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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident’s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28604 Based on interview, record review, and Resident Assessment Instrument (RAI) Manual review, the facility failed to follow the RAI's transmission requirements, which indicate that within 14 days after a facility completes a resident's assessment a facility must electronically transmit encoded, accurate, and complete "Minimum Data Set (MDS) data to the Center for Medicare & Medicaid Services (CMS) System, for one (Resident (R) 25) of one supplemental residents reviewed for Resident Assessment. Specifically, it had been over 120 days since the discharge "MDS" was completed and the "MDS" had not been transmitted to the CMS System. Findings include: Review of R25's undated "Face Sheet" located in the electronic medical record (EMR) under the "Dashboard" tab, revealed R25 was admitted to the facility on [DATE] with the diagnoses of congestive heart failure (CHF) and pneumonia. Review of R25's admission "Minimum Data Set (MDS)" located in the EMR under the "MDS" tab with an "Assessment Reference Date (ARD)" of 04/01/24 revealed R25's "Brief Interview for Mental Status (BIMS)" score was four out of 15 which indicated R25 was severely cognitively impaired. Review of R25's "Progress Note," dated 04/21/24 and located in the EMR under the "ID Notes" tab, revealed, "Resident was discharged at 10:30 am with medications to [another facility]. Discharge instructions were given to resident along with son and daughter. Staff assisted resident out of the building along with his/her family without incident." During an interview on 08/09/24 at 10:39 AM, the MDS Coordinator (MDSC) showed on her computer, that R25's discharge "MDS" with an ARD of 04/21/24 was completed but had not been submitted. MDSC stated that no reports were provided through the EMR to let her know that the MDS was not submitted, and no other staff were auditing the system to ensure that MDSs were submitted timely. The MDSC acknowledged the MDS was not submitted and should have been submitted within seven days from the MDS lock date. During an interview on 08/09/24 at 1:24 PM, the Director of Nursing (DON) stated she expected the MDSC to complete and submit the MDS timely per the RAI Manual and to check to ensure that the MDS were submitted. Review of the Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.18.11, dated October 2023, revealed ". 09. Discharge Assessment-Return Not Anticipated (A0310F = 10) Must be completed when the resident is discharged from the facility and the resident is not expected to return to the facility within 30 days. Must be completed (item Z0500B) within 14 days after the discharge date (A2000 + 14 calendar days). Must be submitted within 14 days after the MDS completion date (Z0500B + 14 calendar days) ."

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. 31982 Based on record review and interview with staff it was determined the facility staff failed to ensure each residents drug regimen was free from unnecessary drugs. This was evident for 1 (#21) of 3 residents reviewed for unnecessary psychotropic drugs. The findings include: Resident #21's record was reviewed on 10/15/24 at 1:45 PM. A consultant pharmacist monthly review was completed on 10/1/24. The review indicated that a recommendation was given. The note to the attending physician identified that Resident #21 had an order for metformin 500 mg(milligrams)(an oral medication used to treat diabetes) twice a day and that his/her A1c (a lab test which reflects blood glucose control over time), was well within the goal. Please consider reducing his/her metformin to 500 mg daily. The physicians response at the bottom of the note, signed and dated 10/4/24, indicated: Agree and Okay to change metformin to 500mg daily. Review of the October Medication Administration Record (MAR) revealed Resident #21 received Metformin 500 mg at 8:00 AM and 5:00 PM each day in October up to and including that morning (10/15/24). Review of the physicians' orders on 10/16/24 at 11:25 AM revealed Resident #21's current active orders included Metformin HCL 500 mg tablet take 1 tablet by mouth twice daily with meals. It was not changed on 10/4/24 to once daily as indicated by the physicians response to the consultant pharmacists recommendation. In an interview on 10/16/24 at 11:31 AM Staff #6 the Unit Manager explained the facilities process for the consultant pharmacists' recommendations were: the pharmacist placed the review recommendations into a folder for the physician. The physician would review, address and write any new orders at the bottom of the form. Occasionally the physician, but usually the nurse, would write the order on the physicians' order sheet, and the physician would sign it. She was made aware of the above findings, reviewed the physicians orders and eMAR then confirmed that the order was not written to decrease Resident #21's metformin as indicated on 10/4/24 and that the resident received 2 doses of metformin 500 mg from 10/4/24 thru 10/16/24 8:00 AM. The DON was made aware of the above concerns on 10/16/24 at 11:40 AM.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28604 Based on observation, interview, record review, and review of facility policy, the facility failed to ensure a medication error rate below five percent. During medication administration two medication errors for two residents (Residents (R) 15 and R65) were made of 39 opportunities resulting in a medication error rate of 5. 13 percent. These failures had the potential to increase or decrease the effectiveness of these medications. Findings include: 1. 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 retrieved 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) from the medication cart, wiped the top with an alcohol wipe, attached a needle to the pen then dialed the dose to five units. LPN3 carried the flex-pen to R15's room. LPN3 washed her hands, applied gloves, observed R15's abdomen to find a spot that was not bruised, cleansed the left lower quadrant with an alcohol wipe, gently inserted the flex-pen needle into the flesh, injected the dose, then removed the needle from the abdomen. Next, LPN3 carried the pen to the medication cart, disposed of the needle, and performed hand hygiene. 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) 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, Director of Nursing (DON) 1 stated she expected the nursing staff to administer insulin correctly according to the manufacturer's guidance. (continued on next page)

