

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215110	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2024
NAME OF PROVIDER OR SUPPLIER Western MD Hospital Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 Pennsylvania Avenue Hagerstown, MD 21742	

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)
<p>F 0559</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48259</p> <p>Based on record review and interviews, it was determined that the facility failed to provide the resident or the resident's responsible party with written notice of a room change, including the reason for the change before the resident's room was changed. This was evident for 2 (Resident #31 and #9) out of 4 residents reviewed for choices during the survey.</p> <p>The findings include:</p> <p>1) A record review on 5/20/24 at 11:00 AM revealed that Resident #31 was admitted to the facility in August 2022 with diagnoses including Dementia. Continued review showed an Minimum Data Set (MDS) assessment dated [DATE] that documented that Resident #31 had severe cognitive impairment with short- and long-term memory loss.</p> <p>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.</p> <p>A subsequent record review revealed that Resident #31 had a room change on 4/18/24. However, the review failed to show that the Resident's responsible party or family was notified of the Resident's room change before the change.</p> <p>The continued review contained a progress note for Resident #31 that recorded that the Resident's room was changed again on 5/7/24. However, the review failed to show that a written notice, including the reason for the change, was given to Resident #31's responsible party before the room change.</p> <p>During an interview on 5/30/24 at 11:25 AM, Staff #37, a social worker, reported that she did not give written notice with reasons to residents or their responsible parties before room changes. Staff #37 continued to say that Resident #31's responsible party did not agree with the room change on 5/7/24.</p> <p>In a subsequent interview on 5/30/24 at 12:07 PM, Staff #3, a unit nurse manager, reported that if a responsible party were not agreeable to a room change, the facility would not move the Resident. However, Resident #31's room was changed after the responsible party voiced disagreement with the move on 5/7/24.</p> <p>(continued on next page)</p>

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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<p>F 0559</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility's policy titled Room move notification contained the statement that if a resident or legal representative is not in agreement with the room move, they should be given 30 days written notice, and an interdisciplinary team meeting should be held to discuss their concerns or other room move options. However, the review failed to show documentation of a discussion of Resident 31's responsible party's concerns about the room change.</p> <p>50573</p> <p>2) Review of Resident #9's medical record on 5/20/24 revealed the resident has resided at the facility for several years, is alert and oriented and able to verbally communicate. Resident #9 is dependent on staff for transfers out of bed and mobility due to weakness.</p> <p>During an interview on 5/20/24 at 2:43 PM, Resident #9 reported a recent room change and expressed concerns about the new room.</p> <p>Review of the progress notes revealed that on 5/3/24 the Social Worker (Staff #37) had a meeting with Resident #9 to discuss a potential room change. The note indicates the resident was in agreement with the move after the discussion but failed to include documentation that written notice was provided to the resident about the room change.</p> <p>Record review revealed that on 5/4/2024 at 11:06 AM Registered Nurse (Staff #20) documented Resident #9's official room move. Further review of medical record failed to reveal documentation indicating written notice was provided to Resident #9, including the reason for the room change, prior to the room change.</p> <p>An interview with Nursing Home Administrator (Staff #1) on 05/28/24 at 11:22 AM revealed that social work will talk with the residents about room changes and if they are not able to understand, social work will call and talk with the family. Further interview with Staff #1 revealed that she is not sure if anything is given in writing about room changes.</p> <p>An interview with Licensed Certified Social Worker (Staff #37) on 05/28/24 at 12:19 PM revealed that residents are not given written notice for room changes and that if room changes are planned they are given verbal notice and when they agree it is documented as so.</p> <p>On 05/31/24 at 4:26 PM, the surveyor reviewed concern with the Director of Nursing (Staff #18), and Nursing Home Administrator (Staff #1) regarding the failure to provide written notice to the resident prior to a room change.</p>		

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<p>F 0578</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45139</p> <p>Based on medical record review and staff interview, it was determined the facility failed to 1.) to have a process in place to ensure that the resident's wishes for resuscitation were communicated to staff so that the staff would know immediately what action to take during an emergency. This resulted in harm to Resident #96, who had a do not resuscitate (DNR) order, receiving cardiopulmonary resuscitation (CPR). The resident was resuscitated, remained at the hospital for 8 days, and returned to the facility with a chest tube inserted in each lung; 2.) reveal evidence that the resident was informed of their right to formulate an advanced directives by failing to document discussions regarding advanced directives and the outcome of the discussion in the resident's medical record and failed to ensure Do Not Resuscitate orders were followed. This was evident for 1 (Resident #6) of 2 residents reviewed for advanced directives, and 1 (Resident #96) out of 1 resident reviewed for choices during a survey.</p> <p>The findings include:</p> <p>Advanced Directive is a written instruction, such as a living will or durable power of attorney for health care, recognized under State law related to provision of health care when the individual was not able to make their own decisions.</p> <p>1. On [DATE] at 8:38 AM, a medical record review revealed Resident # 96 was a long-term resident of the facility. Further review revealed Resident #96 was on a vent to help him/her breathe.</p> <p>On [DATE] at 3:00 PM, a review of Resident #96 ' s hard chart revealed a Medical Order for Life-Sustaining Treatment (MOLST) form, dated [DATE]. A review of the MOLST form revealed that Resident #96 was not to receive CPR. Further review revealed orders for the resident to receive assistance with breathing, but resuscitation attempts did not include CPR and allowed death to occur naturally.</p> <p>A Maryland MOLST (Medical Orders for Life-Sustaining Treatment) form documents a resident's specific wishes for life-sustaining treatments. The MOLST form includes medical orders for Emergency Medical Services (EMS) and other medical personnel regarding cardiopulmonary resuscitation (CPR) and other life-sustaining treatment options for a specific patient.</p> <p>On [DATE] at 8:40 AM, a review of progress notes dated [DATE] at 8:00 AM; revealed that Resident # 96 became apneic, unresponsive, and no pulse was detected. CPR was initiated for 3 cycles of 100 compression. Further review revealed that the MOLST form was reviewed by staff and determined that Resident #96 ' s code status was do not resuscitate. CPR was stopped and the local emergency medical service transported Resident # 96 to the hospital.</p> <p>On [DATE] review of a Physician's note dated [DATE] revealed that the resident was resuscitated with CPR by nursing staff regained his/her pulse and blood pressure, and then transferred to the hospital.</p> <p>On [DATE] at 9:00 AM, continued review of progress notes, nursing note dated [DATE] at 4:23 PM, revealed that Resident #96 was admitted to the hospital and had bilateral chest tubes placed.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 12:00 PM, review of progress notes revealed resident #96 was discharged from the hospital and returned to the facility on [DATE].</p> <p>On [DATE] at 9:20 AM, during an interview with RN supervisor #13, she reported that she was working on the unit during the incident involving Resident #96 on [DATE]. She reported that the usual procedure is that someone is designated to retrieve the resident's hard cart and the MOLST form is verified before starting CPR.</p> <p>On [DATE] at 12:41 PM, review the facility policy titled Cardiopulmonary Resuscitation (CPR) Criteria, Standards, and Licensed Nurse Protocol. (revised date [DATE]) section V. Procedures revealed, The licensed nurse/licensed clinician will assess the situation, review the code status, and determine the need to call a code blue and initiate CPR if the patient/resident is a Full code.</p> <p>On [DATE] at 2:32 PM during an interview with the administrator, she reported that the root cause analysis of the incident was the failure of the staff to verify the MOLST form before initiating CPR and she expects nurses to verify a resident ' s MOLST form status before starting CPR. In addition, she reported training to correct the situation had begun and was still in progress.</p> <p>37276</p> <p>2. On [DATE] at 12:00 PM, an initial review of Resident #6's medical record Resident #6's EMR (electronic medical record) and paper medical record failed to reveal evidence that Resident #6 had an advanced directive in place.</p> <p>On [DATE] at 11:30 AM, a review of Resident #6's medical record revealed the resident resided in the facility for long term care since February 2020. Review of the resident's most recent quarterly assessment with an assessment reference date (ARD) of [DATE] revealed documentation indicating Resident #6 was cognitively intact. Section C, Cognitive Patterns, Staff Assessment for Mental Status documented Resident #6's short term memory and long-term memory was okay, the resident was able to recall the current season, the location of his/her own room, staff names and faces, that the resident was in a nursing home and Resident #6 was independent in making decisions regarding tasks of daily life.</p> <p>Further review of Resident #6's medical record failed to reveal evidence that Resident #6 had an advanced directive, and no documentation was found to indicate the facility periodically informed the resident of his/her right to formulate an advanced directive, or the resident's potential response.</p> <p>On [DATE] at 12:14 PM, an interview was conducted with Social Worker(SW)(Staff #6). During the interview, the SW stated information about formulating an advanced directive was included in the admission packet which was provided to the resident upon admission to the facility and discussed with the resident during the initial care plan meeting. The SW stated if the resident had an advanced directive, the SW would ask for a copy, and the advanced directive would be placed in resident's medical record. If the resident did not have an advanced directive, the SW would educate the resident on what an advanced directive meant and, if s/he wanted an advanced directive and needed help, the SW would assist the resident to complete an advanced directive. The SW stated that the resident's advance directives and MOLST (Maryland Orders for Life-Sustaining Treatment) were reviewed with the resident at least annually as part of the care plan meeting.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Following the interview, the SW was made aware of the above concerns and the surveyor requested documentation of any discussions the SW had with Resident #6 advising the resident of his/her right to formulate an advanced directive. In response, the SW confirmed Resident #6 did not have an advance directive, and indicated that the resident's right to formulate an advanced directive had been discussed with Resident #6, however it was unlikely these discussions had been documented in the resident's medical record. As of the time of the exit from the facility on [DATE], no additional documentation was provided to indicate the facility periodically informed Resident #6 of his/her right to formulate an advanced directive.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>16218</p> <p>Based on observation and interview it was determined that the facility failed to ensure areas in need of repair were identified and work orders were implemented. This was found to be evident for 2 out of 2 nursing units observed.</p> <p>The findings include:</p> <p>On 5/20/24 at 1:59 PM surveyor observed water stains on the ceiling above the foot of one of the residents' bed in room K on unit 1 East.</p> <p>On 5/20/24 at 2:34 PM surveyor observed a wall protector below the hand rail across from room E on unit 1 [NAME] was noted to be cracked.</p> <p>On 5/31/24 at 2:15 PM the Maintenance Director (Staff #55) reported that if problems are reported they can put in an e work order which is a program to request repairs. And if there is damage the nurse usually calls and puts an order in. He went on to report they do room checks every week and a walk thru every morning.</p> <p>On 5/31/24 a tour of the facility was conducted with the Maintenance Director between 2:27 - 2:42 PM. The areas identified on 5/20/24 of the cracked wall protector in the 1 [NAME] hallway and of the ceiling in room K on 1 East were still present. Additionally a ceiling tile in the 1 East hallway was noted with an approximately 3 inch brownish stain, which the Maintenance Director confirmed was a water stain.</p> <p>In regard to the damage to the ceiling in Room K, the Maintenance Director reported at 3:37 PM that there is a chiller pipe just above, and the insulation is bad but there is no way to get to the insulation. When asked if there was a permanent fix to this problem, the Maintenance Director responded: probably not.</p> <p>At the end of the tour the surveyor requested work orders, if there were any, for the areas identified above. The maintenance director indicated there would not be work orders for these areas.</p> <p>On 6/03/24 at 3:13 PM Maintenance Director confirmed there were no work orders for the areas identified above.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48259</p> <p>Based on record review and interviews, it was determined that the facility staff failed to report an allegation of abuse to the Office of Health Care Quality in a timely manner. This was evident for 1 (Resident #31) out of 6 residents reviewed for abuse during the survey.</p> <p>The findings include:</p> <p>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.</p> <p>A record review on 5/21/24 at 11:29 AM revealed that Resident #31 was admitted to the facility in August 2022 with diagnoses including Dementia. Continued review showed an MDS assessment dated [DATE] that documented that Resident #31 had severe cognitive impairment.</p> <p>Further review on the same day of a facility-reported incident related to Resident #31 with MD00202413 was conducted. The review showed that an allegation of abuse was reported to the Nursing Home Administrator (NHA) on 2/7/24 at approximately 4:20 PM.</p> <p>A subsequent review of the investigation into the allegation of abuse on 6/3/24 at 7:46 AM contained a statement: After reviewing these notes, the Administrator decided on 2/9/24 at 8:15 AM a self-report would be sent, and an investigation would be completed.</p> <p>Review of the facility Abuse, Neglect, Injury of unknown origin, & Misappropriation of Property revealed a statement that The NHA or Quality Director and/or designee will notify the appropriate agencies of such an incident within 24 hours (within 2 hours for serious bodily injury or allegation of abuse).</p> <p>However, the review failed to show that the facility first reported the allegation of abuse to the state agency immediately but not later than 2 hours.</p> <p>During an interview with the NHA on 6/4/24 at 10:17 AM, she reported that she was not in the building when the allegation was first reported to the social worker on 2/7/24. The NHA confirmed that the allegation of abuse was not reported to the state agency until 2/9/24.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>45139</p> <p>Based on pertinent documentation review and interviews, it was determined that the facility failed to provide documentation that a thorough investigation of potential abuse was completed. This was evident for 3 (Resident #98, #15, and #9) out of 6 residents reviewed for abuse during the survey.</p> <p>The findings include:</p> <p>1) On 5/22/24, review of facility report revealed that Resident # 98, a long-term resident of the facility, reported an allegation that he/she received abuse from a facility staff member.</p> <p>On 5/29/24 at 9:37 AM, review of social service progress notes dated 7/27/22, revealed that Resident #98 reported to social worker that he/she had received maltreatment by staff. Further review revealed that the resident was unable to provide any further identifying information and that the allegation was reported to nursing staff and administrator who was the abuse coordinator. The facility reported this allegation to the Office of Health Care Quality (OHCQ).</p> <p>On 5/22/24 at 12: 30 PM, the Administrator provided a 1-page document of the facility's findings in their investigations of Resident #98 allegation of abuse. Further review revealed the documents were a summary of the abuse allegation reported to OHCQ. However, she reported she could not provide any of the employee statements or resident interviews that comprised the investigation.</p> <p>On 5/29/24 at 9:45 AM, the Administrator reported she had no additional information or documentation regarding the abuse allegation reported by Resident #98. She reported she was not the administrator at the time the investigation occurred. The Administrator failed to locate the investigation file.</p> <p>50573</p> <p>2) Review of Resident #9's medical record on 5/20/24 revealed the resident has resided at the facility for several years, was alert and oriented and able to verbally communicate. Resident #9 was dependent on staff for transfers out of bed and mobility due to weakness.</p> <p>Review of MD00188264 revealed that on 1/23/23 Resident #9 reported to the psychologist (Staff #54) an allegation of abuse related to an incident during the administration of a medication. The facility reported it to the Office of Health Care Quality (OHCQ) and then initiated an investigation.</p> <p>On 5/21/24 at 2:10 PM surveyor requested the investigation documentation for MD00188264 from the Nursing Home Administrator.</p> <p>On 05/22/24 at 8:45 AM, the Nursing Home Administrator (Staff #1) told the surveyor that she is still looking for additional information on the abuse allegation for Resident #9.</p> <p>On 05/22/24 at 12:30 PM, the Nursing Home Administrator (Staff #1) provided documents for the abuse allegation on Resident #9 and stated she had no additional information.</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/22/24 at 12:32 PM, review of the documentation provided by the facility revealed the final report submitted to OHCQ which concluded no evidence to substantiate the allegation of abuse.</p> <p>Further record review on 5/22/24 of the documentation provided for MD00188264 revealed two facility report sheets from psychologist (Staff #54) to the facility management about the incident based on what Resident #9 had explained. These reports included the full name of Resident #9, Licensed Practical Nurse (Staff #41), and the first name of a GNA who was a witness to the event. No supporting documentation was found to indicate interviews were conducted with staff or residents regarding this allegation. No documentation was found that identified the full name of the GNA who was a witness to the event.</p> <p>On 05/31/24 at 04:21 PM, the surveyor reviewed the concern with the Director of Nursing (Staff #18), and Nursing Home Administrator (Staff #1) regarding the failure to provide documentation of interviews conducted as part of the facility investigation.</p> <p>3) Review of Resident #15's medical record revealed the resident has a past medical history of brain damage, weakness, stiffness of right and left ankle, and a mood disorder that can affect a person's feelings, thoughts, and behavior.</p> <p>Review of MD00190623 revealed that on 3/23/23 staff identified a blister on the resident's leg that was of unknown origin, the facility submitted a report to the Office of Health Care Quality (OHCQ) and then initiated an investigation. Review of the final report indicated an investigation was completed and abuse was not substantiated.</p> <p>On 5/21/24 at 2:10 PM surveyor requested the investigation documentation for MD00190623.</p> <p>On 5/23/24 the Nursing Home Administrator reported she was still looking for investigation documentation.</p> <p>On 5/31/24 at 9:00 AM review of the documentation provided by the facility revealed the final report submitted to OHCQ and a report from the police department. Review of the final report revealed that there was no indication that the injury was caused by abuse. The police report concluded there was no indication that the blister was caused by abuse or neglect and it required no criminal investigation. No documentation was provided to indicate which staff were interviewed during the investigation or what they reported.</p> <p>On 05/31/24 at 08:59 AM, review of final report revealed that the facility attempted to interview Resident #15 on how the blister happened, but the resident was unable to report how it happened.</p> <p>On 05/31/24 at 04:21 PM, the surveyor reviewed the concern with the Director of Nursing (Staff #18), and Nursing Home Administrator (Staff #1) regarding the failure to have evidence that a thorough investigation was completed.</p>		

