STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215225	A. Building B. Wing	08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Homewood at Williamsport MD	16505 Virginia Avenue Williamsport, MD 21795

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42886 Based on medical record review, administrative record review, and staff interview; it was determined that the facility failed to protect a cognitively impaired resident (resident #900) from physical abuse from a facility staff member. This was evident for 1 of 5 residents reviewed during a complaint survey. After the incident, the facility implemented effective and thorough corrective measures.The facility's plan and action were verified during this survey; therefore, this deficiency will be cited as past noncompliance. The date of correction is 2/20/23 The following terms are defined for comprehension of the investigative findings: Minimum Data Set (MDS): The Minimum Data Set (MDS) is a comprehensive assessment of a resident completed by facility staff. The MDS is a multi-discipline tool that allows many facets of the resident's care [cognition, behavior, mobility, activities of daily living, accidents, activities, weight, pain, and medications to name a few] to be addressed. The MDS assessment is part of the broader Resident Assessment Instrument (RAI) process. The RAI process ties the assessment and care plan to the delivery of care to meet the needs of the resident. The findings include: Medical record review on 8/7/24 at 9:25am revealed resident #900 was a memory-impaired long-term care resident as documented in the quarterly MDS assessment dated [DATE]. On 8/7/24 at 9:25am, surveyor review of facility reported incident intake MD#00189249, dated 2/19/23, revealed that on 2/19/23 resident #900 reported to facility nursing staff that I don't want to be hit anymore. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 8/7/24 at 9:30am, surveyor review of the facility investigation dated 2/19/23 revealed a witness statement by LPN #304 which stated that on 2/19/23, resident #900 reported that he/she did not want to be hit anymore. LPN #304 assessed the resident and observed that the resident had purple/red bruises on his/her right temple, right eyebrow, right hand, and left hand. LPN#304 also stated that he/she spoke to GNA #302 regarding the bruising on resident #900's body. GNA#302 admitted that he/she bumped the resident when he/she was attempting to clean barrier cream from the resident ' s face. On 8/8/24 at 9:00am, surveyor interview with the Director of Nursing (DON) revealed he/she interviewed GNA #302 on 2/19/23 at approximately 12:30am, and he/she confirmed that he/she bumped resident #900 when he/she was taking a tube of barrier cream from the resident. The DON also stated that he/she interviewed LPN #304 on 2/19/23 at approximately 12:15 am and was told that he/she spoke to resident #900 and the resident stated, I don't want be hit anymore. LPN #304 observed that the resident was covered with thick, white barrier cream on the right side of his/her face/ hair and bruises on the resident's right temple. LPN #304 escorted the resident to his/her bathroom where the resident was assessed and additional bruises were found on the resident's right eyebrow, top of left hand, and between the 4th and 5th finger on the right hand. The DON stated that LPN #304 also observed that the bruises were purple/red in color. The DON stated that he/she was also able to observe the bruises reported by LPN #304 and he/she agreed with the assessment. The DON stated that he/she took GNA #302 from the unit by 12:30am on 2/19/23 and escorted GNA #302 from the property by 1:30am. On 8/8/24 at 10:40am, the surveyor interviewed Human Resource Director #305. HR Director #305 was able to confirm that GNA #302 last day of pay was on 2/19/23 and GNA#302 worked until 1:30am. On 8/9/24 at 9:31am, surveyor interview with LPN #304 confirmed the details gathered from the DON. The surveyor asked LPN #304 how he/she made initial contact with resident #900. LPN #304 stated that he/she was preparing medications at the medicine cart on 2/19/23 at approximately 12:00am. The resident approached LPN #304 and stated, I don ' t want to be hit anymore. LPN #304 initially thought the resident was involved in a resident-to-resident altercation. LPN#304 stated that when he/she continued to question the resident about his/her statement, the resident was unable to tell him/her any information. LPN #304 then realized the resident had barrier cream all over his/her hair, face and hands. LPN #304 then took the resident to his/her bathroom to clean him/her up and then observed the bruises