

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215198	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Williamsport Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 154 North Artizan Street Williamsport, MD 21795	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0585</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 voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>40927</p> <p>Based on interview and record review it was determined that the facility failed to have a process to ensure that all grievances were investigated and received a response in a timely manner. This was evident for 2 (#87 and #95) of 2 residents reviewed for the grievances.</p> <p>The findings include:</p> <p>1) During an interview with the Director of Nursing (DON) on 4/2/25 at 8:08 AM, she reported that Resident #87 had requested to speak with a surveyor. The DON reported that this resident had an ongoing complaint about the number of staff assigned to the unit. She stated that when the resident used his/her call light, they expected it to be answered right away. She stated that when she had pulled the audit reports the resident's wait time was about 16 minutes. The DON stated they offered the resident a room change, but s/he had declined.</p> <p>An interview with Resident #87 on 4/2/25 at 8:46 AM, revealed that s/he had concerns with the number of staff assigned to their unit because s/he waited extended times for call light response. When asked if the resident had reported this concern to facility staff, the resident stated s/he had multiple times, but they did not listen.</p> <p>The extended wait time for call lights was confirmed on 4/2/25 at 10:00 AM when a review of the call bell audits for 3/20/25 - 4/1/25 was conducted. Resident #87 waited 30 minutes to 3 hours for his/her call light to be answered.</p> <p>A subsequent interview with the DON on 4/2/25 at 12:43 PM DON revealed she was not sure she had written a grievance regarding the resident's complaints about staffing and call light response times. She stated she does not write a grievance when she can immediately fix the issue.</p> <p>The DON confirmed that she had not written a grievance for Resident #87's concerns regarding staffing and call light response times at the time of exit on 4/3/25 at 3:00 PM.</p> <p>2) A review of the facility's Grievance Logs for the last 3 months revealed that on 1/5/25, Resident #95 reported a long wait time for a call light response during a meal. Per the report form this was not addressed or responded to by the facility.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 215198
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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Another grievance form dated 1/13/25, read that Resident #95 had turned on his/her call light at 5:30 PM and by 7:30 PM the resident started calling out to staff because no one answered it. The facility educated the staff member assigned that evening, however failed to show the incident had been investigated to determine the root cause and implement a plan of correction.</p> <p>At the time of these grievances the call bell system did not have a mechanism to run call bell audits. However, a review of the current call bell response times for Resident #95 on 4/2/25 at 10:00 AM revealed that the bathroom call light had rang for 1.5 hours on one occasion and the resident's call light at the bed rang for 30 - 60 minutes at times.</p> <p>An interview with the Social Services Associate #16 on 4/2/25 at 1:46 PM revealed she would make a copy of the grievance form and given to the appropriate department head. She confirmed the incident on 1/5/25 was sent to the dietary department, however she was not sure about the nursing department regarding the call light response. She confirmed that the bottom of the form was to be filled out by Social Services staff and then given to the Nursing Home Administrator (NHA) but was unsure if that had been done these two grievances.</p> <p>An interview with the NHA on 4/3/25 at 10:10 AM revealed that the form used to write up the grievances on 1/5/25 and 1/13/25 had been updated when she came in 11/2024. She was unable to provide a rationale for the reason these forms were not completed and the grievances responded to timely. When asked if a resident's concerns about call lights being answered timely should be written as a grievance, such as with Resident #87, she stated it should be because it cannot be resolved immediately.</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42886</p> <p>Based on record review and staff interview; it was determined that the facility failed to protect a resident (resident #59) from misappropriation of personal funds from a facility staff member. This was evident for 1 of 94 residents reviewed during an complaint survey.</p> <p>The findings include:</p> <p>The surveyor reviewed a complaint (MD00186172) sent to the State of Maryland's Office of Health Care Quality in 12/22 alleging that facility staff made unauthorized charges on resident #59's credit card.</p> <p>Medical record review for resident #59 on 3/31/25 at 11:00am revealed the resident was transferred from the facility on 11/3/22 for a change in condition. The resident was expected to return to the facility, so the resident's belongings remained in the facility.