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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.</p> <p>48470</p> <p>Based on records review and interviews, it was determined that the facility failed to communicate the residents comprehensive care plan goals to the receiving healthcare institution to ensure safe and effective transition of care. This was evident for 2 (Resident #24, and #19) of 4 residents reviewed for hospitalization s.</p> <p>The findings include:</p> <p>1) Resident #24 had been residing in the facility since 2020. On 5/21/24 at 10:46 AM, a review of the resident's medical record at this time indicated that the resident had been sent to the hospital 2 times in 2024.</p> <p>On 5/23/24 at 10:13 AM, a Registered Nurse (RN Staff #20) was interviewed about her process when a resident has an order to be transferred to the hospital. Staff #20 reported her process including the notifications and documentation she would prepare to facilitate the resident transfer. Staff #20 then proceeded to provide the surveyor with a sample of all the documents she would print out for Resident #24 if s/he was to be sent out to the hospital at that time. A review of the documents provided failed to reveal care plan goals were included.</p> <p>On 5/23/24 at 11:27 AM, the unit nurse manager (Staff #3) was interviewed about her expectations from nursing staff regarding resident transfers. The unit nurse manager confirmed Staff #20's process and reported the contents of their transfer packet. The unit manager was asked specifically if care plan goals are included in the transfer packet and s/he reported that it was not.</p> <p>On the same day at 3:14 PM, the concern was discussed with the UM that there was no evidence that comprehensive care plan goals are communicated to the receiving healthcare institution to ensure safe and effective transition of care.</p> <p>37276</p> <p>2) On 5/20/24 at 1:32 PM, a review of Resident #19's medical record revealed the resident had a change in condition on 3/26/24, was transferred to the hospital then was readmitted several days later. Continued review of Resident #19's medical record failed to reveal documentation to indicate that the documents sent to the receiving facility upon the resident's transfer included the resident's comprehensive care plan goals.</p> <p>On 5/23/2024 at 11:26 AM, unit nurse manager (Staff #3) was made aware of the above concerns. At that time, Staff #3 stated that when a resident was transferred to the hospital, a packet of information was sent with the resident to the hospital which included progress notes, labs, and EKG results, and confirmed that a copy of the resident's care plan was not included in the transfer packet.</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>37276</p> <p>Based on medical record review and staff interview it was determined the facility failed to notify residents in writing of a transfer, along with the reason for transfer, and failed to notify the Office of the State Long-Term Care Ombudsman of a transfer/discharges of residents. This was evident for 2 (Resident #19 and #24) of 4 residents reviewed for hospitalization .</p> <p>The findings include:</p> <p>1) On 5/20/24 at 1:32 PM, a review of Resident #19's medical record revealed the resident had a change in condition on 3/26/24, was transferred to the hospital was readmitted several days later. Continued review of Resident #19's medical record failed to reveal documentation to indicate the resident received written notification of the transfer.</p> <p>On 5/23/24 at 11:00 AM, during an interview, Staff #6, Licensed Social Worker (SW), stated that when a resident was capable, nursing verbally informed the resident when s/he was being transferred to the hospital and verbally notified the resident's representative/family.</p> <p>The SW (Staff #6) stated that when a resident was sent to the hospital and remained out of the facility for greater than 24 hours, the social worker would send a written notice of transfer to the resident's representative. If the resident was not admitted to the hospital, it was not considered a transfer and the representative would not be sent a written notification of transfer. The SW stated that when a resident was transferred to the hospital, social work only sent the written notification of transfer to the resident's representative and did not provide the resident or the Ombudsman with written notification of the resident's transfer. The SW was made aware of the guidance related to written notification of transfers and the identified concern with failing to provide written transfer notification to the resident and the Ombudsman when a resident was transferred to the hospital and the SW acknowledged the concern at that time.</p> <p>48470</p> <p>2) Resident #24 had been residing in the facility since 2020. On 5/21/24 at 10:46 AM, a review of the resident's medical record at this time indicated that the resident had been sent to the hospital 2 times in 2024.</p> <p>On 5/23/24 at 10:13 AM, a Registered Nurse (RN Staff #20) was interviewed. Staff #20 reported her process when a resident needed to be transferred and the individuals she would notify about the transfer. Staff #20 printed a transfer packet of Resident #24 as an example and indicated that 2 copies are printed, one would be provided to the Emergency Medical Technicians (EMT) and the other would be for the Emergency Department (ED) of the receiving institution. All other notifications would be done over the phone verbally.</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/23/24 at 10:39 AM, the Unit Nurse Manager (UM- Staff #3) was interviewed about the notifications done when a resident is transferred out. She indicated that the Nursing department is responsible in notifying family members and/or responsible parties (RP) when residents are hospitalized and reported that it is done verbally. The UM was asked if there was any written notifications being sent out and she indicated that these were done through the social work system.</p> <p>On 5/23/24 at 11:02 AM, one of the Social Workers (SW Staff #6) was interviewed. Staff #6 confirmed that the Nursing Department notifies family members and /or RP verbally and his department sends out the written notifications of transfers. Staff #6 was asked specifically if he sends the Ombudsman a copy of the notifications to witch, he answered, No. Staff #6 also indicated that there was no other department or personnel in the facility that sends the transfer notifications to the Ombudsman.</p> <p>Later that day at 1:09 PM, the concern was discussed with the Nursing Home Administrator (NHA) that no one in the facility had been sending notifications of transfers to the representative of the Office of the Long-Term Care Ombudsman. The NHA acknowledged the concern.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37276</p> <p>Based on records review and interviews, it was determined that the facility failed to develop a comprehensive care plan with measurable objectives and timeframe to meet the resident's medical needs. This was evident for 4 (Resident #6, #34, #9 and #24) out of 24 residents reviewed during the survey.</p> <p>The findings include:</p> <p>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.</p> <p>The MDS (Minimum Data Set) is a complete assessment of the resident which provides the facility information necessary to develop a plan of care, provide the appropriate care and services to the resident, and to modify the care plan based on the resident's status.</p> <p>1) On 5/21/24 at 3:15 PM, a review of Resident #6's medical record revealed the resident resided in the facility for long term care since February 2020 and had multiple diagnosis which included a seizure disorder. Review of Resident #6's most recent quarterly assessment, with an assessment reference date (ARD) of 4/13/24, revealed in Section I: Active Diagnose of seizure disorder or epilepsy. Review of Resident #6's May 2023 Electronic Medication Administration Summary (eMAR) revealed a 9/27/22 order for Lamotrigine (anticonvulsant) tablet by mouth 3 times a day for seizure disorder, which was documented as given every day as ordered from 5/1/24 to 5/21/24, and an order for Levetiracetam (anticonvulsant) tablet by mouth 2 times a day for seizure disorder, which was documented as given every day from 5/1/24 to 5/21/24 as ordered. Review of the physician orders also revealed an 11/2/22 order for seizure precautions.</p> <p>Continued review of Resident #6's care plans failed to reveal evidence a comprehensive care plan with measurable goals had been developed to address the resident's seizure disorder and use of anticonvulsant medications.</p> <p>The above concerns were discussed with the unit nurse manager (Staff #3), Registered Nurse (RN), on 5/22/24 at 1:31 PM. Staff #3 acknowledged the concern and offered no further comment at that time.</p> <p>48259</p> <p>2) A record review on 5/28/24 at 11:25 AM revealed that Resident #34 was admitted to the facility in January 2023 with diagnoses including dementia, depression, and a history of Post-traumatic stress disorder (PTSD). Continued review showed an MDS assessment dated [DATE] that documented that Resident #34 had severe cognitive impairment.</p> <p>Post-traumatic stress disorder (PTSD) is a disorder that develops in some people who have experienced a shocking, scary, or dangerous event. People may experience a range of reactions after trauma, and those who continue to experience problems may be diagnosed with PTSD. Symptoms may include flashbacks, nightmares, and severe anxiety, as well as uncontrollable thoughts about the event.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A trigger is a psychological stimulus that prompts a recall of a previous traumatic event, even if the stimulus is not traumatic or frightening.</p> <p>A subsequent review on 5/28/24 at 1:35 PM found a care plan for Resident #34 that contained a statement that [Resident #34] has a history of PTSD. The goal of the care plan stated, [Resident #34] will not experience the trigger of PTSD. The intervention stated, Staff will avoid the trigger and allow [Resident #34] to cooperate. However, the review failed to show Resident #34's potential triggers, which may re-traumatize the Resident, along with interventions to address the possible triggers.</p> <p>During an interview on 5/29/24 at 2:57 PM with Staff #3, a unit nurse manager, she stated that Resident #34's care plan for PTSD was not person-centered and should have contained his/her specific triggers to avoid re-traumatization.</p> <p>In a subsequent interview on 5/31/24 at 11:47 AM, Staff #2, the assistant director of nursing, reported that Resident #34's responsible party was contacted after the surveyor's intervention and the Resident's care plan for the history of PTSD was updated.</p> <p>50573</p> <p>3) Review of Resident #9's medical record on 5/20/24 revealed the resident has resided at the facility for several years, was alert and oriented and able to verbally communicate. Resident #9 was dependent on staff for transfers out of bed and mobility due to weakness.</p> <p>An interview with Resident #9 on 05/20/24 at 3:02 PM revealed that she/he has been experiencing frequent tooth pain.</p> <p>Review of the minimum data set (MDS) with an assessment reference date (ARD) of 1/5/24 revealed in Section L Oral/Dental status that the resident was experiencing mouth or facial pain, discomfort or difficulty with chewing.</p> <p>Review of Resident #9's medical record revealed that on 1/19/24 Licensed Social Worker (Staff #6) documented a care plan update progress note that indicated dental issues were discussed, and the goals to resolve the dental care issue and to find dental care for the resident. However, review of the resident's care plan failed to reveal documentation to indicate the dental issues or the need to identify a dentist for the resident were added to the care plan.</p> <p>Further review of Resident #9's medical record on 05/22/24 at 09:40 AM revealed that there was frequent documentation that noted the resident experiencing tooth pain in February and March 2024.</p> <p>Review of the 3/30/24 MDS assessment revealed that the resident had been experiencing mouth pain under the oral/dental status section.</p> <p>Further review of the medical record revealed a Care Plan Update note, dated 4/3/24, written by Social Worker (Staff #6) that documented that a care plan meeting was held and the resident opted not to attend. No documentation was found in this note to indicate the dental concerns were addressed during this meeting.</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Further review of Resident #9's medical record on 05/22/24 at 11:43 AM revealed that there was no documentation of a dental care plan and tooth pain was not covered under Resident #9's current pain care plan.</p> <p>On 05/31/24 at 04:28 PM, the surveyor reviewed concern to the Director of Nursing (Staff #18), and Assistant Director of Nursing (Staff #2) regarding the failure to update the resident's care plan related to frequent tooth pain.</p> <p>48470</p> <p>1) Resident #24 had been residing in the facility since 2020. A review of the facility matrix on 5/20/24 at 12:29 PM identified the resident as having a pressure ulcer/injury.</p> <p>On 5/22/24 at 2:35 PM, Resident #24's care plan for pressure ulcer was reviewed and revealed a care plan goal that stated, resident will maintain and/or maximize healing process related to wounds. No other care plan goal related to the resident's pressure ulcer was documented with a measurable objective and time frame.</p> <p>Earlier that day at 2:21 PM, the Wound Nurse/Registered Nurse (RN Staff #9) was interviewed about her process with wound care. When Staff #9 was asked about wound measurements, she stated, I would have to say they are not done. She further indicated that floor nurses assess residents with wounds and perform treatments but are not responsible or trained in measuring them. Staff #9 further reported that she used to measure the wounds to track progress but does not anymore because of lack of time since she had been given other roles in the facility. Staff #9 also confirmed that she was responsible for formulating and updating the resident's care plan regarding wound care.</p> <p>At the time of survey Exit on 6/4/24 at 5:09 PM, the concern was discussed with the Director of Nursing, Assistant Director of Nursing, Director of Quality, Chief Medical Officer, Minimum Data Set Coordinator, and the Nursing Home Administrator (joined via phone call) that the care plan did not have measurable objectives and timeframe to meet the resident's needs. All staff acknowledged the concern.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>48470</p> <p>Based on observations, records review and interviews, it was determined that the facility failed to provide a resident unable to carry out activities of daily living the necessary services to maintain good oral hygiene. This was evident in 1 (Resident #11) out of 2 residents reviewed for tube feeding.</p> <p>The findings include:</p> <p>Resident #11 had been residing in the facility since 2016. On 5/20/24 at 2:22 PM, the resident was observed in bed with white secretions in the mouth and surveyor noted concerns regarding oral care.</p> <p>On 5/21/24 at 9:29 AM, Resident #11's Minimum Data Set (MDS) assessment with a reference date of 3/16/24 was reviewed and indicated that the resident was severely impaired with cognitive skills and was dependent on staff for self-care including oral hygiene.</p> <p>Minimum Data Set- The 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.</p> <p>On 5/22/24 at 7:56 AM, a review of Resident #11 orders revealed that oral care was to be provided four times daily at 12:00 AM, 6:00 AM, 12:00 PM, and 6:00 PM. A review of the administration history for the oral care order from 4/23/24 to this date revealed multiple administration times were not documented including days where all four administration times were left blank. 5/7/24 was the only day where the order was documented for all 4 times.</p> <p>The times and dates that were left blank were:</p> <p>4/23/24 - 6 PM</p> <p>4/24/24 - 12 PM, 6 PM</p> <p>4/25/24 - 12 AM, 12 PM, 6 PM</p> <p>4/26/24 - ALL DAY</p> <p>4/27/24 - 12 AM, 6 PM</p> <p>4/28/24 - ALL DAY</p> <p>4/29/24 - 12 AM, 6 AM, 6 PM</p> <p>4/30/24 - 12 AM, 6 AM, 6 PM</p> <p>5/1/24 - ALL DAY</p> <p>(continued on next page)</p>

