return list. She acknowledged that this is concerning. On 5/1/26 at approximately 4:30 PM, the surveyor discussed concerns with the Nursing Home Administrator (NHA) regarding residents not receiving ordered medications and treatments. The NHA acknowledged that this is a concern.2). Dialysis is a life-sustaining treatment that acts as an artificial kidney to filter waste, toxins, and excess fluid from the blood when a person's kidneys have failed. This treatment prevents the harmful buildup of waste products in the body and assists with regulating blood pressure.Adherence to the full medical treatment plan, including prescribed medications and treatments, is essential, as dialysis replaces only a portion of normal kidney function. Medications are necessary to control blood pressure, manage anemia, and reduce excess phosphorus levels, which dialysis alone cannot adequately regulate. Failure to follow the prescribed regimen can result in serious complications.On 4/28/26 at 2:13 PM, Resident #37 reported to the surveyor that they have kidney failure and attend dialysis treatments three times per week.On 4/30/26 at 11:53 AM, the surveyor conducted a record review of Resident #37's care plan, which confirmed diagnoses of renal failure and end-stage kidney disease requiring dialysis three times weekly. The care plan included multiple interventions aimed at managing the resident's chronic condition.Further review of Resident #37's April 2026 Medication Administration Record (MAR) and Treatment Administration Record (TAR) revealed that ordered medications and treatments were not consistently administered as prescribed, including:-Hydralazine HCl Oral Tablet 25 mg - ordered to be administered every 8 hours for hypertension, including on dialysis days, with instructions to notify the physician if blood pressure is low (Start Date: 08/29/2025 at 1400).Missed doses were identified on 4/20/26 and 4/25/26.-Dialysis shunt assessment - ordered every shift to assess for the presence of a thrill (palpated) or bruit (auscultated), with instructions to notify the physician if absent (Start Date: 04/30/2025 at 0630).Assessments were not documented on 4/6/26, 4/8/26, and 4/20/26.On 4/30/26 at 12:11 PM, (continued on next page)

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	05/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westminster Rehabilitation and Wellness 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	the surveyor conducted an interview with the Director of Nursing (DON), who confirmed that Hydralazine was not administered on 4/20/26 and 4/25/26, and that the dialysis shunt was not assessed on 4/6/26, 4/8/26, and 4/20/26. The DON acknowledged that these omissions are a concern.On 5/1/26 at approximately 4:30 PM, the surveyor discussed concerns with the Nursing Home Administrator (NHA) regarding the failure to administer ordered medications and treatments to residents. The NHA acknowledged that this is a concern.

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	05/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westminster Rehabilitation and Wellness 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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, record review, and interview, the facility failed to ensure implementation of physician-ordered pressure-relieving interventions and proper functioning of a pressure-reducing device for 1(Resident #47) of 1 residents reviewed for pressure ulcer care.The findings include: On 4/28/26 at 11:05 AM, during the surveyor's observation of the unit, Resident #47 motioned for the surveyor to enter their room from the hallway.Upon entering, the resident's call bell was not within reach and could not be located.On 4/28/26 at 11:08 AM, the surveyor observed that Resident #47 was lying on a pressure-reducing air mattress that was actively alarming, with a weight setting of 1000 pounds. At that time, Resident #47 stated to the surveyor that they were in pain. The mattress was deflated, and the resident appeared to be lying on the bed frame.Due to the absence of an accessible call bell, the surveyor activated the empty bed call bell to alert staff.On 4/28/26 at 11:18 AM, Staff #6, a Registered Nurse, entered the room in response to the call. The surveyor informed Staff #6 that Resident #47 had motioned for assistance, and the resident's call bell could not be located.On 04/28/2026 at 11:20 AM, Staff #6 located the resident's call bell behind the head of the bed, retrieved it, and secured it to the resident's blanket, making it accessible. Staff #6 also silenced the alarming pressure-reducing air mattress. The surveyor asked Staff #6 if Resident #47 weighed 1000 pounds, as displayed on the mattress setting. Staff #6 did not provide a response.On 4/28/26 at 11:30 AM, a record review revealed Resident #47 had diagnoses including, but not limited to, a Stage 3 pressure ulcer of the sacral region. Review of physician orders revealed an order dated 2/18/25 for an Air mattress to the bed, with settings per the manufacturer's guidelines. Every shift. At the time of observation, the mattress was not set in accordance with manufacturer guidelines, as evidenced by an inappropriate weight setting, and the device was actively alarming without timely correction, indicating the facility failed to ensure proper implementation and monitoring of a physician-ordered pressure-relieving intervention for a resident who had a known pressure ulcer.On 4/30/26 at 12:30 PM, during an interview with the Director of Nursing, they acknowledged the concern regarding the failure related to pressure ulcer prevention for Resident #47.