</p> <p>On 3/31/25 at 11:20am, The surveyor interviewed the Administrator regarding the allegation of facility staff making unauthorized charges to resident #59's credit card in 11/22. The Administrator provided the surveyor with the facility investigation into the misappropriation of resident #59's credit card.</p> <p>The surveyor reviewed the facility investigation on 3/31/25 at 1:30pm. The investigation that LPN #18 admitted to making unauthorized charges to resident #59's credit card to purchase a \$100.00 Amazon Gift Card when he/she was interviewed by the [NAME] County Sherriff's Office. LPN#18 also admitted that he/she took possession of the resident's credit card and driver License on 11/4/22.</p> <p>Interview with the Director of Nursing (DON) on 4/1/25 at 10:30am revealed that LPN [NAME] was employed with the facility as a agency LPN on 11/4/22. LPN #18 was placed on a do not call/do not return list after the facility became aware of the misappropriation of resident #59's credit card in 11/22. The facility made the agency aware of LPN #18's misappropriation of the resident's credit card and the agency reported LPN #18 to the Maryland Board of Nursing.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>42886</p> <p>Based on medical record review and staff interview, the facility staff failed to provide supervision to prevent an accident (Resident #61) This was evident for 1 of 94 residents reviewed during a complaint survey.</p> <p>The findings include:</p> <p>On 4/14/23, the facility reported an incident (Intake # MD00191371). Resident # 61 received a blister/burn from an incorrectly placed warm compress.</p> <p>Medical record review for resident #61 on 4/1/25 at 8:40am revealed a progress note dated 4/15/23 at 1:45pm which reported that the resident sustained a blister/burn to his/her right lower lateral foot after facility nursing staff applied a resident- requested warm compress.</p> <p>Surveyor review of the facility's investigation of the reported incident on 4/1/25 at 9:30am revealed the nursing staff reported an observed right lateral foot blister measuring 2.5cm x 1.2 cm on 4/15/23. Nursing staff applied a skin barrier ointment to the blister. Resident #61 did not complain of any pain. Nursing staff statement on 4/18/23 reported that the warm compress was applied to resident #61's right foot after request. The warm compress was secured with a ace bandage. There were no observed issues with the resident's skin or complains of discomfort after the application of the compress. The facility investigation also contained a statement of admission that nursing staff failed to monitor condition of the resident #61's skin after the warm compress was applied. The facility investigation also contained a policy dated 5/8/23 which instructs nursing staff on the facility procedure on how to apply a warm compress and expectations on how to monitor for resident safety.</p> <p>The surveyor interviewed the Director of Nursing (DON) on 4/1/25 at 11:40pm regarding the results of the facility investigation regarding resident #61's right foot blister. The DON admitted that facility nursing staff failed to monitor the resident's skin after application of the warm compress. This failure to monitor for the resident's safety led to the creation of new policy for the application and monitoring of warm compresses.</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>40927</p> <p>Based on interview and record review it was determined that the facility failed to ensure that there were enough staff on duty to answer call lights in a timely manner for the residents. This was evident for 2 of 3 complaints for call bell response times.</p> <p>The findings include:</p> <p>1) An interview with Resident #87 on 4/2/25 at 8:46 AM, revealed the resident had concerns about the call light response times. The resident recalled that s/he had waited a few hours for staff to answer his/her call light on a day in the last couple of weeks. The resident could not recall the exact date and thought it occurred between breakfast and lunch. The resident reported s/he needed assistance with incontinence care.</p> <p>The extended wait time for call lights was confirmed on 4/2/25 at 10:00 AM when a review of the call bell audits for 3/20/25 - 4/1/25 was conducted. Resident #87 waited 30 minutes to 3 hours for his/her call light to be answered.</p> <p>2) An interview with Resident #95 on 4/3/25 at 9:01 AM, revealed that s/he had extended wait times when s/he put his/her call light to use the bathroom. The resident reported that at times s/he would not make it to the bathroom before having an accident. Furthermore, once the resident was on the toilet, s/he reported sitting there for an extended time until someone could help him/her back to bed or chair. The resident reported that once staff gave out the meal trays, it was difficult to find any staff if s/he needed ketchup, because no one was around. In addition, on shower days the residents' bed linens were not always changed because staff did not have the time to complete both tasks.</p> <p>During an interview with Geriatric Nursing Assistant (GNA) #16 on 4/3/25 at 8:49 AM, she reported that during breakfast it was hard to answer call lights and get the food out to residents while it was hot. She reported that she had a resident who needed fed and was finishing up breakfast at the time of this interview. GNA #16 reported they had 1 GNA for upstairs, 1 GNA downstairs, and 1 float GNA, but the float GNA had been pulled for another assignment. The GNA stated that some residents will not get their showers until the afternoon because it was difficult to get them done in the morning.