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/2/24 - 12 PM, 6 PM 5/3/24 - 12 AM, 6 AM, 6 PM 5/4/24 - 12 AM, 6 AM, 12 PM 5/5/24 - ALL DAY 5/6/24 - 12 AM, 6 AM, 12 PM 5/8/24 - 12 PM, 6 PM 5/9/24 - ALL DAY 5/10/24 - ALL DAY 5/11/24 - ALL DAY 5/12/24 - 12 PM, 6 PM 5/13/24 - ALL DAY 5/14/24 - 12 AM, 12 PM 5/15/24 - 12 PM, 6 PM 5/16/24 - 12 AM, 6 AM, 6 PM 5/17/24 - ALL DAY 5/18/24 - ALL DAY 5/19/24 - ALL DAY 5/20/24 - 12 AM, 6 AM 5/21/24 - 6 PM 5/22/24 - 12 AM On 5/23/24 at 3:10 PM, the findings were reviewed with the Unit Nurse Manager (UM- Staff #3), and she confirmed the days and times that were left blank on the administration history. The concern was discussed with the UM that oral care was not provided to a dependent resident. The UM acknowledged the concern and indicated that in nursing, if it's not documented then it was not done.

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45139</p> <p>Based on pertinent document review and interviews, it was determined that the facility failed to implement physician orders for 15-minute safety checks. This was evident for 1 (Resident #98) out of 1 resident reviewed for behavioral or emotional care during the survey.</p> <p>The findings include:</p> <p>On [DATE] review of medical record revealed that Resident #98 was a long-term resident of the facility with a history of depression and previous suicide attempts, while a resident at the facility.</p> <p>On [DATE] at 12:16 PM, review of a progress note dated [DATE], revealed nursing staff discovered Resident #98 in his/her room with a cord wrapped around his/her neck and the resident refused to surrender the cord when the nursing staff attempted to remove it. Further review revealed the resident was transferred to a local hospital for psychiatric evaluation.</p> <p>On [DATE] at 9:29 AM, review of physician's orders with a start date of [DATE], revealed an order, Every 15 minutes checks for safety document in three ring binder in Nurses station.</p> <p>On [DATE] at 9:30 AM a review of orders revealed that the above order remained active until the Residents death on [DATE].</p> <p>On [DATE] at 12:38 PM, the administrator provided documentation of the 15 minutes checks for Resident # 98. Review of the documentation revealed 15-minute check sheets for the following dates: [DATE], [DATE], [DATE], [DATE], [DATE], [DATE]. The review failed to reveal any 15-minute checks documented following the order on [DATE].</p> <p>On [DATE] at 1:36 PM, during an interview with the Administrator the above concerns were discussed. The administrator reported that she was not at the facility at the time of the suicide attempt. She reported that the facility no longer documents 15 minutes checks in a nursing binder. She reported that the 15-minute safety checks are now recorded in the electronic health record. The facility failed to provide any documentation of 15-minute checks during the time the order was in place for dates other than the ones listed above prior to the end of the survey.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>37276</p> <p>Based on medical record review and interviews it was determined that the facility failed to provide services consistent with professional standards of practice to prevent the development of pressure ulcers and promote healing of existing pressure ulcers/injuries. This was evident for 1 (Resident #6) of 2 residents reviewed for pressure ulcers.</p> <p>The findings include:</p> <p>Pressure ulcers, also known as pressure sore or decubitus ulcer, is any lesion or injury caused by unrelieved pressure that results in damage to the underlying tissue and staged according to their severity from Stage 1 (area of persistent redness), Stage 2 (superficial loss of skin such as an abrasion, blister or shallow crater), Stage 3 (full thickness skin loss involving damage to subcutaneous tissue presenting as a deep crater), Stage 4 (full thickness skin loss with extensive damage to muscle, bone or tendon) or Unstageable Pressure Ulcer (full thickness tissue loss in which the base of the ulcer is covered by slough and/or eschar in the wound bed).</p> <p>On 5/21/24 at 11:04 AM, a review of the facility's Matrix (used to identify pertinent resident care) revealed documentation that Resident #6 had a Stage 3 pressure ulcer. On 5/22/24 at 11:30 AM, a review of Resident #6's medical record revealed a quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 4/13/24 which documented Resident #6 had one unhealed Stage 3 pressure ulcer. Further review of Resident #6's medical record revealed documentation that Resident #6 had a left lower (LL) buttock pressure wound. Resident #6's May 2024 eMAR (electronic medication administration record) Summary revealed a 5/10/23 order for Baza Protect (moisture barrier cream) with ABD pad (abdominal gauze pad) to left buttock one time per day, every day, 7:00 AM - 3:00 PM, change daily & PRN (as needed) if wrinkled, soiled or falls off. The order was signed off every day as ordered from 5/1/24 to 5/21/24, except on Wednesday, 5/15/24.</p> <p>Further review of Resident #6's May 2024 eMAR Summary revealed a 5/5/23 order for general observation and complete skin assessment, one time per day, every week on Tuesday and Saturday at 7:00 AM. The order was signed off as completed on Thursdays and Sundays, not Tuesday and Saturday as ordered. The facility failed to ensure the order was accurately transcribed to reflect assessments were to be done on Tuesday and Saturdays. The order was signed off as completed on Thursday 5/4/24, 5/11/24, and 5/18/24 and on Sunday, 5/7/24, and 5/21/24. In addition, there was no evidence a skin assessment had been completed as ordered on either Saturday 5/13/24 or on Sunday 5/14/24.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Continued review of Resident #6's medical record failed to reveal documentation that described the stage of Resident #6's left lower buttock pressure wound, or evidence that with each dressing change or at least weekly, an evaluation of the resident's LL buttock pressure wound measurements was conducted which included the size, depth, and/or the presence of any undermining or tunneling of the wound. A review of a printed copy of Resident #6's Skin Condition/Wound Progression notes for his/her LL buttock wound recorded from 2/1/24 to 5/21/24 revealed on 2/2/24 at 9:40 AM, the nurse documented Resident #6's wound condition was Pressure Ulcer/Injury, the wound was discovered on 9/13/22 and the wound onset was 9/13/22. Continued review of Resident #6's Skin Condition/Wound Progression notes recorded between 2/1/24 and 5/22/24 revealed wound progress notes written on February 2, 3, 4, 5, 7, 8, 9, 10, 11, 12, 13, 16, 17, 18, 20, 21, 23, 24, 25, 26, and 27, 2024, wound progress notes written on March 1, 2, 3, 4, 5, 6, 7, 9, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, and 31, 2024, and wound progress notes written on April 1, 2, 3, 4, 5, 6, 8, 9, 12, 13, 14, 15, 16, 17, 18, 22, 23, 24, 26, 27, 38, and 30, 2024. There was no documentation in the skin/wound progress notes to indicate Resident #6's left lower buttock wound was a pressure ulcer, and/or the stage of the pressure wound. In addition, there was no documentation in the wound progress notes to indicate wound measurements had been obtained and/or included in the wound assessment. Review of Resident #6's Skin and Progress Check History notes from 4/28/24 to 5/21/24 revealed skin and progress check notes written on 4/28/24, and 4/30/24, and May 4, 5, 6, 7, 10, 11, 12, 16, 17, 18, 19, 20 and 21, 2024 documented the type of issue was Pressure Ulcer/Injury on Left Lower buttocks. The progress notes failed to include the stage of Resident #6's left lower buttock pressure wound, or evidence of pressure wound measurements.</p> <p>On 5/22/24 at 2:21 PM, during an interview, Staff #9 (Registered Nurse (RN)), stated she was the facility's part-time wound nurse. Staff #9 stated that as the wound nurse, she performed the initial wound assessments for residents admitted to the facility, followed residents with skin issues in the facility, and recommended wound treatments. Staff #9 indicated that when there was a special wound treatment, such as a wound vac., she would guide the staff so that the nurse would know what to do, otherwise the nursing staff did the resident wound treatments. Staff #9 stated that she did not measure resident wounds every week and indicated that resident wound measurements were not being done. Staff #9 stated nurses did wound progress checks every day and the nurses were responsible for assessing the wounds, however, the nurses were not required to measure the wounds. Staff #9 indicated that, in order to avoid inconsistency in wound measurements, measuring the residents' wounds use to be her role, however since being given other responsibilities, she has been unable to do it. Staff #9 stated that she does not have time to measure the wounds and the nurses had been instructed to not measure the wounds.</p> <p>The facility staff failed to ensure complete and accurate medical records by failing to ensure wound treatment orders were accurately transcribed, and the facility failed to ensure evaluation of Resident #6's LL buttock pressure wound included wound measurements.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #6's care plans revealed a care plan, Wounds - Pressure Injuries with the goal, Resident will maintain and/or maximize healing process related to wound(s). Current areas will heal by 5 mm (millimeters) per month until resolved barring any complications, [Resident #6] will have no new areas of skin breakdown, and the interventions, 1) conduct twice weekly skin assessments by floor staff on Tuesday/Saturday day shift, twice weekly assessment, observe with each dressing change. Observe for change in color/skin integrity/size of wound and report any deterioration to clinician as indicated, 2) treatments as ordered; nursing to change dressings and monitor for placement, 3) Monitor areas for s/s infection; report increased redness, swelling, drainage, and/or foul order to WM (wound management) RN (registered nurse) and clinician for follow-up, 4) keep dressing and surrounding tissue clean and dry. Change if found soiled during incontinence care, and 5) Pressure relieving device(s) as ordered; LAL (low air loss) mattress, heel lift boots.</p> <p>The care plan was not comprehensive, or resident centered and failed to indicate the location of Resident #6's pressure injury, or the stage of the resident's pressure wound. The care plan intervention, to conduct twice weekly skin assessments by floor staff on Tuesday/Saturday day shift, twice weekly assessment, observe with each dressing change was inaccurate, as per the documentation in the Resident's May 2024 MAR, the wound was assessed on Thursday's and Sundays. In addition, continued review of Resident #6's medical record failed to reveal documentation to indicate the resident's pressure injury care plan was reviewed following each assessment.</p> <p>The facility's failure to complete an ongoing assessment of Resident #6's left lower buttock pressure injury to include an evaluation of the pressure wound measurements to include the size, depth, and/or the presence of any undermining or tunneling of the wound at least weekly, failure to develop a comprehensive care plan, and failure to evaluate and revise the care plan based on changing goals, preferences and needs of the resident and in response to current interventions put the resident at risk for impaired wound healing.</p> <p>Following the interview on 5/22/24 at 2:21 PM, the wound nurse (Staff #9), was made aware of the above care plan concerns and offered no further comments at that time.</p>		