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	05/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westminster Rehabilitation and Wellness 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 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 interviews and record reviews, it was determined that the facility failed to ensure that ordered medications were available for dispensing to residents. This was evident for 1 (Resident #11) of 2 residents reviewed for pain management.The findings include:On 4/28/26 at 4:00 PM, the surveyor interviewed Resident #11, who reported having multiple spinal conditions that cause significant pain. When asked whether the facility effectively manages their pain, the resident stated that staff are generally timely with medication administration; however, there is an ongoing issue with the pharmacy resulting in medications not being available at times. The resident stated, I go crazy about the medications because they use a pharmacy that is always running out of medications. They further reported that it sometimes takes several days for medications to become available.On 4/30/26 at 1:37 PM, the surveyor conducted a record review of the Resident #11's February, March, and April 2026 Medication Administration Records (MARs) and identified multiple gaps in documentation of medication administration on various dates. The surveyor was unable to determine the reason for these gaps based on the record review.On 4/30/26 at 1:49 PM, the surveyor interviewed the Director of Nursing (DON) and inquired whether she was aware of any issues related to medication availability. The DON stated that the facility has experienced ongoing issues with timely medication delivery from Pharm Script (pharmacy provider) for at least two years. She further stated that the facility had previously been cited for this issue and had requested that the pharmacy submit its portion of the plan of correction. According to the DON, the pharmacy had indicated plans to hire additional drivers; however, there had been little improvement, and the pharmacy continued to fail to fulfill resident medication orders. She stated that the facility is currently exploring transitioning to a different pharmacy provider.The surveyor asked the DON what nursing staff are instructed to do when medications ordered are not available. The DON stated that nurses are instructed to document a 9 on the MAR, indicating that the medication was not administered, and to include a rationale, such as the medication being unavailable or out of stock. She further stated that nurses are expected to follow up by contacting the pharmacy. When asked whether residents receive their medications during these periods of unavailability, the DON stated that they do not receive the medication until it becomes available.The DON clarified that the previously identified gaps in MAR documentation represent a separate issue (cross-reference F684) but confirmed that medication unavailability has impacted Resident #11. As an example, the DON provided documentation showing that on 4/25/26, the resident did not receive the ordered medication Tizanidine, which was recorded as a 9 on the MAR with the notation Out of medication/not available.On 4/30/26 at 2:11 PM, the surveyor interviewed the Nursing Home Administrator (NHA), who confirmed awareness of ongoing issues with the pharmacy's failure to consistently deliver ordered medications. The NHA stated that the facility is in the process of transitioning to a new pharmacy provider (the transition was supposed to take place at the beginning of the year). On 5/01/26 at 11:00 AM, the NHA informed the surveyor that the facility had initiated a contract with a new pharmacy, Geri Script, with an anticipated start date of July 2026.Cross-reference F759 and F867

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	05/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westminster Rehabilitation and Wellness 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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on record review and interviews, it was determined that the facility failed to ensure that physicians provide a clinical rationale for not implementing pharmacist recommendations. This was evident for 1 (Resident #113) of 5 residents reviewed for unnecessary medications.The findings include:A pharmacist medication review (Medication Regimen Review or MRR) is a monthly safety evaluation required by federal regulation for nursing home residents. It involves a comprehensive review of a resident's medications by a licensed pharmacist to ensure each medication is necessary, effective, and free from unnecessary risk. When a pharmacist identifies potential concerns, recommendations are made to the attending physician for review and consideration. Federal regulations require that when a physician does not accept or implement these recommendations, a documented clinical rationale must be provided to support that decision.On 4/29/26 at 3:24 PM, the surveyor performed a record review of Resident #113's pharmacy recommendations from January 2026 through April 2026 and identified the following:On 4/13/26, a note titled Recommendations to the Attending Physician/Provider stated: [Resident #113] is receiving multiple medications with anticholinergic effects. Anticholinergic burden is the cumulative effect of medications that block acetylcholine. Higher burden is associated with cognitive decline, delirium, and behavioral symptoms, functional decline, and falls and increased mortality and hospitalization. Please review the medications below for possible dose reduction or alternatives with less cholinergic effects.The pharmacist identified the following medications:TrazodoneMeclizineHydroxyzineDicyclominePRN (as needed) BenadrylThe physician (MD #10) declined the recommendation to reduce dosages or consider alternatives. The documentation stated only MD not in agreement, with no clinical rationale provided.Further review revealed a second pharmacist recommendation dated 4/23/26 stating that Resident #113 was receiving two statins, pravastatin and simvastatin, and recommending discontinuation of one due to duplicate therapy.On 4/28/26, the physician response again documented only MD not in agreement, with no supporting rationale provided.Subsequent review of Resident #113's Medication Administration Record (MAR) showed that as of 4/29/26, the resident continued to receive Trazodone, Meclizine, Hydroxyzine, Dicyclomine, Benadryl, Pravastatin, and Simvastatin despite the pharmacist's recommendations and without documented clinical justification for declining those recommendations.On 4/29/26 at 3:30 PM, the surveyor interviewed the Director of Nursing (DON) regarding the process followed when a physician disagrees with pharmacist recommendations. The DON stated that she writes MD not in agreement and then files it. When asked about the requirement for physicians to document a rationale when declining pharmacist recommendations, she stated that she was not aware of this requirement and added that some doctors don't like to be questioned. She confirmed that the responses for Resident #113 consisted of MD not in agreement without additional explanation documented.On 4/29/26 at 4:02 PM, the surveyor interviewed the Nursing Home Administrator regarding concerns that physician responses to pharmacist recommendations did not include documented rationale. The Administrator acknowledged that this was concerning and stated that the issue would be brought to the Medical Director for awareness and follow-up.On 5/21/26 at 4:30 PM, the surveyor reviewed the facility policy and procedure titled Medication Regimen Review, Policy Number NS 1218-01, revised 9/23/19. The policy under Attending Physician Responsibilities states, If there is to be no change in the medication, the attending physician must document his/her rationale in the resident's medical record. The policy further states, If the attending physician fails to address the irregularity in a timely manner, the DON will escalate the concern to the Medical Director.

