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	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Williamsport Health 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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on record review and interview, it was determined that facility staff failed to provide residents with their right to privacy of personal information by holding care plan meetings in their rooms with roommates present. This was evident for 1 (#3) of 1 resident reviewed for privacy concerns. The findings include: On 12/3/25 at 9:52 AM a review of a complaint received by the state agency (SA) on 8/15/25 revealed that Resident (R)3 had a care plan meeting that was held in his/her room with the roommate present. The complainant reported that the roommate made a comment during the meeting to indicate that they were listening. The complainant reported that when it was brought to the attention of the staff holding the meeting, they were informed that this was how they conducted the meetings since COVID 19 pandemic. On 12/8/25 at 3:59 PM a review of the letter sent to R3's representative regarding the care plan meeting revealed that it specifically stated that the meeting was to be held in the resident's room. In addition, it was noted that the meetings were 20 minutes in length. An interview with the Director of Social Services on 12/8/25 at 3:23 PM revealed that care conferences for residents in the short-term rehab units were held in their rooms. She stated the way the rooms were laid out it afforded them more privacy than the residents on the long-term care units (LTC). After discussing the layout of the rooms in the rehab unit she agreed that it may not be private enough to hold a care plan meeting. She agreed that the rooms on the LTC were not private enough, especially if there was a roommate present. She stated that they just started placing rehab residents on the LTC unit. An interview on 12/8/25 at 3:59 PM with Social Services Staff #16 confirmed that R3's care plan meeting was held in his/her room on the LTC unit. She stated the roommate was present and they had pulled the curtain for privacy. She stated she was accustomed to holding short-term rehab resident's care plan meetings in their rooms that she had not considered the lack of privacy for R3. She reported that the family brought it up but it was at the end of the meeting. On 12/10/25 at 2:31 PM the concerns were discussed with the Director of Nursing (DON) and the Nursing Home Administrator (NHA) who agreed that the residents' rooms were not the appropriate location to hold a care plan meeting unless the roommate was out of the room.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, it was determined that facility staff failed to maintain a clean and homelike environment for their residents. This was evident for 1 (Unit A) of 2 units observed for cleanliness. The findings include: An observation on 12/1/25 at 12:04 PM of the A unit revealed in rooms [ROOM NUMBERS] the floor was carpeted and visibly soiled near the doorway. There was debris on the floor. A second observation on 12/9/25 at 2:29 PM revealed several rooms had crumbs and debris on the floor and in the hallway. room [ROOM NUMBER] A, 214 A and B, 216 A and B had crumbs and debris under the beds. In the hallway outside room [ROOM NUMBER] and 219 there was debris scattered. The door to the room with the ice chest had a cup lid laying in the corner to the left of the door. On 12/8/25 at 10:25 AM an interview with Environmental Director (ED) revealed that housekeeping staff were responsible for ensuring that the residents' room floors and unit hallways were free of debris. She reported that through her weekly quality checks she had identified that the housekeeper responsible for unit A had not been keeping the floors clean on the unit. The employee was disciplined, but there continued to be an issue. When asked what she determined was the issue, she reported that it was a lack of time management skills. The concerns were reviewed with the Nursing Home Administrator at the time of exit on 12/10/25 at 2:30 PM.

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview it was determined that the facility failed to have a process in place to ensure that residents' choice to not have cardiopulmonary resuscitation (CPR) was honored. This was evident for 2 (#8 and #7) of 2 residents reviewed for advanced directives. As a result of these findings, a state of immediate jeopardy (IJ) was declared on [DATE] at 3:20 PM and an IJ summary tool was provided to the facility at that time. The facility submitted the first draft of their plan to remove the immediacy on [DATE] at 4:43 PM and it was not accepted. The facility submitted a second draft at 5:35 PM, and it was not accepted. The third draft was submitted on [DATE] at 6:16 PM and the facility's written plan to remove the immediacy was accepted on [DATE] at 6:31 PM with an alleged date of compliance of [DATE]. After removal of the immediacy, the noncompliance was determined to continue with a scope and severity of F. The findings include:On [DATE] at 9:55 AM an interview with Unit Manager (UM) #13 revealed, the facility had no procedure in place to inform staff where they were to look for residents' Maryland Orders for Life-Sustaining Treatment (MOLST) forms in the medical record.An interview with LPN #5 on [DATE] at 9:49 AM revealed that the code status was on the information bar in the resident's record, the MOLST forms uploaded in the documents in the miscellaneous tab, and it was on the daily assignment sheets used by the nurses. He stated he preferred to look at the actual MOLST.An interview with Registered Nurse (RN) #6 on [DATE] at 9:52 AM revealed that the code status was on the information