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<p>F 0695</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>16218</p> <p>Based on review of medical records and facility investigation documentation and interviews it was determined that the facility failed to ensure respiratory care was provided consistent with professional standards. This was found to be evident for one (Resident #40) out of four residents reviewed for respiratory care.</p> <p>This failure resulted in a determination on 5/31/24 at 9:45 AM of an Immediate Jeopardy for Resident #40.</p> <p>The facility implemented effective and thorough corrective measures following this incident. The facility's plan and action were verified during this survey, therefore this deficiency will be cited as past noncompliance. The date of correction was 5/24/24.</p> <p>The findings include:</p> <p>Review of Resident #40's medical record revealed the resident was admitted to the facility in February of 2024 with a history of stroke and dependence on mechanical ventilation due to respiratory failure. The resident had severe cognitive impairment and was non-verbal.</p> <p>On 5/20/24 the resident was observed resting in bed but did not respond to surveyor's greeting. Tubing connecting the ventilator to the tracheostomy tube was in place with no identified concerns at that time.</p> <p>A tracheostomy (also called a tracheotomy) is an opening surgically created through the neck into the trachea (windpipe) to allow air to fill the lungs. After creating the tracheostomy opening in the neck, surgeons insert a tube through it to provide an airway and remove secretions from the lungs. Residents with prolonged dependence on a ventilator for breathing will often have a tracheostomy. (www.hopkinsmedicine.org)</p> <p>Review of a 4/26/24 primary care physician (Staff #40) progress note revealed ventilator dependent respiratory failure -- stable on current vent settings. Not a candidate for vent weaning/decannulation at this time due to neurologic status remaining largely unchanged. Weaning refers to a process of gradually reducing the amount of ventilator support. Decannulation refers to the removal of the trach tube after it is no longer needed.</p> <p>Review of the progress notes revealed a note, dated 5/14/24 at 4:37 PM, by respiratory therapist (Staff #46) which stated: At approximately 1520 [3:20 PM] while documenting at the nursing station I heard a ventilatory alarming. After getting up and determining where the alarm sound was coming from I made my way to [Resident #40]'s room. When I arrived I witnessed that the patient was in the process of being transferred by two nursing assistants from [his/her] bed to a recliner chair via the hooyer lift and the patient had become disconnected from [his/her] ventilator. I stretched the ventilator to the patient as they were finishing the transfer to the chair and reconnected [Resident #40]. Immediately upon reconnection, the ventilator stopped alarming and the patient began to be ventilated again. The patient did not appear to be in distress at any time that I witnessed.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the progress notes revealed a note, dated 5/14/24 at 5:40 PM, by nurse (Staff #48) which documented: While transferring [Resident #40] from the bed to recliner, the nursing assistant disconnected the trach tube from the patient for the transfer. Vent alarm sounded and respiratory therapist responded to Pt. [patient] room and reconnected the airway to the ventilator. The disconnect time was approximately 2 minutes as per the vent alarm record. Clinical manager was notified.</p> <p>Review of the initial report from the facility for incident MD00205708 revealed that on 5/14/24 the Respiratory therapist reported he heard the vent alarm going off in the resident's room and immediately checked on the resident, when he entered the room, he saw the resident was disconnected from the ventilator while two GNA's [geriatric nursing assistants] were transferring the resident. The respiratory therapist immediately responded to the alarming ventilator and reconnected the ventilator to the resident. The respiratory therapist reported the resident was not in distress after the incident. The nurse assessed the resident after the incident and reported the resident was at baseline. The assigned nurse to this resident educated the GNA on proper ADL care with ventilators. Nursing management was notified, and they took both GNA's off the unit to the nursing manager's office and educated them. The nurse manager and two respiratory therapists were involved in the education. The ADON met with both GNA's after the education and educated them too.</p> <p>Review of a statement dated 5/15/24 and signed by GNA Staff #49 revealed that it was in regard to the incident that occurred on 5/14/24 while transferring a resident. The statement included: I was not aware that I am not supposed to transfer vent residents unless there is a respiratory staff to watch the process.</p> <p>Review of a statement dated 5/14/24 and signed by Staff #48 revealed Nurses aide stated to this nurse that she disconnected the Pt. [patient] vent tube from the patient to transfer [him/her] to the chair. On 5/31/24 at 7:46 AM, after a review of his signed statement, Staff #48 confirmed that the GNA referenced was GNA #49 and that the GNA had said that s/he had un-hooked the resident.</p> <p>On 5/30/24 at 2:30 PM, upon interview, GNA #49 reported she was an agency GNA and had been working at this facility for about 3 months. She confirmed the last time she worked with a resident on a ventilator was 5/14/24. She reported that if transferring a resident on a ventilator she would call staff from the respiratory therapy (RT) department. After review of her statement about the 5/14/24 incident GNA #49 confirmed that she did not call RT that time, and denied having been told prior to that incident that she needed to do so but confirmed that she had received education since then. GNA #49 denied that the tubing was disconnected and stated that it was stretched but it was attached.</p> <p>Review of the Competency: New Employee GNA/CNA staff form for GNA #49 revealed documentation to indicate Competency in regard to: Staff is able to verbalize the safe manner to provide care when working with ventilators and patients & residents with tracheostomies; and Staff is able to discern the difference between the various alarms on the ventilators and the appropriate response. The Respiratory Care Evaluator (RT supervisor Staff #47) signed this form on 2/15/24.</p> <p>On 5/31/24 at approximately 8:00 AM RT supervisor (Staff #47) was interviewed regarding the orientation process. Staff #47 reported that they would have covered that an RT needs to be in the room during a transfer. She also confirmed that there was an RT available on the unit 24 hours per day 7 days per week and they carried radios so they could always be reached. When asked what the Respiratory Care Evaluator Signature indicated, Staff #47 reported it meant they have been oriented.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of a statement written by GNA (Staff #52) revealed s/he had precepted GNA #49. The statement included: I fully educated [him/her] on the transfer of [name of Resident #26], a ventilator patient. I neither disconnected the vent or tube feed from the patient. All tubes were in place during the entire transfer.</p> <p>Review of a statement dated 5/14/24 and signed by GNA (Staff #50) revealed that GNA (Staff #49) had requested assistance with providing care for Resident #40 and included the following: .At the verge of the transfer the vent was disconnected. I queried this action but my partner overrode my reservation and against my better judgment I went along. The resultant beeping attracted the prompt arrival of a respiratory therapist who quickly remediated the situation .</p> <p>Review of a statement signed by respiratory therapist (Staff #45) revealed that on 5/14/24 respiratory therapist (Staff #46) had alerted her to the incident and that she reported it to unit nurse manager (Staff #3). The statement indicates education was immediately provided to both GNAs involved. The statement includes the following: [GNA #50] stated that [s/he] told her not to disconnect the patient and her reply was it is only for a second. On 5/31/24 at 10:54 AM respiratory therapist (Staff #45) reviewed</p> <p>her written statement and confirmed it's accuracy. Staff #45 also reported that they do inform the GNAs not to disconnect residents as part of the orientation and that a respiratory therapist will help with moving or transporting a resident.</p> <p>Review of a statement dated 5/14/24 and signed by the unit nurse manager (Staff #3) revealed that upon learning of the event from respiratory therapists (Staff #46 and #45) at approximately 4:00 PM, the unit nurse manager immediately identified the two GNA's involved (Staff #49 and #50). The GNAs were then both educated by RT (Staff #45) on the importance of never disconnecting a resident from the ventilator as this is their 'life support' and could die from being disconnected.</p> <p>Further review of the unit nurse manager (Staff #3)'s statement revealed: [GNA #50] expressed remorse for following [GNA #49]'s lead and not being more forceful in stopping [GNA #49] from disconnecting the resident from the vent.</p> <p>On 5/31/24 at 9:21 AM during an interview with Staff #3 surveyor read this portion of the statement to Staff #3 and when asked if this was accurate, Staff #3 stated: absolutely correct. Staff #3 also confirmed that she was told by GNA #49 that she had disconnected the vent.</p> <p>On 5/31/24 at 7:13 AM GNA #50 reported he is employed by a staffing agency and had worked at this facility 3-4 days per week for the past year. GNA #50 reviewed his written statement and confirmed it's accuracy. GNA #50 reported the GNA who was the lead thought it was ok to transfer the resident without a respiratory therapist and during that process the tubing got extended and it got pulled off. During this</p> <p>interview, GNA #50 denied that the other GNA disconnected the vent but reported that it came off during the transfer and that the section of the statement about overrode my reservation was that he told the other GNA they should have a therapist in the room but the other GNA said no it would be easy. GNA #50 went on to report that he has received education regarding this issue and that he can no longer be assigned as the primary GNA for a resident with a vent.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 5/31/24 at 10:12 AM during an interview, the respiratory therapist (Staff #46) reiterated what was in the note he wrote on 5/14/24. Staff #46 also reported when he arrived the ventilator was 7 - 8 feet away from the resident, the tubing wasn't stretched out and it was sitting with the ventilator. Staff #46 also reported that staff were supposed to have an RT called in prior to a transfer and indicated that no one said anything about moving the resident to him prior to the incident.</p> <p>Further review of facility documentation revealed a statement that RT (Staff #45) verbally educated GNA #49 on the following:</p> <ol style="list-style-type: none"> 1. Never disconnect a ventilator circuit or remove a resident from a ventilator during transfer or dressing or removing clothing. Not even for a moment. This also pertains to the trached residents who are on jet neb or room air. Always get a nurse or respiratory therapist for help. 2. Never stretch the ventilator circuit too far from the resident as this can cause a disconnection of the circuit from the resident's trach or it may cause decannulation from the resident's stoma [name of the hole the trach tube is inserted through]. Decannulated trachs may not be immediately visible, it can come out and lay on the chest under the trach dressing. Do not try to insert the trach. 3. Ventilators are needed to keep residents alive. This is how they breathe. They are on a ventilator because they cannot breathe on their own. If disconnected from a ventilator whether accidentally or intentionally, the resident could possibly pass away due to lack of oxygen. 4. There are always respiratory therapists on staff who are willing to help get residents out of bed to handle the ventilators and tubing. Please get them to help with any ventilator residents, even if it is for care while the resident is in bed. <p>This document included the statement I agree that I have been educated by Respiratory Therapist on the topics stated above on May 14, 2024 witnessed by [RT Staff #46 and Unit Nurse Manager Staff #3]. The form was signed by GNA #49 and by Staff #3 on 5/14/24.</p> <p>On 5/30/24 review of the completed facility-reported incident follow-up investigation report regarding the 5/14/24 incident revealed the following statement: Summary of the interviews include that the GNA disconnected the resident from the ventilator to transfer the resident. This was observed by another GNA in the room.</p> <p>Further review of the follow-up investigation report revealed the following corrective action was taken: Agency GNAs are not to be assigned to ventilator-dependent residents and all GNAs receiving education by the respiratory therapist regarding proper care of ventilator/tracheostomy residents.</p> <p>Further review of the facility documentation revealed an Education Sign-in Sheet for GNA Respiratory Education for May 20 - 24, 2024 that included 28 GNA signatures. Review of the list of GNAs who work at the facility revealed 25 employees and 5 agency GNAs. On 5/30/24 at 4:10 PM the NHA confirmed education was completed by May 24, except for one GNA who was on leave and then provided documentation that GNA was educated on 5/28 when she returned to work. NHA also indicated one of the 5 agency GNAs has not worked at the facility since the incident but has been made aware will need to be educated prior to working again.</p> <p>Review of the GNA Respiratory Education sheet revealed the following were covered in the training:</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<ol style="list-style-type: none"> 1. Never disconnect the ventilator circuit or remove a patient from the ventilator during transfer, or to dress/remove clothing from a patient. Always ask the respiratory therapist for assistance. 2. Vent tubing placement- Make sure that vent tubing moves freely to prevent pulling of the trach while performing patient care. 3. Decannulation - If the trach becomes dislodged during patient care, call for respiratory to re-insert the trach back into the stoma. Do NOT attempt to re-insert the trach yourself. 4. Do NOT silence the alarm on the ventilator by hitting the Silence Alarm button. 5. Suction regulators should not be turned on FULL suction while performing mouth care. Regulators should be turned no higher than 150 mmHg. Regulators should also be turned back down when finished. <p>On 5/30/24 based on review of facility documentation and interview with several GNAs surveyor confirmed the facility completed the GNA training.</p> <p>On 5/31/24 at 8:00 AM the NHA confirmed that they will be following up in Quality Assurance regarding this issue and indicated that they address all their facility-reported incidents in QA. NHA also reported that they will be reviewing their training materials.</p> <p>Review of GNA #49's employee file revealed a Nursing Service Orientation Topic Validation 2023 form that was noted to be blank. On 5/31/24 at 9:28 AM the NHA reported that this form had not been implemented prior to the event on 5/14/24. This form included a section for Respiratory Training/Ventilator Equipment: Types of Tracheostomies & Tracheostomy Care; Ventilator Functionality; T-piece functionality - Aides Should Not Disconnect to Move Patient; Turning and Positioning Safety for Patient with Tracheostomy; Trach Collar, Respiratory Training/Ventilator Equipment and Ventilator Alarm Recognition & Safety: Disconnections etc.</p> <p>On 5/31/24 at 9:30 AM the NHA confirmed that moving forward they will be utilizing the Nursing Service Orientation Topic Validation form and will also be including the training that was completed with all of the GNAs post incident for new hires.</p>