on the resident ' s face and hands. While LPN #304 was assisting resident#900, GNA #302 came into resident ' s room to speak to LPN #304 about other residents. LPN #304 stated that he/she told GNA #302 that he/she was unable to speak to him/her because the resident was injured in an altercation. LPN#304 stated that GNA#302 told him/her that not one hit the resident and he/she must have bumped the resident ' s glasses with my arm or hand when I was taking the barrier cream from her. LPN#304 then realized that the facial bruises were in the shape of the resident ' s glasses. LPN #304 realized at that moment that GNA #302 may have hurt the resident so he/she did not let the resident out of his/her sight until the DON came to the unit to take GNA#302 off the unit. On 8/9/24 at 11:00am, the surveyor then expressed concern to the Administrator and the DON that the facility failed to protect a cognitively impaired resident (resident #900) from physical abuse from a facility staff member. The DON stated that the facility self-initiated the following actions to correct and re-enforce facility abuse policy as of 2/19/23: 1.) The DON terminated GNA #302 from facility employment on 2/20/23. 2.) The facility reported GNA #302 to the State of Maryland ' s Board of Nursing after termination. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	3.) All facility nursing staff were re-educated on abuse prohibition and neglect policies on 2/20/23 and any staff not educated on 2/21/23 were not allowed to work in the facility until re-educated on abuse prohibition and neglect policies.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 42886 Based on medical record review, administrative record review, and staff interview; the facility failed to protect a vulnerable resident (resident #901) from a fall with major injury when facility nursing staff failed to delete an incorrect order for sleep medication (Ambien) from the resident ' s medical record. This was evident for 1 of 4 residents reviewed during a complaint survey. The findings include: Surveyor review of resident #901's medical record on 8/8/24 at 12:00pm revealed resident #901 was admitted to the facility for rehabilitation after orthopedic surgery. Further review of the resident ' s medical record on 8/8/24 at 12:05pm revealed the resident had a witnessed fall on 9/11/22 at 8:30am. The resident was transferred to a local hospital and was diagnosed with a fracture of the bones near the left eye. Surveyor review of the fall incident report on 8/8/24 at 12:34pm revealed resident #901 fell while being assisted by his/her assigned GNA to the bathroom. The resident was ambulating with a rolling walker when the resident lost his/her balance and fell toward his/her left side, bruising the left side of the resident's forehead. The resident was assessed and ordered to be sent to a local hospital for evaluation by the primary provider. Surveyor review of a self-report (MD00190723) on 8/8/24 at 12:45pm, dated on 9/15/22, revealed the facility completed an investigation of the resident's fall and discovered the root cause of the resident's fall was over-administration of the resident's prescribed sleep medication (Ambien) on 9/10/22. The facility further discovered in the investigation that the facility nursing staff that over-administered the resident's sleep medication was following provider orders transcribed by facility nursing staff on 9/8/22 at 5:38pm. Surveyor review of a medication error report on 8/8/24 at 1:15pm revealed the document, dated 9/11/22, reported that RN #307 transcribed a provider order for a one-time dose of Ambien for 12.5mg on 9/8/22 at 5:38pm. RN #307 administered the one-time dose of Ambien and failed to discontinue the medication after administration. On 9/10/22 at 9:38pm, RN #308 administered the resident's standing dose of Ambien of 6. 25mg and the one-time dose 12.5mg of Ambien. Surveyor interview with the RN #310 on 8/8/24 at 2:08 pm revealed RN #310 assessed resident #901 after the 9/11/22 fall incident. RN #310 observed a red bump/bruise on the resident's left side of his/her head. RN #310 contacted the provider and was ordered to have the resident sent to the local hospital. The resident's family was also contacted. RN#310 started a medication review after the resident's fall because GNA #309, the facility nursing staff member who assisted the resident when he/she fell , noticed the resident was lethargic when he/she assisted the resident to the bathroom. RN #310 discovered that RN#308 administered a higher dose of the resident's sleep medication when he/she gave the resident the standing dose and a one-time dose of the sleep medication on 9/10/11 at 9:38pm. RN #310 also discovered that RN #307 transcribed a one-time dose of sleep medication from a provider phone order. RN #307 administered the one-time dose of the sleep medication on 9/8/22 and failed to discontinue the one-time dose after administration of the medication. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Surveyor interview with the Director of Nursing (DON) on 8/9/24 at 8:30am confirmed the statements made by RN #310 and the fall incident report. The DON also stated the facility added steps to the order reconciliation process to avoid the mistake made in resident #901's medication order record. The facility now requires a nurse on the 11-7 shift on each floor of the facility to reconcile all resident orders for that floor daily. Any new orders must be written in an order book. This step is in addition to the nurse printing out all orders and reconciling all orders to the electronic record.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28604 Based on interview, record review, and policy review, the facility failed to provide education for two staff members to possess the competencies and skill sets necessary to ensure residents were free of medication errors for two of four residents (Resident (R) 174 and R15) reviewed for medications in a total sample of 26 residents. These failures resulted in the residents receiving the wrong dose of medications. Findings include: 1. Review of R174's undated Face Sheet, located in the electronic medical record (EMR) under the Dashboard tab, revealed R174 was admitted to the facility on [DATE] with multiple diagnosis including other disorder of bone, cervical disc degeneration and arthritis. Review of R174's Physician's Orders, dated 04/16/22 and located under the Physician Orders tab of the EMR, revealed an order for oxycodone hydrochloride (HCL) immediate release (IR) 5 milligrams (MG) tablet take 1/2 tablet (2.5 MG) by mouth every 8 hours and every 6 hours as needed (PRN) for severe pain. Review of R173's Physician's Orders, dated 05/17/22 and located under the Physician Orders tab of the EMR, revealed an order for oxycodone 5 MG tablet take one by mouth every 6 hours as needed for pain. Review of the facility's document titled Medication Error Report, undated, provided by the facility, revealed the type of error was the wrong dose and wrong resident. The description of the error was R174 received 5 MG of oxycodone from R173's medication card of oxycodone when Certified Medicine Aide (CMA) 1 pulled the wrong medication card from the medication cart. During an interview on 08/08/24 at 2:49 PM, CMA1 confirmed she administered the wrong medication to R174 due to removing R173's medication card from the medication cart in error on 05/09/22. CMA1 stated R174's card was next to R173's card in the medication cart but she should have checked the card to ensure it was the right resident and right medication before administering the medication. CMA1 stated she was tested every two years on medication administration to continue her medicine aide certification but did not receive education and was not observed passing medications from the staff development coordinator (SDC) until after the incident. During an interview on 08/08/24 at 3:36 PM, Director of Nursing (DON) 1 acknowledged there had been several SDCs over the years and the former SDC was expected to provide education on medication administration and conduct observations of medication administration for all nursing staff. DON1 stated she could not find documentation that medication administration education was provided, and observations of medication administration were performed for CMA1 prior to the medication error on 05/09/22. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility-provided undated document titled, Medication Technicians Observational Checklist revealed CMA1 was observed administering medications to the correct resident, right medication, right time, correct route, correct dose, and correct time in 2023 and 2024; however, CMA1's medication administration performance was not observed in 2022. Review of the facility-provided job description titled, Certified Medicine Aide, revealed Job Summary: Provide the activities of daily living care to the residents under license staff supervision and provides administers non-parenteral medications. Essential Functions: . 11. Prepares, administers, and records medications as physician-ordered and in accordance with certification regulations . 