bar in the resident's record or she looked at the MOLST form that was uploaded in the documents under the miscellaneous tab. RN #6 stated that it took a little while to retrieve the information since it was only on the computer.1. A medical record review for Resident # 8 revealed in the miscellaneous tab two active MOLST had been uploaded. The MOLST dated [DATE] documented the resident wished to be a full code and it was not voided and the title did not indicate voided. On [DATE] Medical Record (MR) #14 uploaded a new MOLST dated [DATE] that documented the resident did not want CPR to be performed. Also she uploaded a copy of the [DATE] MOLST which had been voided. However, she failed to remove the active [DATE] MOLST. Further review of the medical record revealed a progress note dated [DATE], that documented the resident was found unresponsive and CPR was initiated. Staff failed to document the time CPR was initiated. On [DATE] at 8:43 AM, Emergency Medical System (EMS) staff arrived and the resident was pronounced dead at 8:44 AM.On [DATE] at 4:26 PM an interview with LPN #1, who was assigned to the resident that day, revealed she had no memory of the incident.During an interview with Licensed Practical Nurse (LPN) #3 she confirmed that R8 received CPR until EMS staff arrived. She stated that when the paperwork was brought to EMS to take the resident to the hospital it was discovered the resident's wish was no CPR and the code was stopped. She stated that she called the previous Director of Nursing (DON) #2 and they did a whole house audit to ensure only one active MOLST was in the residents' medical record.An interview with the previous DON #2 on [DATE] at 4:41 PM revealed she investigated the incident. She reported there were 2 active MOLST in the document section of the medical record and there were 2 physician orders that populated to the code status on the information bar on the resident's medical record.One order stated the resident was a full code and the other stated no CPR.She reported that she asked LPN #3 to conduct a whole house audit that day, she wrote a performance improvement plan (PIP), and education was provided to staff.On [DATE] at 12:10 PM a review of the audit report revealed there were other residents identified who had more than one active MOLST on their record and conflicting code status orders. Review of the Performance Improvement Plan revealed that they reiterated the MOLST process and clearly outlined whose role and what their responsibilities were. A review of the process revealed the provider was responsible for changing the orders in the computer when the MOLST was updated and to void the previous order. The provider was to give the new MOLST and the voided MOLST to medical records during the week and to the Supervisor on the weekend, and they were responsible to upload the documents in the medical record. Nurses on the unit were responsible for a second check that both matched and for alerting the DON or ADON to delete the previous active MOLST from the medical record. A review of the education provided revealed that not all nursing staff were educated regarding the process. On [DATE] at 12:49 PM the concerns were discussed with the current DON and the Nursing Home Administrator (NHA).A subsequent interview with the previous DON #2 on [DATE] at 2:37 PM confirmed that all nursing staff, including agency staff, received education regarding how to determine the code status of a resident. They had not addressed the issue of 2 active MOLST on the record, and the fact

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on record review and interview, it was determined that the facility failed to provide incontinent care for a resident in need of these services. This was evident for 1 (#5) of 2 residents reviewed for incontinent care. The findings include: On 9/18/25 the State Agency (SA) received a complaint that the Resident (R)5 did not receive incontinent care on 9/16/25 and on 9/17/25. The complainant noted that there was a strong smell of urine in the resident's room and that the brief and bed were saturated with urine on both days. On 12/10/25 at 10:00 AM a review of the facility's assignment sheets for the unit where R5 resided were reviewed. On 9/16/25 on night shift there was 1 nurse and 1 geriatric nursing assistant (GNA) scheduled to care for 35 residents. On 9/16/25, during the day shift there was 1 nurse and 2 GNAs scheduled to care for 34 residents. On 9/16/25, during the evening shift there was 1 nurse and 3 GNAs scheduled to care for 32 residents. On 9/17/25, there were 32 residents and during night shift there was 1 nurse and 1.5 GNAs (because 1 GNA was split between 2 units), on day shift there was 1 nurse and 3 GNAs, and on evening shift there was 1 nurse and 3 GNAs. A medical record review for Resident (R)5 on 12/10/25 at 12:35 PM revealed a progress note written by Nurse Practitioner (NP) #17, who treated R5's wounds, documented the resident needed assistance with personal care. The recommendation was to provide thorough skin care for each incontinent episode. A review of the GNA's documentation for incontinent care for 9/15/25 night shift revealed the GNA documented that this activity did not occur for the resident and n/a for bladder incontinence care. On 9/16/25 there was no documentation to indicate that staff provided incontinence care for the resident on day shift. On evening shift the GNA documented the resident refused care, however, there were no progress notes to indicate that the nurse was made aware and provided education to the resident. On night shift, 9/16/25 into 9/17/25 there was no documentation that staff provided the care. The same on 9/17/25 day shift and evening shift. The days that the complainant indicated the resident had not been changed and the urine was soaked through to the bedding. An interview with the Director of Nursing (DON) with the Nursing Home Administrator (NHA) present on 12/10/25 at 10:25 AM revealed that they agreed there was a concern that incontinent care was provided since it was not signed off or documented that the activity had not occurred or n/a. The DON stated that if staff did not sign off the task, then it was not done.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. (continued on next page)