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>16218</p> <p>Based on medical record and other pertinent documentation review and interviews it was determined that the facility failed to ensure geriatric nursing assistants were competent to provide care to a resident dependent on mechanical ventilation. This was found to be evident for one (Resident #40) out of four residents reviewed for respiratory care.</p> <p>The findings include:</p> <p>Review of Resident #40's medical record revealed the resident was admitted to the facility in February of 2024 with a history of stroke and dependence on mechanical ventilation due to respiratory failure. The resident had severe cognitive impairment and was non-verbal.</p> <p>Review of the facility investigation documentation for MD00205708 revealed that on 5/14/24, in response to a ventilator alarm sounding, Respiratory Therapist (Staff #46) entered the resident's room and observed two agency GNAs (Staff #49 and #50) transferring the resident to a chair using a hooyer lift. The tubing used to provide mechanical ventilation to the resident was not attached at this time. The Respiratory Therapist re-connected the tubing to the resident.</p> <p>Review of the completed facility-reported incident follow-up investigation report regarding the 5/14/24 incident revealed the following statement: Summary of the interviews include that the GNA disconnected the resident from the ventilator to transfer the resident. This was observed by another GNA in the room.</p> <p>Review of a statement, signed by the NHA on 5/17/24, revealed that on 5/15/24 the NHA was made aware that the GNA had willfully disconnected the ventilator and the GNA had reported to the unit nurse manager after the incident that she was not aware she could not do that and didn't understand the difference between ventilator and tracheostomy residents.</p> <p>A tracheostomy (also called a tracheotomy) is an opening surgically created through the neck into the trachea (windpipe) to allow air to fill the lungs. After creating the tracheostomy opening in the neck, surgeons insert a tube through it to provide an airway and remove secretions from the lungs. Residents with prolonged dependence on a ventilator for breathing will often have a tracheostomy. (www.hopkinsmedicine.org). Some residents who are not dependent on mechanical ventilation may also have a tracheostomy.</p> <p>Review of a statement dated 5/15/24 and signed by GNA Staff #49 revealed that it was in regard to the incident that occurred on 5/14/24 while transferring the resident. The statement includes: I was not aware that I am not supposed to transfer vent residents unless there is a respiratory staff to watch the process.</p> <p>On 5/30/24 at 2:30 PM GNA #49 reported that if transferring a resident on a ventilator she would call staff from respiratory therapy department. After review of his/her statement about the 5/14/24 incident GNA #49 confirmed that s/he did not call RT that time, and denied having been told prior to that incident that she needed to do so, but confirmed that she has received education since then.</p> <p>(continued on next page)</p>