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F 0759 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 . 2. Review of R65's undated Face Sheet, located in the EMR under the Dashboard tab, revealed R65 was admitted to the facility on [DATE] with the diagnoses including duodenal ulcer and acute gastritis (inflammation of the stomach lining) without bleeding. Review of R65's Physician Orders, located in the EMR under the Physician Orders tab, revealed an order dated 07/03/24 for sucralfate [a protectant that sticks to damaged ulcer tissue and protects against acid and enzymes so healing can occur] 1 [one] gram tablet one by mouth four times a day for stomach ulcer. Review of R65's Medication Administration Record (MAR), dated August 2024, located in the EMR under the eMAR/TAR tab, revealed the medication sucralfate tablet was due at 11:00 AM daily. During an observation on 08/08/24 at 11:42 AM, Registered Nurse (RN) 2 searched through the medication cart for R65's sucralfate medication card then stated she could not find it. RN2 stated the medication was due at 11:00 AM, she would notify the physician that the medication was not administered (missed dose) and would contact the pharmacy for a refill of the medication. During an interview on 08/09/24 at 11:01 AM, DON1 verified the pharmacy delivered the sucralfate medication card to the facility on [DATE] and that the medication card was on the medication cart facing backwards. DON1 indicated when new medication cards were received, the nursing staff would place the new cards facing backwards then turned them facing forward when the last medication card was empty. DON1 acknowledged R65 should not have missed the medication on 08/08/24 at 11:00 AM because the medication was in the cart.

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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)

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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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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 .

