STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215198	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Williamsport Nursing and Rehabilitation Center	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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. (continued on next page)

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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record reviews and interviews, it was determined that the facility failed to honor the resident's/resident representative's right to access personal and medical records. This was evident for 1 (Resident #133) of 2 residents reviewed for neglect. The findings include:A review of the intake information related to MD00217274 indicated that Resident #133's representative had requested medical records after the resident's death and was wrongfully denied the request.In an interview with the resident representative on 7/17/25 at 12:31 PM, s/he reported filling out a medical records request form at the front desk of the facility. Then after some time, had received a phone call from a facility staff informing him/her that the request was denied and no further explanation was provided.The Director of Nursing (DON) was interviewed on 7/23/25 at 2:16 PM. During the interview, she reported the process to request medical records and indicated that a record request form is filled out and submitted to the medical records coordinator (Staff #44) to be processed.On 7/23/25 at 2:45 PM, Staff #44 was interviewed. During the interview, she reported that she had been with the facility since February of 2025. She also provided a copy of the records request form to the surveyor and reported that she kept the filled-out forms for her records.When Staff #44 was asked about resident #133, she immediately pulled out the record request form that was filled out by the resident representative dated 4/28/25 and indicated that the DON had already informed her of what the surveyor was looking for. Staff #44 reported that the medical records request was denied because the representative only had a financial Power of Attorney (POA) and was ultimately decided by a third-party company (Rytes company) that the representative lacked the clearance to obtain the medical records.Staff #44 further explained the process for records request, indicating that once the form is filled out, she sends them to Rytes company via email for determination, then after Rytes company reviews the request and the resident's medical record, they would inform Staff #44, via email, if the records can be released.Staff #44 provided the surveyor with a copy of the email received on 4/29/25 from Rytes company, addressed only to her, stating records could not be released due to: The request lacks supporting documents demonstrating that the person signing the authorization and/or making the request is the personal representative of the resident and has the authority to request/release medical records. Qualifying documents could include a power of attorney for healthcare, health care surrogacy or proxy, guardianship document or advanced directive. Instructions on the email stated, In the event that you have additional relevant documents in your file, please provide to Rytes by responding to this email with the additional documents.Subsequently, Resident #133's medical records were reviewed with Staff #44 on 7/23/25 at 2:58 PM. The review revealed the resident's advanced directive with an upload date of 3/19/25, that stated the representative's name as appointed POA for healthcare in the event that the resident cannot make healthcare decisions him/herself. Staff #44 reported that she did not see the advanced directive because she does not review resident records. She indicated that she solely relies on Rytes company to figure that out.On 7/23/25 at 3:41 PM, the findings were discussed with the Regional Director of Clinical (Staff #9). Staff #9 confirmed that both Rytes company and Staff #44 had complete access to Resident #133's medical record that included the advanced directive.Staff #9 agreed that based on the advanced directive, the representative should have been deemed eligible for the medical records request by Rytes company. Also, the medical records coordinator should have reviewed Resident #133's medical record and provided the advanced directive document to Rytes company, as instructed in the email and inform the Director of Nursing and Nursing Home Administrator. Staff #9 verbalized understanding of the concern and stated, I will contact Rytes and find out what happened.On 7/24/25 at 8:56 AM, Staff #9 reported that she had talked to staff from Rytes company and investigated the concern. They indicated that they had made a mistake and were looking at the wrong resident. Staff #9 indicated that she had instructed Staff #44 to contact Resident #133's representative about providing the medical records as initially requested.