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Competency: New Employee GNA/CNA staff form for GNA #49 revealed documentation of Y to indicate Competency next to the following statements: Staff is able to verbalize the safe manner to provide care when working with ventilators and patients & residents with tracheostomies; and Staff is able to discern the difference between the various alarms on the ventilators and the appropriate response. The last page of this form included a signature page where the employee and various evaluators signed. The Respiratory Care Evaluator (RT supervisor Staff #47) signed this form on 2/15/24. On 5/31/24 at approximately 8:00 AM RT supervisor (Staff #47) was interviewed in regard to the orientation process. Staff #47 reports that they would of covered that an RT needs to be in the room during a transfer. When asked what does Respiratory Care Evaluator Signature indicate, Staff #47 reported it means they have been oriented.</p> <p>Review of the Facility Reported Incident Follow-Up Investigation Report revealed the following: There is a signed competency form in the alleged staff members education chart with a signature from the staff member and the respiratory manager [on] 2/15/24 indicating the staff member was trained on respiratory care. On this signed form it does not describe the information that was reviewed.</p> <p>Further review of the facility documentation revealed an Education Sign in Sheet for GNA Respiratory Education for May 20 - 24, 2024. Twenty-eight GNAs had signed indicating having received the education. Review of the GNA Respiratory Education sheet revealed the following were covered in the training:</p> <ul style="list-style-type: none"> -Never disconnect the ventilator circuit or remove a patient from the ventilator during transfer, or to dress/remove clothing from a patient. Always ask the respiratory therapist for assistance. -Vent tubing placement- Make sure that vent tubing moves freely to prevent pulling of the trach while performing patient care. -Decannulation - If the trach becomes dislodged during patient care, call for respiratory to re-insert the trach back into the stoma. Do NOT attempt to re-insert the trach yourself. -Do NOT silence the alarm on the ventilator by hitting the Silence Alarm button. -Suction regulators should not be turned on FULL suction while performing mouthcare. Regulators should be turned no higher than 150 mmHg. Regulators should also be turned back down when finished. <p>On 5/30/24 at 4:10 PM interview with the NHA who confirmed education was completed by May 24 with the GNA staff.</p> <p>Review of GNA #49's employee file revealed a Nursing Service Orientation Topic Validation 2023 form that was noted to be blank. On 5/31/24 at 9:28 AM the NHA reported that this form had not been implemented prior to the event on 5/14/24. This form included a section for Respiratory Training/Ventilator Equipment: Types of Tracheostomies & Tracheostomy Care; Ventilator Functionality; T-piece functionality - Aides Should Not Disconnect to Move Patient; Turning and Positioning Safety for Patient with Tracheostomy; Trach Collar, Respiratory Training/Ventilator Equipment and Ventilator Alarm Recognition & Safety: Disconnections etc.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/31/24 at 9:30 AM the NHA confirmed that moving forward they will be utilizing the Nursing Service Orientation Topic Validation form and will also be including the training that was completed with all of the GNAs post incident for new hires.</p> <p>Cross reference to F 695</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>37276</p> <p>Based on medical record review and interview with staff it was determined that the facility failed to ensure that irregularities identified by the pharmacist were reviewed by the attending physician, and that the attending physician documented in the medical record that the review has been completed and what, if any, action has been taken to address it; and failed to develop policies and procedures that included time frames for the physicians to complete this review. This was evident for 2 (Resident #6 and #9) of 5 residents reviewed for unnecessary medication.</p> <p>The findings include:</p> <p>1) On 5/24/24 at 9:00 AM, a review of Resident #6's electronic health record (EHR) reveal Medication Management - Medication Regimen Review (MM-MRR) notes that documented the pharmacist's results of the MRR and the pharmacist's recommendations for identified irregularities.</p> <p>1a) On 9/14/23, in a MM-MRR note, the pharmacist wrote that on 8/18 and 9/11, under chronic pain syndrome, the physician documented that Resident #6 was on Oxycodone (narcotic) and Gabapentin (treats nerve pain) for pain. The pharmacist wrote that the resident was on a significant routine dose of Morphine and recommended Morphine be included in the facility's pain evaluation with monitoring of side effects, efficacy and drug interactions, as well as considering tapering, and to please evaluate all.</p> <p>Continued review of the resident's medical record failed to reveal documentation that the attending physician documented in the resident's medical record that the identified irregularity had been reviewed and what, if any, action has been taken to address it.</p> <p>1b) Review of Resident #6's pharmacist medication regimen review progress notes revealed on 12/18/23 in a MM-MRR results note, the pharmacist recommended a follow-up with the resident's anemia issue and possible history of OBS (occult blood stool). In the note, the pharmacist indicated that recent notes or labs were not found and recommended the physician consider a PPI (proton pump inhibitor) (reduce stomach acid) until colonoscopy due to Eliquis (anticoagulant).</p> <p>Continued review of the resident's medical record failed to reveal documentation that the attending physician documented in the resident's medical record that the identified irregularity had been reviewed and what, if any, action has been taken to address it.</p> <p>1c) On 1/16/24, in a medical progress assessment note, the attending physician documented the resident had GERD (Gastroesophageal reflux) (heartburn) and a PPI was added for recent frequent chest pain complaints. The physician also documented Resident #6's Cologuard (non-invasive stool DNA test that screens for colon and rectal cancer), was positive, colonoscopy is indicated and will be ordered. Continued review of the resident's medical record failed to reveal evidence that a PPI had been prescribed for Resident #6 at that time. In addition, there was no documentation that the attending physician reviewed the pharmacist's identified irregularity, or that the physician was responding to the pharmacist's recommendations from 12/18/24.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/16/24, in a MM-MRR note, the pharmacist documented that Resident #6's most recent progress notes indicated the resident was to start PPI therapy and the pharmacist had not seen a new order for the PPI. The pharmacist also wrote that the November pharmacy recommendation had not received a documented response. Review of a MM-MRR note on 11/25/24, for Resident #6 the pharmacist wrote No issues found during review, however, the review of Resident #6's MM-MRR notes revealed the pharmacist wrote for the physician to consider a PPI on 12/18/23.</p> <p>Continued review of the medical record failed to reveal documentation to indicate the attending physician reviewed the pharmacist's recommendation and the physician's potential response.</p> <p>1d) On 2/24/24, in a MM-MRR note, the pharmacist recommended follow-up with a positive Cologuard test and intention to start PPI from progress note on 1/16/24. The pharmacist documented the resident was on Eliquis and recommended CBC (complete blood count) and BMP (basic metabolic panel) lab work at this time to determine if PPI would be beneficial, and that it did not appear that a PPI had ever been started.</p> <p>Continued review of the resident's medical record failed to reveal documentation that the attending physician documented in the resident's medical record that the identified irregularity had been reviewed and what, if any, action has been taken to address it.</p> <p>On 5/24/24 at 12:45 PM, during an interview, the unit nurse manager (Staff #3), was made aware that the review of the resident's medical record failed to provide documentation to indicate the attending physician reviewed the irregularities that were identified by the pharmacist, and what if any action had been taken by the physician to address it. Staff #3 acknowledged the concerns at that time.</p> <p>On 5/24/24 at 2:04 PM, the above concerns were discussed with the Chief Medical Officer (Staff #10). During the interview, Staff #10 stated that the medication regimen review process had recently changed, as they had identified a problem with the previous process. Staff #10 indicated that the pharmacist now writes a note in the Pharmacy Recommendation Tab of the EHR and the provider responds to the pharmacist in their own pharmacy recommendation note. Staff #10 indicated she was responsible for the tracking of the MRR, and a PIP (Performance Improvement Plan) was done in April for changes to process.</p> <p>50573</p> <p>2) Review of Resident #9's medical record on 5/20/24 revealed the resident has resided at the facility for several years.</p> <p>Review of medical on 05/28/24 at 09:05 AM revealed that the resident had been ordered both ibuprofen and warfarin.</p> <p>Warfarin is a medication that thins blood and international normalized ratio (INR) is a blood level monitored while taking warfarin. The blood level is determined by a lab test using blood and it reveals how thin or thick blood is to evaluate if the Warfarin dose needs to be increased or decreased. Ibuprofen is a common pain medication that can affect the INR level if taken with warfarin.</p> <p>Further review of medical record on 05/29/24 at 10:10 AM revealed that the monthly medication review (MMR) are being done each month.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Further review of medical record revealed from the monthly pharmacy recommendation, or MMR, on 11/25/23 the pharmacist (Staff #57) documented: it is notable that patient is using PRN (as needed) medications several times a day for Ibuprofen, Tylenol, tums. Also the INR has been increasing and Warfarin dose has been adjusted downward. It appears the Ibuprofen may be contributing to drug interactions and side effects (ie. possible reason for tums use). Recommend evaluate at this time to consider alternative pain therapies and discontinue ibuprofen.</p> <p>Further review of the medical record failed to reveal documentation that the primary care provider reviewed and addressed the recommendation from 11/25/23.</p> <p>Further review of the monthly pharmacy recommendation revealed that on 12/17/23 the pharmacist (Staff #57) documented, MRR completed. Please see the 11/25/23 Pharmacy recommendations to address.</p> <p>Further review of the medical record failed to revealed documentation that the primary care provider reviewed and addressed the recommendation from 12/17/23</p> <p>Further record review of the monthly pharmacy recommendation revealed that on 1/16/24 the pharmacist (Staff #57) documented, MMR completed. Patient is noted to have unstable INR. Of note, [s/he] uses PRN ibuprofen, which may cause a drug interaction with INR fluctuation. Recommend consider discontinue the ibuprofen/NSAID use.</p> <p>Further review of the medical record failed to revealed documentation that the primary care provider reviewed and addressed the recommendation from 1/16/24</p> <p>An interview with Primary Care Provider, OD (Staff #40) on 05/29/24 at 03:27 PM revealed that the pharmacist (Staff #57) will notify Staff #40 when a recommendation has been made. Further interview with Staff #40 revealed that the facility has had many different procedures over the years on how physicians are notified of pharmacy recommendations. The current process consists of pharmacists documenting the MMR in the electronic medical record platform used at the facility and the physicians can reply to the notes or create a new note following it.</p> <p>Review of the Drug Regimen Review for Comprehensive Care policy, that was provided during the survey, failed to reveal a date that it was established. Review of the procedures section of this policy revealed The attending physician will review the pharmacist's recommendations but fails to include a time frame for the physicians to respond to pharmacists recommendations or that this response needs to be documented in the medical record.</p> <p>On 05/31/24 at 4:25 PM, the surveyor reviewed the concern with the Director of Nursing (Staff #18), and Nursing Home Administrator (Staff #1) regarding the failure to have a system in place to ensure that physicians reviewed and addressed monthly pharmacy recommendations.</p> <p>As of survey exit on 6/4/24 at 5:00 PM, the facility failed to have provided additional documentation regarding this concern.</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>48259</p> <p>Based on record review and staff interviews, it was determined that the facility failed to ensure a resident received medication according to an attending physician's orders. This was evident for 1 (Resident #32) out of 5 residents reviewed for unnecessary medications.</p> <p>The findings include:</p> <p>Medical record review on 5/28/24 at 11:52 AM found that Resident #32 was admitted to the facility in December 2022 with diagnoses including hypertension (high blood pressure).</p> <p>Further review on 5/31/24 at 10:30 AM showed an attending provider's order dated 12/20/22 for an antihypertensive medication to be administered twice daily to Resident #32. The order had parameters to hold (not to give) the medication for an SBP less than 100 mmHg (millimeters of mercury) and an apical pulse less than 55.</p> <p>Blood pressure (BP) is often written as an upper and lower number. Systolic blood pressure (SBP) is the upper number. It measures the pressure in the arteries during heart muscle contraction. A pulse is the heart rate. It's the number of times the heart beats in one minute. The apical pulse is the heartbeat from the apex of the heart. An adult's regular apical pulse is 60-100 beats per minute. A radial pulse is the pulse of the radial artery, which can be felt in the wrist. A regular radial pulse has a rate of 60-100 beats per minute.</p> <p>A review of Resident #32's medication administration records (MARs) for April -May 2024 showed that the resident received the medication daily. The MARs did not contain documentation of the parameters.</p> <p>A review of Resident #32's vital signs history for April-May 2024 showed a record of radial pulse on 4/5/24, 4/14/24, 4/23/24, 4/26/24, 4/27/24, 5/10/24, 5/11/24, 5/14/24, 5/15/24, 5/16/24, 5/29/24, and 5/30/24. However, it did not show documentation of apical pulse.</p> <p>In an interview on 5/31/24 at 11:14 AM, Staff #17, a licensed practical nurse, reported that before administering a medication with those parameters, she would first assess the BP and the apical pulse and document it under the vital signs section of the facility's electronic medical record (EHR) if she could not record it in the MAR.</p> <p>In a subsequent interview on 5/31/24 at 11:37 AM, Staff #48, a licensed practical nurse, reported that an apical pulse was assessed differently from a radial pulse.</p> <p>During an interview on 5/31/24 at 11:49 AM, the assistant director of nursing (ADON) confirmed that Resident #32's vital signs history for March-April 2024 contained radial pulse on 4/5/24, 4/14/24, 4/23/24, 4/26/24, 4/27/24, 5/10/24, 5/11/24, 5/14/24, 5/15/24, 5/16/24, 5/29/24, and 5/30/24. The ADON stated that the nurses were to check the apical and not the radial pulse and added that he would modify the special instructions for the medication after contacting the attending provider.</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>37276</p> <p>Based on medical record review and staff interviews, it was determined that the facility staff failed to ensure that a resident's medication regimen was free from unnecessary medication by failing to adequately monitor a resident for behavior, side effects, or adverse consequences related to a resident's use of psychotropic medication. This was evident for 1 (Resident #6) of 5 residents reviewed for unnecessary medications.</p> <p>The findings include:</p> <p>On 5/21/24 at 3:15 PM, a review of Resident #6's medical record revealed the documentation that the resident resided in the facility for long term care since February 2020 and had diagnoses that included bipolar disorder (manic depression) (disorder associated with episodes of mood swings ranging from depressive lows to manic highs). Review of Resident #6's May 2023 Electronic Medication Administration Summary (eMAR) revealed a 9/27/22 order for Mirtazapine (Remeron, an antidepressant) Tablet by mouth one time per day for bipolar disorder that was documented as given every day as ordered from 5/1/24 to 5/21/24.</p> <p>Continued review of the resident's medical record failed to reveal documentation to indicate the facility staff conducted ongoing monitoring of Resident #6 for the resident specific behaviors for which a psychotropic medication had been prescribed and there was no documentation to indicate the resident was monitored for the side effects of the antidepressant medication.</p> <p>On 5/22/24 at 1:31 PM, during an interview, the unit nurse manager (Staff #3) stated that when a resident received psychotropic medication, the physician wrote the order for the psychotropic and for the behavior monitoring. Staff #3 indicated she was not sure how that was attached to the electronic health record (EHR). Staff #3 stated that as far as she knew, the doctor wrote the order, and the order should populate into the resident's administration record so the nurses could document on something that flows. At that time, Staff #3 was made aware of the above concerns related to failing to monitor Resident #6 for behavior and potential antidepressant medication side effects, and Staff #3 offered no further explanation at that time.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>45139</p> <p>Based on observation, interview, and pertinent document review, it was determined that the facility failed to properly store medical devices and medications according to the manufacturer's guidelines to ensure their safe and effective use. This was evident for 2 out of 2 nursing units during the survey.</p> <p>The findings include:</p> <p>1. On 5/29/24 at 1:15 PM, an observation was made of medication cart #1 with Nurse Supervisor Staff #13. Observation of the medication cart drawer revealed a box of approximately 20 safety lancets (a device that is used to measure blood glucose). The lancets were not in their original box and Staff #13 reported she could not report the expiration date of the devices.</p> <p>On 5/29/24 at 1:20 PM, during a brief interview with Staff #13, she reported that all the medication carts are designed for the safety lancets being placed in the cart and not in their original box with an expiration date.</p> <p>On 5/29/24 at 2:14 PM, an observation was made of the East Wing medication storage room with Nurse Supervisor Staff #13. Observation revealed a wall cabinet. Further review of the third shelf of the cabinet revealed a bin containing over 50 safety lancets. The lancets were not in their original box and the expiration date was unknown. Staff #13 reported she did not know the lancets were up there and could not report what date they were placed in the cabinet.</p> <p>2. On 5/29/23 at 2:11 PM, an observation was made of the [NAME] Wing medication room with Staff #13. The observation revealed a thermometer inside the medication refrigerator. Further observation of the thermometer revealed a temperature reading between 30- and 32 degrees Fahrenheit. This temperature reading was confirmed by Staff #13.</p> <p>On 5/30/24 at 9:27 AM, during an interview the Maintenance Director Staff # 55 reported that he had not been notified of any concerns regarding the refrigerator temperatures.</p> <p>On 5/30/24 at 9:34 AM, a second observation of the medication refrigerator in the [NAME] Wing medication room was made with the Assistant Director of Nursing (ADON) and the Maintenance Director Staff # 55. Observation of the medication refrigerator thermometer revealed a temperature reading of 32 degrees Fahrenheit. This temperature reading was confirmed by the ADON and Staff # 55.</p> <p>On 5/30/24 at 11:42 AM the Maintenance Director reported that the temperature is now 34 degrees Fahrenheit and that he made adjustments and will continue to monitor the temperature.</p> <p>On 5/31/24 at 2:12 PM, an observation of medications in the refrigerator revealed the following medications:</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Trulicity (a diabetic medication), manufactured storage directions to refrigerate at 36 degrees Fahrenheit.</p> <p>Pneumococcal 20-valent Conjugate vaccine, manufacturer storage directions indicate to store in a refrigerator at a temperature between 36 F and 46 F.</p> <p>ASPART (insulin), manufacturer storage directions indicate to keep in refrigerator and do not freeze.</p> <p>On 5/31/24, the facility's policy titled Policy & Procedure: Medication Management: Hospital Long Term Care was reviewed. A review of the policy revealed that medications are stored according to the Pharmacist's instructions, as based on the manufacturer's instructions.</p> <p>On 5/31/24 at 2:15 PM discussed all concerns with Administrator, and ADON regarding the refrigerator temperature and the medications kept in the refrigerators. Administrator and ADON reported that they would investigate the concern.</p>

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain dental services for each resident.</p> <p>50573</p> <p>Based on record review and staff interviews, it was determined that the facility failed to ensure an order was in place for a resident requiring and requesting dental services and failed to develop a care plan to address this issue as well. This was evident for 1 (Resident #9) of 2 Residents reviewed for dental.</p> <p>The findings include:</p> <p>Review of Resident #9's medical record on 5/20/24 revealed the resident had resided at the facility for several years, was alert and oriented and able to verbally communicate. Resident #9 is dependent on staff for transfers out of bed and mobility due to weakness.</p> <p>An interview with Resident #9 on 05/20/24 at 03:02 PM revealed that she/he has been experiencing frequent tooth pain.</p> <p>Review of medical record revealed that on 12/26/2023 the Nurse Practitioner (Staff #22) completed a progress note that included the resident reporting tooth pain. Staff #22 assessed the finding and prescribed Anbesol gel for the pain to be given as the resident needs. Anbesol gel is an oral topical gel used for temporary mouth discomfort.</p> <p>Review of the minimum data set (MDS) with an assessment reference date (ARD) of 1/5/24 revealed in Section L Oral/Dental status that the resident was experiencing mouth or facial pain, discomfort or difficulty with chewing.</p> <p>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. Assessment reference date (ARD) is an endpoint or look back for observation periods in the MDS assessment process.</p> <p>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. The expectation is that the care plan will be updated based on each assessment completed.</p> <p>Review of Resident #9's medical record revealed that on 1/19/24 Licensed Social Worker (Staff #6) documented a care plan update progress note that indicated dental issues were discussed, and the goals to resolve the dental care issue and to find dental care for the resident. However, review of the resident's care plan failed to reveal documentation to indicate the dental issues, or the need to identify a dentist, for the resident were added to the care plan.</p> <p>(continued on next page)</p>

