STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215110	A. Building B. Wing	12/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Western MD Hospital Center	1500 Pennsylvania Avenue Hagerstown, MD 21742

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on interviews it was determined that the facility failed to employ a qualified food service director. This was found to be evident for the one food service director and has the potential to affect all residents. On 11/20/25 the Food Service Director (FSD #13) confirmed that he is not a Certified Dietary Manager (CDM). The FSD reported he has taken the class and is eligible to take the exam but was not yet scheduled for the test. On 11/21/25 at 12:51 PM the FSD reported the facility has a dietitian (#11) who they consult and contact for guidance. On 11/21/25 at 12:51 PM interview with the dietitian revealed she works at the facility 20 hours per week conducting primarily clinical work such as nutritional assessments. The dietitian reported she does answer kitchen questions as needed but confirmed she is not involved in the day-to-day running of the kitchen. On 11/21/25 at 2:50 PM surveyor reviewed with the Nursing Home Administrator the concern regarding the failure to have a qualified food service director. As of time of survey exit on 12/2/25 at 1:50 PM no documentation was provided to indicate the current food service director had the required credentials.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview it was determined that the facility failed to ensure staff identified when the automatic dishwasher was in need of maintenance and repair, and failed to ensure containers used for food preparation and service were stored in a sanitary manner. This was found to be evident during 3 out of 3 observations made in the kitchen during the survey and has the potential to affect all residents.The findings include: 1.On 11/19/25 at 8:45 AM surveyor started the initial tour of the kitchen. Dietary Clerk (#14) informed the surveyor that the Food Service Director was not working today and indicated she would get a supervisor. During this tour the surveyor observed the automatic dishwasher was running and the final rinse temperature was ranging between 192-200 degrees F. The Food Service Supervisor (FSS #12) arrived during this observation and reported the staff have no control over the temperature of the dishwashing machine. The surveyor then observed the final rinse temperature was 205 and this reading was confirmed by FSS #12.On 11/19/25 at 12:45 PM surveyor discussed with Dietary Clerk (#14) the final rinse temperature being above 200 and the concern that if the temperature is too high the water would evaporate before the rinse was completed. The Dietary Clerk (#14) indicated she would contact the dishwasher manufacturer.Review of the operation manual for the dishwasher revealed the minimum temperature for the rinse cycle was 160 and the final rinse was 180.On 11/20/25 the surveyor addressed the concern regarding the dishwasher final rinse temperature with the Food Service Director (FSD #13), who stated he did not know the temperature could be too high and indicated he would contact the manufacturer.On 11/21/25 surveyor obtained a copy of the Dishwasher Temperature Log from the main dishwasher area from the FSD #13. Review of this log revealed the final rinse temperature was recorded as being at or above 200 degrees on 45 out of 61 occasions.On 11/21/25 at 2:18 PM surveyor and the FSD #13 observed the dishwasher while it was running. The rinse temperature maxed at 155 and the final rinse temperature reading went as high as 218 then dropped to 199-202. The FSD confirmed that he had not yet contacted the manufacturer.On 11/21/25 at 2:25 PM surveyor reviewed the potential concern regarding the final rinse temperature being too high with the FSD. He indicated he would tell the Maintenance Director that the rinse was not high enough and the final rinse may be too high.On 11/21/25 at 3:10 PM the Maintenance Director #1 provided an update to surveyor regarding the dishwasher, stating : you are correct. The Maintenance Director reported that he had spoken with the manufacturer, and they confirmed the Rinse should be at 160, ours is getting to 155; and final rinse should be 180 and that our machine is too high. The Maintenance Director also reported that the manufacturer would be coming out to the facility the following week and they had indicated that it could just be that a sensor was wrong. Surveyor discussed the concern that no one at the facility had identified this as a potential concern, despite staff documenting the final rinse temperature at or above 200 on multiple occasions.On 12/2/25 at approximately 1:45 PM the facility provided a copy of the [Manufacturer] Service Repair Estimate Summary, dated 11/25/25. Review of this document revealed Summary of Work: needs new final rise sprayers because they are clogged.2.During the 11/19/25 initial kitchen tour that was started at 8:45 AM, surveyor observed, with FSS #12, shelving near the three compartment sink that contained metal pans like those used to store food during the tray line service. A small amount of water was observed in 2 out of the 3 nested metal pans observed. The practice of storing dishes prior to being completely air dried is known as wet nesting. Wet nesting creates conditions in which microorganism can grow.On 11/20/25 at 11:57 AM surveyor and the FSD #13 observed the shelving near the three-compartment sink. Three out of three of the metal pans were found to be dry, but one out of one large plastic nested container observed revealed water was present.On 11/21/25 at approximately 12 noon the FSD #13 reported they had ordered a new drying rack for the dish pan area to address the problem with the wet nesting in that area.