2. Review of R15's undated Face Sheet located in the electronic medical record (EMR) under the Dashboard tab, revealed R15 was admitted to the facility on [DATE] with the diagnoses including type 2 diabetes mellitus (DM). Review of R15's Physician Orders, located in the EMR under the Physician Orders tab, revealed an order dated 08/03/24 for Lantus Solostar U-100 insulin 100 unit/milliliters (ML) (3 ML) subcutaneous pen [insulin glargine, a long acting insulin] - 5 [five] units subcutaneous every day for DM. During an observation on 08/09/24 at 8:53 AM, Licensed Practical Nurse (LPN) 3 was observed to administer R15's insulin pen (a pen contains the vial of insulin inside the pen and has a mechanism where the dose to be administered is set on a dial at the top of the pen, and only that amount can then be injected). LPN3 was not observed to prime the pen prior to dialing the dose to five units and was observed to remove the pen from the insertion site after administration without waiting. During an interview on 08/09/24 at 9:22 AM, LPN3 confirmed she did not prime the pen prior to dialing the dose to five units and did not hold the pen in R15's abdomen for five seconds after depressing the plunger. LPN3 stated she was not trained to prime the pen and hold the pen in the abdomen for five seconds. During an interview on 08/09/24 at 9:49 AM, the Infection Preventionist (IP) stated she assisted the staff development coordinator (SDC) with staff education and verified LPN3 did not attend the skills fair conducted in March 2024. The IP stated that a medication administration observation was completed on 05/13/24 but it did not include insulin pen administration. The IP indicated she expected nursing staff to prime the pen to two units before administering the insulin to ensure the needle worked and hold the pen in the abdomen for 10 seconds after depressing the plunger to ensure all the insulin was administered. During an interview on 08/09/24 at 10:27 AM, the Director of Nursing (DON) stated she expected the nursing staff to administer insulin correctly according to the manufacturer's guidance and she was not aware that LPN3 had not been trained on insulin pen administration. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the insulin pen guidance titled How to use your Lantus SoloStar Pen, undated, provided by the facility, revealed . Step 3. Perform a Safety Test Dial a test dose of 2 [two] units. Hold pen with the needle pointing up and lightly tap the insulin reservoir so the air bubbles rise to the top of the needle. This will help you get the most accurate dose. Press the injection button all the way in and check to see that insulin comes out of the needle . Step 5. Inject your Dose clean site with an alcohol swab. Keep the pen straight. Insert the needle into your skin. Use your skin. Use your thumb to press the injection button all the way down. When the number in the dose window returns to zero as you inject, slowly count to 10 before removing. (Counting to 10 will make sure you get your full insulin dose). Release the button and remove the needle from your skin . Review of the facility-provided document titled, Facility Assessment Tool, dated December 2023, revealed . A.1. Function - Sufficiency Analysis Summary . Staff training/Education and competencies [the facility] provides an ongoing educational program for the development and improvement of all co-workers. The staff training and education program is designed to ensure knowledge competency for all staff. Education is provided through a combination of online training and using the Relias Learning System, peer monitoring and classroom sessions. Competencies are based on the care and services needed by the resident population. Each job description identifies the required education and credentials for the job. Competencies are verified upon orientation and as needed. Competencies are based on current standards of practice and may include knowledge and test, knowledge and return demonstration, knowledge and observed behaviors, and annual performance evaluation. Annual nursing competencies include . medication administration observations .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 42886 Based on medical record review, administrative record review, and staff interview; the facility failed to maintain an accurate resident (resident #901) medication order history. This was evident for 1 of 4 residents reviewed during a complaint survey. The findings include: Surveyor review of a self-report (MD00190723) on 8/8/24 at 12:45pm, dated 9/15/22, revealed the facility completed an investigation of the resident's fall and discovered the root cause of the resident's fall was over-administration of the resident's prescribed sleep medication (Ambien) on 9/10/22. The facility further discovered in the investigation that the facility nursing staff over-administered the resident's sleep medication was following provider orders transcribed by facility nursing staff on 9/8/22 at 5:38pm. Surveyor review of a medication error report on 8/8/24 at 1:15pm revealed the document, dated 9/11/22, reported that RN # 307 transcribed a provider order for a one-time dose of Ambien for 12.5mg on 9/8/22 at 5:38pm. RN #307 administered the one-time dose of Ambien and failed to discontinue the medication after administration. On 9/10/22 at 9:38pm, RN#308 administered the resident's standing dose of Ambien of 6. 