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, it was determined that the facility failed to protect residents from verbal and psychosocial abuse. This was evident for two (Resident's #13 and #52) out of six residents reviewed for abuse.The findings include:1. Resident #13 has a medical history of heart failure, type 2 diabetes, chronic kidney disease, anxiety, and depression.On 7/15/2025 at 2:06 PM, the surveyor reviewed Facility-Reported Incident (FRI) #335325 in which Resident #13 alleged they were subjected to verbal and emotional abuse. The facility investigated the allegation and substantiated findings of verbal and psychosocial abuse by a nursing assistant (GNA #20).According to the facility report, Resident #13 stated that GNA #20 consistently acted rudely, refused to assist, stated she did not have time to help, and told the resident to stop going home because all [you] do is fall. The facility investigation included a statement from GNA #20, who admitted to making inappropriate comments, including that other staff avoided caring for the resident and would ask to switch assignments. Specifically, GNA #20 stated, People [other GNAs] ask to switch [assignments] with me and make me take [Resident #13]. Another staff member, GNA #39, corroborated the abuse, stating that she heard GNA #20 say to Resident #13, This is why no one comes in [your room] and no one likes you.On 7/16/2025 at 8:51 AM, the surveyor interviewed Resident #13 regarding the incident. The resident stated that GNA #20 told them that they were disliked by both staff and other residents and alleged that the GNA ignored their call bell in retaliation. Resident #13 further stated that the GNA called them ugly and that the verbal abuse caused them to cry. They initially responded with anger but later became emotional, stating, I cussed them out, but then I cried-it was really hurtful. The resident reported that GNA #20 resigned while under investigation. Resident #13 stated, I used to be fearful to be here, but things have improved.On 7/21/2025 at approximately 2:00 PM, the surveyor interviewed the Nursing Home Administrator (NHA) regarding the facility's process for handling allegations of abuse. The NHA explained that any staff member accused of abuse is immediately suspended pending an internal investigation, which includes collecting written statements from staff and other residents and conducting a full examination and assessment of the involved resident. When asked about the incident involving Resident #13, the NHA confirmed familiarity with the case and stated that the employee no longer worked at the facility. The surveyor explained that despite the investigation and reporting being completed, the incident still constituted a deficiency, as the facility failed to prevent the abuse from occurring. The NHA verbalized understanding.2. Resident #52 has a history of insulin-dependent type 1 diabetes, heart failure, asthma, chronic obstructive pulmonary disease (COPD), anxiety, depression, syncope (fainting), and chronic pain.On 7/15/2025 at 1:56 PM, the surveyor reviewed Facility-Reported Incident (FRI) #335296, in which Resident #52 alleged verbal and psychosocial abuse. The facility investigated and determined the allegations were substantiated for both verbal and psychological abuse.According to the complaint, Resident #52 reported to the evening shift nurse supervisor (Nurse #40) that another nurse (Nurse #38) made threatening and inappropriate comments. Specifically, the nurse reportedly said, Be careful how you treat people who are going to be giving you insulin.Review of the facility's investigation revealed that the facility believed Nurse #38's statements were considered threatening and intimidating. The facility's report stated: The facility concludes that employee [Nurse #38] was in violation of abuse. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes deprivation by an individual, including a caretaker, of goods or services necessary to maintain physical, mental, and psychosocial well-being.The report further detailed specific statements made by Nurse #38 that supported the abuse finding, including: Cursing in the hallway is not going to get me to you any sooner, and If it were me and I wanted my medication, I would be a little nicer. The facility determined that these remarks were delivered in a tone and manner that could cause fear and intimidation, especially given that the resident was dependent on the nurse for critical medications. The report noted that Resident #52 explicitly asked the nurse, Is that a threat? and expressed feeling fearful because of the interaction.On 7/15/2025 at 2:49 PM, the surveyor interviewed Resident #52, who stated, They fired the person that threatened to withhold my medications. I feel safer now that he is gone.On 7/21/2025 at 1:47 PM, the surveyor interviewed Resident #52 and their spouse. The spouse, tearfully, stated they [the spouse] were in constant anguish worrying over the care [Resident #52] is receiving and expressed ongoing concern for the resident's safety. They further stated that they were fearful to report issues for fear that [Resident #52] will be retaliated upon.On 7/21/2025