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. Based on interview and record review it was determined that the facility failed to ensure that resident personal funds accounts were held in an interest-bearing account. This was evident for 1 resident (Resident #51) of 4 residents who had personal funds accounts held by the facility.The findings include:During the initial screening resident interviews on 11/19/25, one resident (Resident #35) indicated that he/she had a personal funds account at the facility. When asked if he/she received periodic statements, the resident stated he/she was unsure. This triggered an investigation of the facility task for Personal Funds.As part of the Personal Funds task investigation, on 11/24/2025 at 12:10 PM, the facility was asked to provide a list of all residents who had personal funds accounts. On 11/24/2025 at 1:06 PM two lists were provided by the Fiscal Accounts Technician (Staff #8). One list had 12 resident names listed in one column and the other column titled BANK had the notation PNC for each resident. The other list had 4 resident names listed in one column and in the column titled BANK had the notation HOUSE. Staff #8 explained that the list which indicated the bank was HOUSE meant that those resident funds were kept by the facility.On 11/24/2025 at 3:05 PM another interview was conducted with Staff #8. When asked if any of the in house accounts earned interest, she said she was not sure. The surveyor requested copies of the in house resident personal funds statements. On 11/24/2025 at 3:32 PM Staff #8 provided the requested statements of accounts and was interviewed as the four account statements were reviewed. One of the statements (Resident #51) had a balance of over $100. Resident #51's statement was opened on 12/01/21 with an opening balance of $500. There were two deposits: $60 on 1/06/23, and $40 on 5/15/23. Resident #51's statement did not include any withdrawals or earned interest, and the ending balance was $600. When asked about earned interest, Staff #8 said she thought that if the facility held the account, no interest was paid.On 11/25/25 in the afternoon an interview was conducted with the Nursing Home Administrator (NHA) to review the finding that 1 resident who qualified to have an interest-bearing account had not earned interest on their balance which was over $100. The NHA said that he was unaware that interest needed to be paid on that account.On 11/25/25 at 3:40 PM the Fiscal Services Chief was interviewed to review that the facility failed to pay interest on facility-held personal funds accounts for 1 of 4 residents. No further information regarding these accounts was received by the end of the survey.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record reviews and interviews, it was determined that the facility failed to ensure as needed (PRN) orders for psychotropic medications were limited to 14 days. This was evident for 1 (Resident #5) of 5 residents reviewed for unnecessary medications. The findings include: Resident #5 was admitted into the facility in mid-2025. Diagnosis includes but is not limited to schizoaffective disorder.Schizoaffective disorder is a mental health condition that combines symptoms of both schizophrenia, like hallucinations and delusions, and a mood disorder, such as bipolar disorder or depression. Symptoms include psychotic features and significant mood shifts that are intense enough to cause distress or interfere with daily life. Treatment typically involves a combination of medication and counseling to manage these complex symptoms. A review of Resident #5's medical record on 11/20/25 at 1:28 PM, revealed that s/he was taking an antipsychotic medication routinely and on a as needed (PRN) basis. The PRN antipsychotic medication order had a start date of 11/14/25. However, the order did not indicate a stop date for the medication.The Director of Nursing (DON) was interviewed on 11/24/25 at 10:09 AM. During the interview, she explained the facility's process with psychotropic medications (Including antipsychotic medications) noting that when these medications are prescribed on a PRN basis, they put a 14-day limit for its use.A copy of the facilities policy for psychotropic medication monitoring and assessment was provided and reviewed with the DON on 11/24/25 at 10:30 AM. The review revealed that PRN psychotropic medications are limited to 14 days.The [NAME] was asked to look up Resident #5's medical orders, specifically the PRN antipsychotic medication on 11/24/25 at 10:31 AM. She confirmed that the order did not indicate a limit and/or end date. The concern was discussed that the facility failed to ensure PRN orders for psychotropic medications were limited to 14 days. the DON acknowledged the concern.A subsequent review of Resident #5's medical record on 11/25/25 at 3:24 PM revealed that the PRN antipsychotic medication order had been discontinued on 11/24/25 at 2:03 PM.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, record reviews and interviews, it was determined that the facility failed to ensure residents with pressure injuries receive appropriate services for treatment and prevention. This was evident for 1 (Resident #7) of 2 residents reviewed for pressure ulcer/injury. The findings include: Resident #7 was admitted into the facility in late 2020 with diagnosis that include unstageable pressure ulcers of the left and right buttocks, Alzheimer's disease, and type 2 Diabetes melllitus. A review of the resident's medical record on 11/19/25 at 1:28 PM indicated that the resident currently had pressure ulcers.On 11/19/25 at 3:45 PM, an observation was made of Resident #7 being transferred by 2 staff using a mechanical lift, from a wheelchair to the resident's bed. The resident's bed was equipped with an air mattress with its controls located at the foot of the bed. The air mattress control indicated that it was set to alternating and on max weight setting of 400 lbs.A subsequent review of Resident #7's medical record on 11/20/25 at 11 AM revealed that his/her most recent weight was 115.8 lbs. taken on 11/19/25 at 9:43 AM.On 11/21/25 at 3:03 PM, Resident #7 was observed in bed with the air mattress