25mg and the one-time dose 12.5mg of Ambien. Surveyor review of resident #901's medication administration record (MAR) for September 2022 revealed the one-time dose order transcribed by RN#307 was used to administer 12.5mg of Ambien to the resident on 9/8/22, 9/9/22, and 9/10/22. Surveyor interview with the Director of Nursing (DON) on 8/9/24 at 8:30am confirmed the accuracy of the medication error report and the 9/2022 MAR. The DON stated that the facility added steps to the order reconciliation process to avoid the mistake made in resident #901's medication order record. The facility now requires a nurse on the 11-7 shift on each floor of the facility to reconcile all resident orders for that floor daily. Any new orders must be written in an order book. This step is in addition to the nurse printing out all orders and reconciling all orders to the electronic record.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 42886 Based on medical record review, administrative record review, and staff interview; the facility failed to ensure a resident's medication regimen was free from unnecessary PRN (as needed) medications (resident #901). This was evident for 1 of 4 residents reviewed during a complaint survey. The findings include: Surveyor review of a self-report (MD00190723) dated 9/15/23 revealed the facility completed an investigation of the resident's fall and discovered the root cause of the resident's fall was over-administration of the resident's prescribed sleep medication (Ambien) on 9/10/22. The facility further discovered in the investigation that the facility nursing staff over-administered the resident's sleep medication was following provider orders transcribed by facility nursing staff on 9/8/22 at 5:38pm. Surveyor review of a medication error report on 8/8/24 at 1:15pm revealed the document, dated 9/11/22, reported that RN # 307 transcribed a provider order for a one-time dose of Ambien for 12.5mg on 9/8/22 at 5:38pm. RN #307 administered the one-time dose of Ambien and failed to discontinue the medication after administration. On 9/10/22 at 9:38pm, RN#308 administered the resident's standing dose of Ambien of 6. 25mg and the one-time dose 12.5mg of Ambien. Surveyor interview with the RN #310 on 8/8/24 at 2:08pm revealed RN #308 assessed resident #901 after the 9/11/22 fall incident. RN#310 observed a red bump/bruise on the resident's left side of his/her head. RN#310 contacted the provider and was ordered to have the resident sent to the local hospital. The resident's family was also contacted. RN#310 started a medication review after the resident's fall because GNA #309, the facility nursing staff member who assisted the resident she he/she fell , noticed the resident was lethargic when he/she assisted the resident to the bathroom. RN#310 discovered that RN#308 administered a higher dose of the resident's sleep medication when he/she gave the resident the standing dose and a one-time dose of the sleep medication on 9/10/11 at 9:38pm. RN#310 also discovered that RN#307 transcribed a one-time dose of sleep medication from a provider phone order. RN#307 administered the one-time dose of the sleep medication on 9/8/22 and failed to discontinue the one-time dose after administration of the medication. Surveyor interview with the Director of Nursing (DON) on 8/9/24 at 8:30am confirmed the statements made by RN #310 and the fall incident report. The DON added that the facility added steps to the order reconciliation process to avoid the mistake made in resident #901's medication order record. The facility now requires a nurse on the 11-7 shift on each floor of the facility to reconcile all resident orders for that floor daily. Any new orders must be written in an order book. This step is in addition to the nurse printing out all orders and reconciling all orders to the electronic record.