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on record review and staff interviews it was determined that the facility failed to ensure Geriatric Nursing Assistants (GNAs) received an annual performance review and 12 hours/year of in-service training for 2 (GNA #20 and GNA #21) out of 2 employee records reviewed during the survey.The findings include:Geriatric Nursing Assistants (GNA) require a performance appraisal to be completed at least every 12 months to identify the potential for and receive at least 12 hours/year of in-service education. On 7/23/25 between 1:00 and 4:00 PM six employee training records were reviewed. On 7/24/25 at 9:18 AM in an interview with the Director of Nursing (DON) it was revealed that the facility uses Relias, an online training and education application. It was also revealed that the Staff Development Coordinator (SDC) tracks employees’ compliance of the training required. On 7/24/25 at 9:31 AM in an interview with the SDC (RN #19) it was revealed that her position was started in April 2025. She acknowledged that it was her responsibility to track staff compliance via Relias. On 7/24/25 at 1:00 PM, the DON acknowledged that the employees’ files lacked documentation of required annual performance reviews and 12 hours/year in-service for calendar years 2022-2025 and that she could not locate further documentation otherwise. This concern was communicated to the DON.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview, and record review it was determined that the facility failed to post nursing staffing data on a daily basis and failed to ensure 18 months of posted nursing data were retained. This was evident for 5 of 5 nursing units.The findings include:On 7/15/25 at 8:00 AM surveyors entered the facility and observed a posted nursing staffing document at the receptionist's desk that was dated 7/10/25. The receptionist was questioned about the posting date and said she would provide an updated posting. Within the hour an updated nursing staff posting document was provided that indicated it was for 7/15/25.On 7/24/2025 at 12:14 PM an interview was conducted with the Director of Nursing (DON) to review that the daily nursing staff posting on 7/15/25 displayed data for 7/10/25. She explained that the Staff Scheduler (Staff #) posted that information and that she did not work weekends. However, she concurred that 7/15/25 was a Tuesday and that the posting for that day was not present. When the DON was asked for copies of nursing staff posted data for the previous six months, she said that the facility did not keep records of the daily nursing staff posting. She further explained that the facility's previous ownership had kept the records electronically and she did not have access to that information. She confirmed the deficiency that the facility did not post nursing staff daily and did not retain records of the nursing staff posting.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on pertinent document review and interview it was determined that the facility failed to provide the residents with medications as ordered by the physician. This was evident for 1 Resident (resident #135) out of 4 residents reviewed for neglect during a survey. The findings include: On 7/22/25 8:00 the Review of a complaint submitted from a county agency revealed a concern that Resident #135 did not receive her/his medications on time.On 7/22/25 at 10:10 AM the surveyor requested the medication administration audit for Resident # 135 for the following dates: 2/26/25 through 3/03/25 07/22/2025 11:31 AM the Nurse Unit Manager (Staff # 8) was interviewed. She provided interpretation of the medication administration audit. She reported that the first column indicated what time the medication was ordered the second column indicated what time the medication was administered.On 7/22/2025 11:22 AM a review of the audit included but was not limited to the following medications not being administered according to professional standards. Medication: hydroxyzine HCL Oral Tablet, give 1 tablet by mouth every 6 hours for anxiety for 14 days. Ordered administration time 12:00 PM 3/1/25. The medications was administered at 2:02 PM on 3/1/25. An additional dose of hydroxyzine HCL was ordered to be administered at 6:00 PM. However, it was administered at 3:39 PM, less than 2 hours from the first dose. On 7/22/25 1:05 PM during an interview the Assistant Director of Nursing (ADON), (Staff #29) confirmed that medications administered greater than 1 hour before or 1 hour after the ordered administration time were considered too early or too late. The surveyor and ADON reviewed the medication audit sheets that were provided. The ADON confirmed that Hydorxyzine was administered less than 2 hours from its previous doses, which is a medication error.On 7/22/25 11:30 Further review of the Medication Administration audit included, but were not limited to the following medications which were administered late;1.On 2/26/25 Resident # 135 had an order for Doxycycline Monohydrate 100mg capsule (antibiotic) to be administered at 8:00 AM and 10:00 PM for pneumonia, However the medication was documented as administered at 12:00PM. 2. On 2/26/25 Resident # 135 had an order for Entresto oral tablet 0.5 tablet by mouth two times a day for atrial fibrillation to be administered at 8:00 AM, however the documented time of administration was 11:07 PM. 3. On 2/26/25 Resident #135 had an order for Trimethoprim oral tablet 100 mg by mouth once a day for urinary tract infection to be administered at 8:00AM, However, the medication was administered at 11:08 PM4. On 3/1/15 Resident #135 had an order for Entresto oral tablet 0.5 tablet by mouth two times a day for atrial fibrillation to be administered at 8:00 AM, however the documented time to administration was 11:27 PM.On 7/24/2025 at 1:11 PM the above concerns were shared with the Director of Nursing. She confirmed the above listed medications were not administered as ordered.