</p> <p>On 4/2/25 at 12:08 PM a review of the call bell audits for C wing unit for 3/21/25 - 3/24/25 and 4/1/25 - 4/2/25 revealed there were multiple days and timeframes that residents waited 30 minutes to 3 hours for call light responses. The schedules were reviewed for the corresponding days and determined that they consistently staffed 1 nurse and 2 GNAs per shift. On some shifts they scheduled a Certified Medicine Aid (CMA) to help with medications and some shifts they had a 3rd GNA scheduled.</p> <p>(continued on next page)</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Director of Nursing (DON) was interviewed regarding her expectations for call light response times on 4/2/25 at 12:43 PM. She reported that call lights should be answered within a reasonable timeframe, but no later than 20 minutes. Reviewed the findings of the call light response times. When asked how she determined the level of staffing needed, she stated it was based on the required staff to resident ratios. The DON stated she thought it was ideal to have 3 GNAs on day and evening shift on C wing unit, but at times it was difficult to staff at that level. She reported that on the days there were 2 GNAs the staffing was adequate, and staff should work as a team and provide care. However, when shown the audits for call light responses, she was unable to provide a rationale for the concern.</p> <p>On 4/3/25 at 10:10 AM the call light audits were reviewed with the Nursing Home Administrator. She reported that she did not specify a time frame for answering call lights but expected them to be answered timely. Reviewed the concerns with her.</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>30428</p> <p>Based on the review of a complaint, medical record review and interview with residents and staff, it was determined that the facility staff failed to administer medications to residents without any significant medication errors by inappropriately administering insulin to 2 residents that were not diabetic. This was evident during the review of a complaint that affected 2 of 2 residents during a medication pass.</p> <p>The findings include:</p> <p>Complaint #MD00190191 was initiated on 3/27/25 at 11:31 AM regarding Resident #36. The allegation was that s/he was given insulin on 3/17/23 inappropriately as s/he is not diabetic. According to medical record review at this time, Resident #36 was admitted to the facility over 5 years ago for care related to a kidney/pancreas transplant, Resident #36 is also diagnosed as legally blind and monitored for hypoglycemia. Second, to the transplant, Resident #36 is not considered diabetic and does not take any insulin products.</p> <p>Review of the complaint #MD00190191 on 3/27/25 at 11:40AM revealed an allegation that on 3/17/23 Resident #36 was 'stuck in the arm with a needle without warning.' The complaint further reported that the resident asked the nurse what she had injected into [his/her] arm. LPN #17 reported that she gave Resident #36 the scheduled insulin. Resident #36 stated 'I am not diabetic.' LPN #17 left the room, according to the resident, and returned with a glucose tablet (given to treat low blood sugar).</p> <p>The DON was interviewed on 3/27/25. The facility had not completed an internal investigation into this incident or reported it to the Office of Health Care Quality. The only report that they had was a report to the Board of Nursing regarding the agency LPN #17 who inappropriately gave Resident #36 insulin.</p> <p>Resident #36 was interviewed on 3/27/25 at 12:15 PM regarding the incident. S/he stated that his/her glucose was monitored hourly all day. S/he reported that at first, they could not keep the glucose up, it would go to 115mg/dl, then drop, it was stressful. Resident #36, then stated that s/he was not the only one that this occurred to and named another resident who was inappropriately administered insulin on 3/17/23.</p> <p>Resident #86's medical record was reviewed on 4/1/25 at 12:32 PM. Medical diagnosis for Resident #86 included chronic obstructive pulmonary disease, anemia, dysphagia and heart disease but no diabetes diagnosis.</p> <p>A change in condition note was entered on 3/17/23 at 07:35 AM for Resident #86 noting that the resident stated, I don't know what she gave me, but it was a shot, and she gave it to me in my stomach. Resident #86's glucose was checked and was reading 99mg/dl at the time.</p> <p>Resident #86's glucose too was monitored hourly and treated as needed on 3/17/23.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The letter sent to the Maryland Board of Nursing regarding LPN # 17 stated; 2 residents at our facility insulin incorrectly. Neither resident is to receive insulin, Resident #36 is hypoglycemic, so s/he receives blood sugar checks, but does not receive insulin, Resident #86 is not diabetic at all but [his/her] roommate is. The nurse in question admitted giving Resident #86 the dose of insulin stating that she got the residents mixed up. The nurse in questions stated that she did not give Resident #36 medication, but the alert and oriented Resident maintains that s/he was given insulin in shot form.</p> <p>The concerns for the significant medication errors were reviewed with the facility Administrator and the DON throughout the survey and again with the DON on 4/3/25.</p>		