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F 0867 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 interview it was determined that the facility failed to implement corrective action when they determined that staff had inaccurate and inconsistent code status information on residents' medical records which resulted in residents receiving unwanted Cardiopulmonary Resuscitation (CPR). This failure led to another resident receiving unwanted CPR for the same reason. This was evident for 11 of 11 months of QAPI meeting minutes reviewed. The findings include:1. On [DATE] at 3:23 PM a medical record review for Resident (R)8 revealed in the miscellaneous tab there were 2 active Maryland Orders for Life Sustaining Treatment (MOLST) forms uploaded. The MOLST dated [DATE] documented the resident wished to be a full code and the one dated [DATE] documented the resident wished not to have CPR, but to die naturally. Further review of the medical record revealed a progress note dated [DATE], that documented the resident was found unresponsive and CPR was initiated. Staff failed to document the time CPR was initiated. On [DATE] at 8:43 AM EMS arrived and the resident was pronounced dead at 8:44 AM. An interview with the previous Director of Nursing (DON) #2 on [DATE] at 4:41 PM revealed she was the DON at the time of the incident and investigated it. She confirmed that when she reviewed R8's medical record that there were 2 active MOLST with conflicting code statuses. She stated that the resident had 2 code status physician orders on the medical record that populated to the code status on the information bar at the top of the medical record. One order stated the resident was a full code and the other stated no CPR. She reported that she asked Licensed Practical Nurse (LPN) #3 to conduct a whole house audit that day to ensure other residents had the appropriate MOLST and code status orders, she wrote a performance improvement plan (PIP), and education was provided to staff. She reported that she emailed the PIP to the Nursing Home Administrator (NHA) to approve and add to the agenda for Quality Assurance Performance Improvement (QAPI) committee meeting. On [DATE] at 12:10 PM a review of the audit report dated [DATE] revealed there were other residents identified who had more than one active MOLST on their record and conflicting code status physician orders. Review of the Performance Improvement Plan revealed that she planned for them to reiterate the MOLST process and clearly outline each person's role and responsibility. A review of the process revealed the provider was responsible for changing the orders in the computer when the MOLST was updated and void the previous order. The provider was to give the new MOLST and the voided MOLST to medical record staff during the week and to the supervisor on the weekend, and they were responsible for uploading the documents in the medical record. Nurses on the unit were responsible for a second check that both matched and to let the DON or ADON know there was an active MOLST that needed deleted from the medical record. A review of the education provided revealed that not all nursing staff were educated regarding the process. However, this PIP was not discussed in the QAPI meetings. A review of the QAPI committee meeting minutes on [DATE] at 1:39 PM revealed that the meeting minutes for [DATE] - [DATE] failed to mention the MOLST PIP that was created by the DON. 2. A medical record review for R7 on [DATE] at 5:24 PM revealed that the resident had an active MOLST dated [DATE] that read the resident's wishes were no CPR. This document was not uploaded into the documents section until [DATE]. Review of the physician orders revealed on [DATE] agency Registered Nurse (RN) #11 entered an order for DNI (Do Not Intubate) which matched the MOLST completed on [DATE]. However, on [DATE] an order was entered by the previous DON #2 for a full code and verified by the attending physician. This order did not coincide with the resident's MOLST and was active until [DATE], the day the resident coded. This created 2 conflicting code statuses on the medical record. A progress note written on [DATE] by RN #12 revealed that the resident coded on [DATE] and CPR was initiated at 6:37 AM, EMS continued CPR when they arrived at 6:49 AM and then at 6:59 AM the resident was pronounced dead. The resident received 12 minutes of CPR that was unwanted. The previous DON #2 reported during an interview on [DATE] at 4:41 PM that she collected statements from staff who were involved in the code for R7. She stated she was unable to recall where RN #12 looked for the code status of the resident before initiating CPR on [DATE], but that the nurse was not technically savvy.On [DATE] at 12:15 PM a review of the statement written by RN #12 failed to reveal where she looked for the resident's code status. She wrote what occurred during the code, however failed to reveal the events leading up to the code to determine the reason a resident was given CPR against their wishes. DON #2 failed to investigate the incident to determine the cause, so the facility could implement corrective action to prevent future occurrences. A subsequent interview with the previous DON #2 on [DATE] at 1:42