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	05/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westminster Rehabilitation and Wellness 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 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. Based on observations, record review, and interviews, it was determined that the facility failed to serve residents meals that reflected their preferences. This was evident in one out of two kitchen observations during the survey.The findings include:During an observation of the facility's Lunch tray line service on 4/30/26 at 1.15 PM, the surveyor requested a test tray as the last tray was being prepared. The tray included a meal slip for Resident #75, indicating that the Resident was on a regular diet and was to receive double portions of the entree. The Resident was to be served Italian sausage, 1/2 cup of sauteed spinach with garlic, 1/2 cup of Parmesan noodles, 1 buttered dinner roll, margarine, spiced peaches, 4 oz yogurt, and 8 oz fruit punch.An inspection of the tray revealed Italian sausage, sauteed spinach, Parmesan noodles, buttered dinner roll, margarine, spiced peaches, and 8 oz of fruit punch. However, the kitchen failed to provide Resident #75 the 4-oz yogurt as indicated on the meal slip. A record review later that day for Resident #75 contained a dietitian's note dated 1/9/26 that stated that Resident #75 requested that [he/she] no longer receive double portions of entrees and breakfast meats. Change noted in diet order and noted in Meal Tracker. However, earlier observations of Resident #75's lunch meal slip noted that he/she continued to receive double portions of entree.The review also included another dietitian's note dated 1/15/26 that recorded that Resident #75's Food preferences updated per [patient] request. [He/she] wants yogurt with meals. Changes noted in Meal Tracker. However, earlier observation of Resident #75's lunch tray did not show that he/she received yogurt.In an interview on 4/30/26 at 2:24 PM, the surveyor asked the dietary manager about Resident #75's double-portion order on the meal slip and stated that his staff had grabbed the wrong tray for Resident #75.

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	05/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westminster Rehabilitation and Wellness 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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on resident interviews, observation, and staff interviews, it was determined that the facility failed to serve residents meals that were appetizing in appearance and at the appropriate temperature. This was evident for 1 of 2 kitchen observations. The findings include:During the initial screening of the survey on 4/28/26, Residents #26, #37, #10, #82, and #84 reported that the facility's food was served cold and tasted bland and terrible.An observation of the kitchen on 4/30/26 at 11:54 AM revealed that Staff #11 (Cook) was preparing food for lunch. An inspection of the steam table revealed that the cook had begun adding items before the surveyor arrived. Sausage and dinner rolls were on the steam table, and during the observation, spinach and parmesan noodles were added. Before preparing the trays to be sent to the units, staff #36 failed to check the temperatures of the food items on the steam table to determine the holding temperatures of the hot foods.During continued observation on 4/30/26 at 1.15 PM, the surveyor requested a test tray as the last tray was being prepared. The tray had a meal slip for Resident #75. The slip read that the Resident was on a regular diet and was to have double portions of the entree. The Resident was to be served Italian sausage, 1/2 cup of sauteed spinach with garlic, 1/2 cup Parmesan noodles, 1 buttered dinner roll, margarine, spiced peaches, 4 oz yogurt, and 8 oz fruit punch.The surveyor tasted each food item on the plate: the Parmesan noodles were dry, and the sauteed spinach was bland and flavorless. The sausages were 83.4 degrees F, and the spinach was 114.6 degrees F. In a follow-up interview, the dietary manager indicated that the acceptable holding temperature for hot foods on the tray line should be 135degrees F and verbalized understanding of the concern.