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42886 Based on medical record review, administrative record review, policy review and staff interview; the facility failed to protect vulnerable residents (resident #901 & #174) from a significant medication error. This was evident for 2 of 30 residents reviewed during the survey. This deficient practice resulted in harm to resident # 901 who had a fall incident (accident) with major injury. The findings include: 1.) Surveyor review of resident #901's medical record on 8/8/24 at 12:00pm revealed resident #901 was admitted to the facility for rehabilitation after orthopedic surgery. Further review of the resident's medical record on 8/8/24 at 12:05pm revealed the resident had a witnessed fall on 9/11/22 at 8:30am. The resident was transferred to a local hospital and was diagnosed with a fracture of the bones near the left eye. Surveyor review of the fall incident report on 8/8/24 at 12:34pm revealed resident #901 fell while being assisted by his/her assigned GNA to the bathroom. The resident was ambulating with a rolling walker when the resident lost his/her balance and fell toward his/her left side, bruising the left side of the resident's forehead. The resident was assessed and ordered to be sent to a local hospital for evaluation by the primary provider. Surveyor review of a self-report (MD00190723) dated 9/15/23 revealed the facility completed an investigation of the resident ' s fall and discovered the root cause of the resident ' s fall was over-administration of the resident ' s prescribed sleep medication (Ambien) on 9/10/22. The facility further discovered in the investigation that the facility nursing staff that over-administered the resident ' s sleep medication was following provider orders transcribed by facility nursing staff on 9/8/22 at 5:38pm. Surveyor review of a medication error report on 8/8/24 at 1:15pm revealed the document, dated 9/11/22, reported that RN #307 transcribed a provider order for a one-time dose of Ambien for 12.5mg on 9/8/22 at 5:38pm. RN #307 administered the one-time dose of Ambien and failed to discontinue the medication after administration. On 9/10/22 at 9:38pm, RN #308 administered the resident's standing dose of Ambien of 6. 25mg and the one-time dose 12.5mg of Ambien. Surveyor interview with the RN #310 on 8/8/24 at 2:08 pm revealed RN #310 assessed resident #901 after the 9/11/22 fall incident. RN #310 observed a red bump/bruise on the resident's left side of his/her head. RN #310 contacted the provider and was ordered to have the resident sent to the local hospital. The resident ' s family was also contacted. RN #310 started a medication review after the resident ' s fall because GNA #309, the facility nursing staff member who assisted the resident when he/she fell , noticed the resident was lethargic when he/she assisted the resident to the bathroom. RN #310 discovered that RN#308 administered a higher dose of the resident's sleep medication when he/she gave the resident the standing dose and a one-time dose of the sleep medication on 9/10/11 at 9:38pm. RN #310 also discovered that RN #307 transcribed a one-time dose of sleep medication from a provider phone order. RN #307 administered the one-time dose of the sleep medication on 9/8/22 and failed to discontinue the one-time dose after administration of the medication. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215225	A. Building B. Wing	08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Homewood at Williamsport MD	16505 Virginia Avenue 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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F 0760 Level of Harm - Actual harm Residents Affected - Few	28604 2.) Review of R174's undated Face Sheet, located in the electronic medical record (EMR) under the Dashboard tab, revealed R174 was admitted to the facility on [DATE] with diagnoses that included disorder of bone and other cervical disc degeneration. R174 had the following drug allergies: Penicillin's, Avelox, Bactrim, and cephalosporins. Review of R174's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/21/22, located in the EMR under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating R174 was cognitively intact. It was recorded R174 had experienced occasional pain the last five days and had received opioids in the preceding seven days. Review of R174's Physician's Orders, dated 04/15/22 and located in the EMR under the Physician Orders tab, revealed an order for Oxycodone 5 mg [milligrams] tablet 0.5 tab (2.5 mg) by mouth every 8 hours for pain. Review of R173's Physician's Orders, dated 04/29/22 and located under the Physician Orders tab of the EMR, revealed an order for Oxycodone 5 mg tablet one by mouth every 4 hours as needed for moderate to severe pain. Review of R173's facility provided Controlled Substance Record, dated 05/09/22, revealed 26 medications noted at 