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Further review of Resident #9's medical record on 05/22/24 at 09:40 AM revealed that there was frequent documentation that noted the resident experiencing tooth pain. This documentation included, but was not limited to: on 2/5/24 Registered Nurse (Staff #42) documented that the resident complained of tooth and gum pain, requested and received acetaminophen and that there were plans to consult a dental provider; on 2/25/24 Registered Nurse (Staff #43) documented that the resident complained of a toothache and received Anbesol gel and tylenol; on 3/8/24 Occupational Therapy Assistant (Staff #44) documented that the resident was complaining of ongoing tooth pain and that the request was passed on to the Nurse, Physician, and Social Worker recently; on 3/13/24 Nurse Practitioner (Staff #22) wrote a progress note that included the resident requesting a dental appointment for tooth pain and the plan was to continue searching for a dentist in the area who will take a wheelchair bound resident who is unable to transfer into a dental chair; on 3/15/24 Occupational Therapy Assistant (Staff #44) documented a progress note that revealed the resident reporting ongoing tooth pain, wants to see a dentist and that social work and physician are aware; on 3/20/24 Occupational Therapy Assistant Staff #44 documented a progress note that revealed the resident having frustration with wanting to see a dentist and told the nurse after the physical therapy session that the resident is requesting pain medication for the tooth pain; and on 3/21/24 Licensed Physical Therapist (Staff #8) documented a progress note that included the resident reported tooth pain.</p> <p>Review of Resident #9's medical record on 05/22/24 at 11:43 AM revealed that there was no documentation of a dental care plan and tooth pain is not covered under Resident #9's current pain care plan.</p> <p>Review of Resident #9's medical record on 05/23/24 at 10:38 AM revealed that the documentation from the most recent MDS with an ARD of 3/30/24 indicated that the resident had been experiencing mouth pain under the oral/dental status section.</p> <p>Further review of the medical record revealed a Care Plan Update note, dated 4/3/24, written by Social Worker (Staff #6) that documented that a care plan meeting was held and the resident opted not to attend. No documentation was found in this note to indicate the dental concerns were addressed during this meeting.</p> <p>Further review of the medical record revealed on 4/19/24 Primary Care Provider, OD (Staff #40) documented a medical note which included the resident requesting a dental visit.</p> <p>Further review of the medical record on 5/22/24 failed to reveal a current order for a dental consult.</p> <p>On 5/23/24 at 3:14 PM the unit nurse manager (Staff #3) reported that the primary care provider (Staff #40) had not been able to get Resident #9 in with any dental provider.</p> <p>On 5/29/24 03:27 PM surveyor reviewed the concern with the primary care provider (Staff #40) that, according to the April progress note the resident requested a dental appointment but no order for an appointment, or care plan addressing dental issues, was found in the medical record. The primary care provider (Staff #40) revealed that finding a dental provider had been a challenge, especially for non-ambulatory residents. Staff #40 indicated she has recently identified a provider and has scheduled an appointment for Resident #9, and that several other residents have already been to the new provider. Staff #40 indicated she would order an appointment for Resident #9 today.</p> <p>(continued on next page)</p>		

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 05/31/24 at 04:28 PM, the surveyor reviewed concern to the Director of Nursing (Staff #18), and Assistant Director of Nursing (Staff #2) regarding the failure to update the resident's care plan related to frequent tooth pain.</p> <p>On 6/3/24 further review of the medical record revealed an order to Consult Dentistry by Staff #40 for routine hygiene/cleaning and general dental assessment/treatment was put in place on 5/29/24.</p> <p>On 6/03/24 at approximately 3:30 PM the Director of Quality (Staff #11) reported that they did not at present have an appointment for Resident #9 for dental due to non-ambulatory status and that this is still a work in progress.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48259</p> <p>Based on observations and interviews with facility staff, it was determined that the facility failed to store food in accordance with professional standards. This deficient practice has the potential to affect all residents.</p> <p>The findings include:</p> <p>1) On [DATE] at 8:49 AM, an initial tour of the facility's kitchen was conducted by two surveyors. An observation of the kitchen's walk-in freezer noted a metal container with pureed turkey covered with saran wrap dated [DATE]-[DATE]. The facility's food service administrator (Staff #53), was present during the tour and stated that the expiration date should have been [DATE].</p> <p>Continued observation noted semi-mac and cheese in a metal bin covered with aluminum foil dated [DATE]-[DATE] and semi-turkey in a metal bin covered with aluminum foil dated [DATE]-[DATE]. Staff #53 stated they were all expired and took them to discard.</p> <p>Further observation of the facility's walk-in refrigerator on [DATE] at 8:55 AM showed the following: a metal bin covered with saran wrap, labeled Tropical fruit for dinner expires [DATE], a plastic bin with mandarin oranges dated ,d+[DATE]-,d+[DATE] and a small metal bin with meatballs covered with saran wrap dated , d+[DATE] -,d+[DATE]. Staff #53 confirmed they were all expired and should have been discarded. He removed them to discard them.</p> <p>The surveyor continued the observation of the kitchen and noted a walk-in refrigerator that led to a freezer. The observation found the following: Liquid eggs in a metal bin thawing out with no date marked when they were pulled or the use-by date, liquid eggs labeled with a pulled date of ,d+[DATE], but no use-by date was noted. Staff #53 said the eggs were frozen and took ,d+[DATE] days to get thawed.</p> <p>Continued observation showed a container of Ken's Italian dressing that had been opened, and about half of it had been used. However, no date was marked as to when it was opened.</p> <p>Further observation on [DATE] at 9:15 AM noted the kitchen's walk-in dry food area. The observation found a large, dented can with diced pears on the floor under a metal shelving on the right side. Staff #53 picked up the can, confirmed it was dented, and stated he did not know how it got to the floor but should be discarded.</p> <p>The above concerns were discussed with the Nursing Home Administrator on [DATE] at 12:10 PM, who acknowledged the concerns at that time.</p> <p>45139</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>2) On [DATE] at 1:54 PM, the Food service administrator (Staff # 53) reported that his department provided the temperature logs for refrigerator that contain residents' personal food and that records the temperatures. The kitchen then maintains the completed temperature logs for residents' refrigerators. The logs contained a space to document a daily refrigerator temperature and a space for initials.</p> <p>On [DATE] at 2:05 PM, Observation was made of Nursing unit 1 East refrigerator revealed a document attached to the refrigerator titled, Daily Freezer refrigerator Temperature Log, dated [DATE]. Review of the temperature log revealed that temperatures should be maintained between 33 degrees Fahrenheit (F.) and 41 degrees F.</p> <p>Review of the temperature log for the 1 East resident refrigerator revealed that the temperatures that were documented were outside of the recommended temperature range in 26 out of the 31 days that temperatures were recorded.</p> <p>[DATE] temp recorded as 30 F</p> <p>[DATE] temp recorded as 30 F</p> <p>[DATE] temp recorded as 29 F</p> <p>[DATE] temp recorded as 30 F</p> <p>[DATE] temp recorded as 30 F</p> <p>[DATE] temp recorded as 30 F</p> <p>[DATE] temp recorded as 29 F</p> <p>[DATE] temp recorded as 30 F</p> <p>[DATE] temp recorded as 32 F</p> <p>[DATE] temp recorded as 32 F</p> <p>[DATE] temp recorded as 32 F</p> <p>[DATE] temp recorded as 32 F</p> <p>[DATE] temp recorded as 30 F</p> <p>[DATE] temp recorded as 30 F</p> <p>[DATE] temp recorded as 30 F</p> <p>[DATE] temp recorded as 30 F</p> <p>[DATE] temp recorded as 32 F</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>[DATE] temp recorded as 32 F</p> <p>[DATE] temp recorded as 32 F</p> <p>[DATE] temp recorded as 30 F</p> <p>[DATE] temp recorded as 30 F</p> <p>[DATE] temp recorded as 30 F</p> <p>[DATE] temp recorded as 30 F</p> <p>[DATE] temp recorded as 30 F</p> <p>[DATE] temp recorded as 30 F</p> <p>On [DATE] at 2:23 PM, an observation of Resident #12's personal room refrigerator was made with GNA # 59 and the Food Service Administrator Staff #53. Observation revealed a document titled Daily Freezer/Refrigerator Temperature Log was secured to the side of the refrigerator. Further review of the document revealed the date of [DATE], Resident #12's name and spaces to document the daily temperatures and initials of the recorder. Continued review of the March temperature log revealed only 5 out of 31 days had documented temperatures accompanied by initials.</p> <p>On [DATE] at 2:23 PM, during a brief interview GNA staff #59 reported that it was the responsibility of the dietary staff to record the temperatures of the refrigerators that contained residents' personal food. GNA failed to provide Resident's #12 refrigerator logs for the months of April and [DATE].</p> <p>On [DATE] at 2:34 PM and during a brief interview with the Food Service Administrator #59 he reported that there was a temporary halt in the dietary staff coming up to the nursing units during a COVID outbreak. In addition, he reported he was unable to provide Resident's #12 refrigerator logs for the months of April and [DATE].</p> <p>On [DATE] the facility policy titled Resident Outside Food Storage on Unit was reviewed. The review revealed that the Hostess service will maintain daily temperature log recording and daily cleaning for resident personal food items.</p> <p>On [DATE] at 2:34 PM, observation of Resident #9 room revealed a small personal refrigerator with a lock on it. Further observation failed to reveal a temperature log.</p> <p>On [DATE] at 2:36 PM the Food Service Administrator reported that the term Hostess refers to the dietary staff. He reported that the facility had a policy that dietary staff did not come up on the units during the COVID outbreak and there was a break in the monitoring of the refrigerators.</p>		