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	05/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westminster Rehabilitation and Wellness 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and record review, it was determined that the facility failed to store food in accordance with professional standards. This was evident in 1 of 2 observations of the facility's kitchen during the recertification survey.The findings include:An initial tour of the facility's kitchen with the staff #12, dietary manager, on 4/28/26 at 8:52 AM revealed the following:- An observation of the walk-in freezer noted 3 slices of chicken patty in a zip-lock bag, with no label of when it was opened or the use-by date. Staff said, I got you, and added, I will just trash it.- An Observation of the facility's walk-in refrigerator revealed the following:-3 slices of bologna in a zip-lock bag; it had no label indicating when it was opened or its use-by date.-chunks of pineapple in a container with a label that stated, use by 4/22. Staff indicated that the labeling was a mistake. He said the date on there was the date it was prepared; however, it lacked an expiration date.-Butter scotch pudding labeled use by 4/25. Staff said it was a mistake and that the date was the opening date, not the use-by date, but it lacked a use-by date.-Prepared brown Beans with a label that read use-by 4/18. Staff said it was not supposed to be a use-by date; it should have been the prepared date, and it should have still had a use-by date.-Pureed chicken with no label of the prepared date or use-by date, staff said, I'm going to dump it in the trash.In a follow-up interview with Staff #12, he verbalized understanding of the concern about not labeling food items. He said he would address the concerns.

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	05/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westminster Rehabilitation and Wellness 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on medical record review, observation and interview it was determined that the facility failed to ensure staff maintained physician ordered enhanced barrier precautions when providing care. This was found to be evident for one (Resident #7) out of one resident reviewed for tube feeding.The findings include: Review of Resident #7's medical record revealed the resident received medications and feedings via a feeding tube. A feeding tube refers to a medical device used to provide liquid nourishment, fluids and medications by bypassing oral (by mouth) intake. Feeding tubes can also be called enteral tubes, PEG tubes or g-tubes. Review of the facility's policy for Enhanced Barrier Precautions (EBP) revealed: EBP refers to an infection control intervention designed to reduce transmission of multi-drug resistant organisms that employs hand hygiene, as well as targeted gown and glove use during high contact resident care activities. These activities include, but are not limited to, accessing/use of a feeding tube.On 5/1/26 at 8:33 AM surveyor observed Nurse #13 access the resident's feeding tube to administer three separate medications. The nurse also provided water flushes before and after each medication administration. After the medication administration the nurse cleaned the tube entry site and applied a clean gauze dressing. The nurse did not wear a gown during either the medication administration or the tube site care.On 5/1/26 at 8:53 AM further review of the medical record revealed an order, in effect since 4/25/25, to Use enhanced barrier precautions when providing hands on care or accessing the enteral tube site.On 5/1/26 at 8:56 AM surveyor asked Nurse #13 what EBP means. The nurse responded: clean your hands and use gloves for the dressing. Surveyor then asked about gown usage, to which Nurse #13 responded: that is my bad. Surveyor then observed the sign about Enhanced Barrier Precautions, which was posted outside the resident's room, with Nurse #13. The sign indicated a gown was required when providing care. Nurse #13 reported she had asked if any residents were on precautions this morning and was told no. The nurse also pointed out that there was no supply of gowns outside the resident's room.On 5/1/26 at 9:06 AM surveyor reviewed the concern with the Director of Nursing (DON) regarding the staff's failure to wear a gown while accessing the feeding tube for medication administration and providing site care. The DON reported the gowns are located on the door inside the room.

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	05/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westminster Rehabilitation and Wellness 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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation and interview, the facility failed to ensure that a resident call system was within reach and readily accessible to meet resident needs for 1 (Resident #47) of 1 resident reviewed for call bell accessibility.The findings include: On 4/28/26 at 11:05 AM, observation on the unit revealed Resident #47 motioned for the surveyor to enter their room from the hallway.Upon entering, the resident's call bell was not within reach and could not be located. Resident #47 stated they were in pain.Due to the absence of an accessible call bell, the surveyor activated the empty bed call bell to alert staff.On 4/28/26 at 11:18 AM, Staff #6, a Registered Nurse, entered the room in response to the call. The surveyor informed Staff #6 that Resident #47 had motioned for assistance, and the resident's call bell could not be located.On 4/28/26 at 11:20 AM, Staff #6 located the resident's call bell behind the head of the bed, retrieved it, and secured it to the resident's blanket, making it accessible. Staff #6 acknowledged the surveyor's concern related to Resident #47's call bell being inaccessible. On 4/30/26 at 12:30 PM, during an interview with the Director of Nursing, they acknowledged the concern regarding the resident's call bell being inaccessible.