setting still at 400 lbs.The Registered Nurse (RN #10) currently assigned to Resident #7 was interviewed regarding the use of air mattresses on 11/21/25 at 3:05 PM. During the interview, RN #10 explained that her usual practice is to ensure that the mattress is on and inflated during her shift. She did not indicate that she checks the weight setting to confirm that it is appropriate to the resident's weight. RN #10 was asked to accompany the surveyor to Resident #7's room on 11/21/25 at 3:10 PM. At this time, RN #10 confirmed the resident's air mattress weight setting to be 400 lbs. RN #10 reported that she did not know the resident's weight but indicated that it was not 400 lbs. RN #10 indicated that the facility's wound nurse (RN #4) was responsible for setting up and ensuring settings for use of air mattresses were appropriate to the residents. RN #4 Was interviewed on 11/21/25 at 3:17 PM. During the interview, she reported her process with air mattresses and indicated that choosing the appropriate air mattress was also based on the resident's weight. She also reported and confirmed that she was responsible for ensuring the residence is weight matched the setting for the air mattress.RN #4 conducted an observation of resident #7 with the surveyor on 11/21/25 at 3:25 PM. During the observation, RN# 4 confirmed the resident's mattress setting to be 400 lbs. and stated, It obviously needs to be adjusted. RN #4 reported that she sees the resident 1-2 times per week for wound management and part of that is to ensure that the bed settings are appropriate. RN #4 stated, it got missed referring to checking the resident's mattress settings. The concern was discussed with the Director of Nursing (DON) on 11/24/25 at 11:12 AM that Resident #7's mattress setting was not appropriate for prevention and treatment of pressure ulcers/injuries. The DON acknowledged the concern.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview it was determined that the facility ownership failed to ensure identified issues with the roof were repaired. This was found to be evident on one of the three nursing units observed.The findings includeOn 11/19/25 at approximately 11:15 AM surveyor observed on the 2 East hallway, across from room H E232, that one of the ceiling tiles was askew with a gap running the length of the tile. A clear plastic tube about 1.5 inches in diameter was extended from the ceiling down to a large (approximately 3 feet tall) metal can with a green liner and a sign that read: THIS CAN IS NOT FOR TRASH !!!. The can was sitting on a white bath towel.A resident was assigned to the H E232 room at the time of the survey.On 11/19/25 at 2:06 PM the Maintenance Director (#1) reported that there was a roof leak on 2 East and when it leaks water drips and that whole section of floor gets wet. In regard to the tubing and the can, he reported about a year or so ago they established this system so the water would funnel into the can rather than the floor and risk someone falling. He indicated they check the can about once a week.The Maintenance Director went on to report the issue with the roof has been going on for seven years and that funding has not been approved for a new roof. He reported that the Department of General Services (DGS) has inspected but they have not approved the money yet.On 11/21/25 at 2:50 PM the surveyor reviewed with the Nursing Home Administrator (NHA) the concern regarding the leaking roof and that the facility should be in good repair. The NHA re-iterated the Maintenance Director's report that they are waiting on approval of funding; and confirmed that he has seen the tube coming down from the ceiling.On 12/2/25 at approximately 1:45 PM the facility provided documentation to support that they have been attempting to obtain approval to initiate repairs on the roof for several years. This documentation included a Project Justification Form FY 25 , with a date of 1 [DATE], to replace the entire roof; a Project Manual for Roof Replacement from the DSG dated 1/8/24, as well as multiple emails from the facility to DGS since December 2023. No documentation was found to indicate a request for bids had been initiated.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observations and interviews, it was determined that the facility failed to ensure nurse staffing information was posted on a daily basis. This deficient practice was evident for 7 of the 8 days of the recertification survey.The findings include: The facility lobby was observed on 11/19/25 at approximately 8:30 AM. During the observation, it was noted that a whiteboard was in the central area of the lobby that indicated the facility name, current date, and census of each unit of the facility. However, there was no indication of the staffing information.The assistant Director of Nursing (ADON) was interviewed about the federal regulation about posting the nurse staffing information, on 12/1/25 at 3:11 PM. The ADON referred to the whiteboard located in the facility's lobby and reported that they used to post on that whiteboard the complete schedule, including staff names. He indicated that they stopped posting the staffing information since it became a safety concern, as a resident's family member started looking up staff names in social media platforms.The ADON also reported that staffing information is posted in each unit of the facility in front of the nursing stations.On 12/1/25 at 3:31 PM, during an interview with the Nursing Home Administrator (NHA), he confirmed that the facility had stopped posting the staffing information on the whiteboard in the facility lobby. He indicated that this practice was started in November 2025. The concern was discussed with the NHA that federal regulation requires the facility to post daily, the facility's staffing information in a prominent place readily accessible to residents, staff, and visitors. The NHA verbalized understanding and acknowledged the concern.On 12/2/25 at 10:25 AM, an observation of the whiteboard in the facility's lobby revealed a printed paper was posted on it that indicated the facility name, current date, facility census, and staffing hours of corresponding licensed and unlicensed staff.