11:00 PM on 05/09/22 count; resident on leave of absence (LOA) pulled in error. Review of the facility's investigative documents revealed the following nursing staff statements written on 05/10/22: Certified Medicine Aide (CMA) 1: On 05/09/22 at 1:00 PM, she pulled R173's medication card from the medication cart and administered R174 the wrong pain medication (Oxycodone 5.0 MG instead of Oxycodone 2.5 MG). Licensed Practical Nurse (LPN) 7: On 05/09/22 at 11:00 PM, during the change of shift count, she noticed R173's medication card was missing one Oxycodone which was not correct because he was out of the facility. During an interview on 08/08/24 at 2:49 PM, CMA1 confirmed she pulled R173's Oxycodone medication card from the medication cart and administered the pain medication to R174 in error. CMA1 stated she should have checked the medication card to ensure she had the right resident and correct medication, but she was distracted by coworkers at the time. LPN7 was unavailable for interview. During an interview on 08/08/24 at 3:36 PM, Director of Nursing (DON) 1 stated she was notified by LPN7 on 05/09/22 at 11:00 PM that one of R173's Oxycodone pills was missing from the medication card and R173 was in the hospital. DON 1 stated she completed the investigation on 05/10/22 and determined CMA1 pulled the wrong medication card from the cart in error and administered R174 Oxycodone 5 MG which was double the dose he/she was supposed to receive per the physician order. DON1 indicated R174 was assessed with no adverse reaction or change of condition and the physician was notified on 05/10/22. DON1 indicated she expected nursing staff to administer medications to the right resident. (continued on next page)

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	215225	A. Building B. Wing	08/09/2024

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Review of the facility's policy titled, Administering Medications, revised April 2019 ad provided by the facility, revealed policy medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation . As required or indicated for a medication, the individual administering the medication records in the resident's medical record: a. the date and time the medication was administered; b. the dosage; c. the route of administration; d. the injection site (if applicable); e. any complaints or symptoms for which the drug was administered; f. any results achieved and when those results were observed; and g. the signature and title of the person administering the drug .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 42886 Based on medical record review, administrative record review, and staff interview; the facility failed to maintain an accurate resident (resident #901) medication order history. This was evident for 1 of 4 residents reviewed during a complaint survey. The findings include: Surveyor review of a self-report (MD00190723) on 8/8/24 at 12:45pm, dated 9/15/22, revealed the facility completed an investigation of the resident's fall and discovered the root cause of the resident's fall was over-administration of the resident's prescribed sleep medication (Ambien) on 9/10/22. The facility further discovered in the investigation that the facility nursing staff over-administered the resident's sleep medication was following provider orders transcribed by facility nursing staff on 9/8/22 at 5:38pm. Surveyor review of a medication error report on 8/8/24 at 1:15pm revealed the document, dated 9/11/22, reported that RN # 307 transcribed a provider order for a one-time dose of Ambien for 12.5mg on 9/8/22 at 5:38pm. RN #307 administered the one-time dose of Ambien and failed to discontinue the medication after administration. On 9/10/22 at 9:38pm, RN#308 administered the resident's standing dose of Ambien of 6. 25mg and the one-time dose 12.5mg of Ambien. Surveyor review of resident #901's medication administration record (MAR) for September 2022 revealed the one-time dose order transcribed by RN#307 was used to administer 12.5mg of Ambien to the resident on 9/8/22, 9/9/22, and 9/10/22. Surveyor interview with the Director of Nursing (DON) on 8/9/24 at 8:30am confirmed the accuracy of the medication error report and the 9/2022 MAR. The DON stated that the facility added steps to the order reconciliation process to avoid the mistake made in resident #901's medication order record. The facility now requires a nurse on the 11-7 shift on each floor of the facility to reconcile all resident orders for that floor daily. Any new orders must be written in an order book. This step is in addition to the nurse printing out all orders and reconciling all orders to the electronic record.