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<p>F 0838</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies.</p> <p>48470</p> <p>Based on records review and interviews, it was determined that the facility failed to include staff competencies that are necessary to provide the level and types of care needed for the resident population. This deficient practice has the ability to affect all residents in the facility.</p> <p>The findings include:</p> <p>On 6/4/24 at 12:34 PM, a review of the facility assessment had identified about 23 to 34% of the facility's resident population sampled over the last year had behavioral health needs. However, in reviewing the list of annual competencies that the facility had identified and recommended to provide to their staff, behavioral health training was not part of the list.</p> <p>On the same day at 3:15 PM, a sample of employee files were reviewed for competencies and revealed no evidence for behavioral health training.</p> <p>Later at 3:50 PM, the Director of Quality (Staff #11) who was part of the staff listed as involved in the completion of the facility assessment, was interviewed. The concern was discussed with Staff #11 that the competencies listed in the facility assessment did not cover the level and type of care needed for all the identified resident populations. Staff #11 acknowledged the concern and stated, There is a lot of training that the staff need for our residents, and we are working on it.</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>37276</p> <p>Based on record reviews and interviews, it was determined that the facility failed to maintain complete and accurate medical records for its residents. This was evident for 3(Resident #6, #21, and #96) of 24 residents reviewed during the survey.</p> <p>The findings include:</p> <p>1a) On 5/20/24 at 11:24 AM Resident #6 was observed to have his/her hands in a cupped position indicating possible contractures (fixed resistance to passive stretch of a muscle). There was no splint or device in place in either of the resident's hands and soft palm protectors were observed on the resident's bedside table.</p> <p>On 5/21/24 at 3:15 PM, a review of Resident #6's medical record revealed the resident resided in the facility for long term care since February 2020 and had multiple diagnosis, including traumatic spinal cord dysfunction and contractures of muscle of his/her right lower leg, left lower leg, right upper arm and left upper arm. Resident #6's quarterly assessment with an assessment reference date (ARD) of 4/13/23 documented Resident #6 had a functional limitation in range of motion (ROM) in both upper extremities and a functional limitation in ROM in both lower extremities and the resident received restorative nursing.</p> <p>Review of Resident #6's May 2024 eMAR (electronic medication administration record) revealed a 9/28/22 order for bilateral palm protectors 4 hours at a time, 2 times/day, evening as needed. There was no documentation in the eMAR to indicate the palm protectors had been applied to Resident #6 during the review period of 5/1/24 to 5/22/24.</p> <p>On 5/24/24 at 3:42 PM, during an interview, the occupational therapist (Staff #27) stated that when Resident #6 was admitted to the facility, the resident was evaluated by therapy, noted to have hand contractures and issued palm protectors. When made aware there was no documentation to indicate the palm protectors had been applied to the resident, Staff #27 indicated Resident #6 received restorative nursing, and the restorative aides applied the palm protectors to the resident for 4 hours at a time, two times a day. The OT stated that problem was with the way therapy entered the order into the EHR, which prevented accurate documentation in the eMAR, and therapy had just recently become aware of the problem</p> <p>1b) Further review of Resident #6's electronic medication administration (eMAR) record revealed a 9/26/22 order for Silver Nitrate (medication used for cauterization) (process of burning the skin to stop bleeding or prevent a wound infection) as needed: cleanse area with Normal Saline (NS), pat dry. Apply A & D ointment around site to keep silver nitrate from migrating to healthy tissue. Touch Hypergranulation tissue with silver nitrate stick(s); apply DSD [dry sterile dressing] over area for a minimum of 24 hours. There was no indication in the order to as to where the Silver Nitrate was to be applied.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The concerns with the Silver Nitrate order were discusses with the unit nurse manager (Staff #3) on 5/22/23 at 3:50 PM. At that time, Staff #3 acknowledged the concern and indicated she would follow-up with physician.</p> <p>2a) On 5/20/24 at 11:32 AM, Resident #21 was observed to have both hands bent in a cupped position, indicating possible contractures and there was no splint or device in place in either of the resident's hands.</p> <p>Review of Resident #21's medical record revealed the resident had diagnosis which included spastic quadriplegic cerebral palsy and contracture of unspecified joint. Review of Resident #21's annual MDS 3/23/24 revealed documentation that Resident #21 had passive range of motion and splint, or brace assistance performed 3 times for at least 15 minutes and in the last 7 days.</p> <p>Review of Resident #21's May 2024 eMAR revealed a 2/1/24 order for pillow rolls/bolsters on bilateral upper extremity's 4 hours each shift as needed for contracture management as needed. Following the order, there was no documentation in the eMAR to indicate the order had been implemented and the pillow rolls/bolsters applied to Resident #21's upper extremities in May 2024.</p> <p>On 6/4/24 at 12:58 PM, during an interview the Therapy Services Manager (Staff #25) and the Restorative Nurse/MDS Coordinator (Staff #5), were made aware that there was no documentation in the resident's May 2024 eMAR to indicate pillow rolls/bolsters were employed for management of Resident #21's contractures. At that time, Staff #25 reported that Resident #21 received restorative nursing care for management of his/her contractures, and because of the limitations of the EHR software, restorative aides were not able to accurately document in the EHR. Staff #5 stated that the documentation makes it look like they were non-compliant, when they actually were, and indicated the problem was due to cut off time for documenting in the EHR.</p> <p>2b) Further review of Resident #21's May 2024 eMAR summary revealed an 8/7/23 order for 1 mineral oil rectal enema rectally as needed one time per day. The order indicated the enema could be given once a day, however the order failed to include an indication as to the reason the enema could be administered to the resident.</p> <p>Following an interview on 6/4/24 at 12:58 PM, Staff #5 was made aware of the concern that Resident #21's enema order failed to have a clear indication of when the enema was to be administered as needed, and Staff #5 acknowledged the concern at that time.</p> <p>45139</p> <p>3) On 5/23/24 at 3:00 PM, the chart of Resident # 96, a long-term resident of the facility, was reviewed. A review of the chart revealed several Maryland Orders for Life-Sustaining Treatment (MOLST). The recent MOSLT was dated 1/02/2024. Further review revealed a prior MOLST dated 1/9/23 that failed to reveal a diagonal line through the sheet, the word void, and the physician or nurse practitioner's signature.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Maryland MOLST (Maryland Orders for Life-Sustaining Treatment) is a portable and enduring medical order form covering options for cardiopulmonary resuscitation and other life-sustaining treatments. Medical orders are based on a patient's wishes about medical treatments. Per the MOLST instructions, to void the MOLST order form, a physician or nurse practitioner shall draw a diagonal line through the sheet, write VOID in large letters across the page, and sign and date below the line. Keep the voided order form in the patient's active or archived medical record,</p> <p>On 5/24/24 at 2:42 PM, the above concerns were discussed with the Medical Director (Staff # 10). She confirmed the presence of more than one MOLST in Resident # 96's chart. In addition, she confirmed that the old MOLST was not voided correctly. She is aware of the correct way the MOLST is to be voided and stated she would educate her staff.</p>		

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<p>F 0843</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have an agreement with at least one or more hospitals certified by Medicare or Medicaid to make sure residents can be moved quickly to the hospital when they need medical care.</p> <p>45139</p> <p>Based on pertinent documentation review and interviews, it was determined that the facility failed to have a current written transfer agreement with a local hospital. This has the potential to affect all residents in the facility.</p> <p>The findings include:</p> <p>On 6/4/24, review of facility assessment failed to reveal a written agreement with a local hospital that is willing to accept residents transported from the facility.</p> <p>On 6/04/24 at 2:00 PM, during an interview with the Director of Quality, she reported that she could not provide a written transfer agreement between the facility and a local hospital. She reported that the facility had routinely transferred the residents to the local hospital without incident. No additional documentation was provided prior to the end of survey.</p>

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>40927</p> <p>Based on record review and interview it was determined that the facility failed to 1) conduct a root cause and analysis on the deficiencies cited during the recertification survey which resulted in reciting the same deficiencies and 2) ensure that they were in compliance by their alleged compliance date. This was evident throughout the revisit.</p> <p>The finding include:</p> <p>1a. During the revisit survey it was determined that the facility was not sending the transfer notice to the resident's representative [F623]. An interview with the Social Work Supervisor Staff #7 on 9/12/24 at 1:30 PM, confirmed that if a resident had capacity the transfer notice was not being sent to the resident representative as required. They failed to ensure that the regulatory requirement was implemented.</p> <p>1b. During the revisit it was determined that the facility was not in compliance with providing quality of care to the residents [F684] as staff continued to fail to follow physicians' orders. During a medication pass observation on 9/10/24 at 8:15 AM it was determined that the nurse failed to give a medication during the timeframe specified in the order.</p> <p>On 9/13/24 at 1:00 PM, a review of the facility's plan of correction in response to the recertification survey ending 6/4/24 revealed they had focused on the staff's failure to follow physician's orders for 15-minute checks and failed to address all physician's orders being followed.</p> <p>An interview with the Chief Nursing Officer on 9/13/24 at 2:00 PM confirmed that staff had been educated on orders for 15-minute checks and suicide prevention. She stated they had audited those types of orders and not all physician orders.</p> <p>1c. During the revisit it was determined that the facility failed to effectively implement a plan of correction for the deficient practice of failing to ensure that resident's care plans were reviewed and revised with each minimum data set (MDS) assessment. An interview with the MDS coordinator on 9/13/24 at 1:35 PM revealed that she had been told by the Chief Nursing Officer that the Social Work staff were to write a summary of the care plan evaluations at this time. A social worker was not qualified to evaluate a resident's care plan to determine if they met their goal or not and based on this information if the interventions needed to be updated for each discipline (i.e. nursing, therapy, and dietary) involved in the resident's care.</p> <p>1d. During the revisit it was determined that the facility had failed to obtain a transfer agreement with a local hospital [F843]. A review of their plan of correction stated that they would make a good faith attempt to get one by 8/30/24. However, the facility failed to provide evidence during the survey to show they had made a good faith attempt.</p> <p>An interview with the Director of Quality on 9/12/24 at 4:15 PM revealed that the facility had failed to conduct a root cause and analysis for the deficient practice to ensure that the plan of correction implemented was effective.</p> <p>(continued on next page)</p>

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Cross Reference: F623, F684, F657, and F843.</p> <p>2) The facility alleged on the plan of correction following the recertification survey ending 6/4/24 that the compliance date for the following tags was 8/30/24; 1) unnecessary medications [F757], 2) unnecessary psychotropic medications [F758], 3) medication storage [F761], 4) routine/emergency dental services [F791], and 5) facility assessment [F838].</p> <p>However, review of the facility education documentation throughout the revisit survey revealed that the staff education for F838 was completed on 9/3/24, F758 and F791 was completed on 9/10/24 after the start of the revisit survey, and F757 and F761 was completed on 9/11/24. There were 5 staff members past the 8/30/24 compliance date; GNA #15 (Geriatric Nursing Assistant), GNA #16, RN #17 (Registered Nurse), GNA #18, and RN #19.</p> <p>During an interview with the Director of Quality on 9/12/24 at 2:40 PM, she confirmed that 1 (GNA #18) staff out of the 5 who were not educated by 8/30/24 was on extended leave. However, she returned on 9/3/24 and her education had not been completed until 9/11/24.</p> <p>An interview on 9/13/24 at 11:24 AM with the Director of Education revealed that her department was primarily responsible for ensuring that staff were educated by the alleged compliance date. Reviewed the staff who had not been educated timely. She reported that there were some barriers with GNA #15, however, they failed to intervene until the day the revisit survey started on 9/9/24. She was unable to provide a rationale for GNA #16, RN #17, and GNA #18. When asked why she had not educated RN #19 upon return to the facility she stated the nurse had not returned until Friday 9/6/24, which was a weekend, so they met with her the following Monday. However, review of the education sheet that was signed by RN #19, they had not met with her until 9/11/24, 3 days into the revisit survey.</p> <p>The findings were reviewed with the Chief Nursing Officer, in the absence of the Administrator, on 9/13/24 at 2:00 PM.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215110	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2024
NAME OF PROVIDER OR SUPPLIER Western MD Hospital Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 Pennsylvania Avenue Hagerstown, MD 21742	

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<p>F 0868</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Have the Quality Assessment and Assurance group have the required members and meet at least quarterly</p> <p>45139</p> <p>Based on pertinent document review, and interviews it was determined that the facility failed to establish a quality assurance committee which would include an Infection Preventionists at every committee meeting.</p> <p>The findings include:</p> <p>On 5/31/2024 at 1:15 PM, The Administrator provided the attendance sign in sheet for the facility QAPI committee meetings May 2023 through May 2024. Review of the attendance sign in sheets failed to reveal that the infection Preventionists attended the QAPI meetings for 6 consecutive months: The months that did not have a infections preventionist attend were as follows. 4/17/24, 3/20/24, 2/21/24, 1/17/24, 12/20/23, 11/15/23.</p> <p>On 6/04/24 at 12:02 PM, the Director of Quality was interviewed. During the interview she confirmed that the infection preventionists failed to attend the above-mentioned committee meetings. She reported that in 2023 the Infection preventionist was not required to attend every QAPI meeting, however beginning in January 2024 the Infection preventionists were required to attend every meeting.</p>

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<p>F 0909</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame.</p> <p>48470</p> <p>Based on observations, records review, and interviews, it was determined that the facility failed to conduct regular inspection of all bed frames, mattresses, and bed rails, as part of a regular maintenance program to identify areas of possible entrapment. This was evident for 1 (Resident #16) of 3 residents reviewed for accidents.</p> <p>The findings include:</p> <p>Resident #16 had been a resident of the facility since 2016. During an interview with the resident, s/he reported weakness on the left arm and would use the bed rails for position and mobility. An observation of the resident's bed rails during the interview revealed that they were loose as the resident would pull or push on them demonstrating his/her use of the bed rails.</p> <p>On 5/29/24 at 1:41 PM, the Unit Nurse Manager (UM Staff #3) was interviewed about bed rails and reported that there are several assessments that pertain to bed rails. Some of the assessments can be found in the electronic health record while some are in the hard charts.</p> <p>On 5/29/24 at 2:01 PM, Resident #16's medical records were reviewed and revealed consent and side rail utilization assessment but did not reveal documentation regarding regular inspections for bed and bed rails.</p> <p>On the same day at 3:05 PM, the UM was again interviewed about bed rails, and she reported that regular maintenance of beds and bed rails were conducted by the Maintenance Director (Staff #55). Soon after at 3:14 PM, Staff #55 was interviewed about bed rails, and he reported that the Nursing department calls him whenever bed rails needed to be installed or removed, but as far as regularly inspecting them for maintenance, he does not do them. Staff #55 further stated, we are guilty with that, we didn't know we were supposed to do that.</p> <p>On 5/31/24 at 4:09 PM, the concern that regular inspection of the bed and bed rails were not being done was discussed with the Nursing Home Administrator (NHA), Director of Nursing, and Assistant Director of Nursing. The NHA indicated that Staff #55 might have misunderstood the question because she recalls going around the units and taking measurements of resident beds and bed rails with Staff #55 a few weeks prior to the start of the survey. The NHA also indicated that she would provide the documentation from the inspection she had done with Staff #55.</p> <p>On 6/3/24 at 11:46 AM, the Director of Quality (Staff #11) came to see the surveyor and reported that the NHA is out of the facility and asked if there was anything that the surveyor needed. The surveyor explained the prior conversation with the NHA regarding bed rails and the documentation she was supposed to provide the surveyor. Staff #11 indicated that she would collect the documents as discussed.</p> <p>(continued on next page)</p>		

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<p>F 0909</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Later that day at 2:03 PM, Staff #11 provided the documents titled Bed Rail Safety Inspection and reported that they were done by Staff #55. A review of the documents revealed that the inspection was all done on the same day (6/3/24). Staff #11 was interviewed about the inspection and confirmed that it was not being done prior to the start of the survey and stated, You're looking for what was done in the past right? It was not done.</p> <p>At the time of the survey exit conference on 6/4/24 at 5:10 PM with the facility staff, including the NHA who joined via phone conference, the concern that the facility was not conducting regular inspection of resident beds and bed rails was brought up and no further comments or documentation was provided by the facility.</p>