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 12679 Based on record review, staff interview, and policy review, the facility's administration failed to implement its Resident Immunization policy related to current Centers for Disease Control (CDC) recommendations to provide residents the opportunity to receive the Prevnar (Pneumococcal conjugate vaccine (PCV) 20) or the PCV15. Eight out of eight residents ((R) 14, R21, R10, R32, R35, R2, R19, and R36) reviewed for immunizations were not offered pneumococcal vaccinations in compliance with CDC recommendations, the facility had never had PCV20 available, and the facility failed to identify the potential for deficient practice in quality assurance. These failures had the potential to increase the risk of residents contracting pneumonia. Findings include: Review of a facility policy titled Resident Immunization dated 11/08/23 indicated . The facility will offer residents immunization against vaccine-preventable diseases that may be encountered in the facility and as recommended by the CDC Advisory Committee for Immunization Practices . Upon admission or shortly thereafter, each resident's status for influenza, pneumococcal . will be determined and recorded in the medical record . Residents will be offered pneumococcal vaccine (PPV) using these criteria . Primary physician will be contacted for pneumococcal vaccine for information if not received upon admission . For adults [AGE] years or older who have not previously received any pneumococcal vaccine, CDC recommends you . Give 1 dose of PCV15 or PCV20 . If PCV 15 is used, this should be followed by a dose of PPSV23 at least one year later. The minimum interval is 8 weeks and can be considered in adults with an immunocompromising condition, cochlear implant, or cerebrospinal fluid leak . If PCV20 is used, a dose of PPSV23 is not indicated . For adults [AGE] years or older who have only received a PPSV23, CDC recommends you . May give 1 dose of PCV15 or PCV20 . The PCV15 or PCV20 dose should be administered at least one year after the most recent PPSV23 vaccination . Regardless of if PCV15 or PCV20 is given, an additional dose of PPSV23 is not recommended since they already received it . For adults [AGE] years or older who have only received PCV13, CDC recommends you . Give PPSV23 as previously recommended. The incremental public health benefits of providing PCV15 or PCV20 to adults who have received PCV13 only or both PCV13 and PPSV23 have not been evaluated . For adults who have received PCV13 but have not completed their recommended pneumococcal vaccine series with PPSV23, one dose of PCV20 may be used if PPSV23 is not available. If PCV20 is used, their pneumococcal vaccinations are completed. 1. Review of Influenza and Pneumococcal Immunizations. Cross Reference F883: Failure to offer eight residents ((R) 14, R21, R10, R32, R35, R2, R19, and R36), the opportunity to be vaccinated in accordance with CDC standards and failed to offer PCV20. 2. Review of Quality Assurance and Performance Improvement. Cross Reference F867: Failure to identify potential deficient practice for implementation of CDC recommendations for pneumococcal vaccinations. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 08/07/24 10:17 AM, the Consultant Pharmacist stated she brought up education on the PCV20 vaccination in the Quality Assurance (QA) meetings, but it was never addressed by the members of the QA meetings. The Consultant Pharmacist stated she called the facility's pharmacy to verify if PCV20 vaccines were ordered by the facility. The Consultant Pharmacist stated there were no orders placed by the facility for the PCV20. During an interview on 08/07/24 12:42 PM, the Medical Director confirmed he attended the monthly QA meetings and stated he remembered the Consultant Pharmacist addressed the CDC recommendations of the PCV20. The Medical Director was then informed the facility never ordered the PCV20 vaccination. The Medical Director stated he was aware that the PCV20 was the current standard vaccine and the residents who received the PCV15 and the PPSV23 did not need to be vaccinated for another five years. During an interview on 08/09/24 12:10 PM, the Director of Nursing (DON) 1 stated she did not know why the PCV20 was not picked up as potential deficient practice.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 12679 Based on interviews, review of the facility documentation, and policy review, the Quality Assessment (QA) committee failed to identify quality deficiencies related to the facility's infection control program and take corrective action to ensure that Prevnar (PCV) 20 was offered and provided in accordance with recognized national standards. This failure had the potential to affect all residents who were eligible for the PVC20 vaccine who currently live in the facility. Findings include: Review of a facility document titled Quality Assurance, dated 03/25/22, indicated the Consultant Pharmacist provided the QA committee members with the Centers for Disease Control and Prevention (CDC) recommendations of Prevnar20. During an interview on 08/07/24 at 10:17 AM, the Consultant Pharmacist confirmed she participated in the quarterly QA meetings. The Consultant Pharmacist stated during one QA meeting in 2022 she provided the QA members information on the Prevnar20 vaccination and the CDC recommendations. The Consultant Pharmacist was asked why the facility never implemented the CDC recommendations on the use of the Prevnar 20. The Consultant Pharmacist stated there was staff turnover with the Infection Preventionist (IP) position. The Consultant Pharmacist stated the facility never asked her to assist with the tracking of pneumococcal vaccines with the current resident population. The Consultant Pharmacist stated she called the facility's pharmacy to verify if PCV20 vaccines were ordered by the facility. The Consultant Pharmacist stated there were no orders placed by the facility for the PCV20. During an interview on 08/07/24 at 8:29 AM, the Director of Nursing (DON) 1 stated she was not sure why the facility missed the CDC recommendations for the PCV20 in the QA meetings. During an interview on 08/07/24 1:17 PM, Registered Nurse (RN) 1, who was also a nursing supervisor and attended the QA meetings, stated she did not remember the Consultant Pharmacist going over the CDC recommendations for the PVC20 vaccination. Review of a facility document titled Quality Assurance Program dated 08/2012 indicated . This facility shall develop, implement, and maintain an ongoing program designed to monitor and evaluate the quality of resident care, pursue methods to improve quality, and to resolve identified problems . To provide a means whereby negative outcomes relative to resident care and safety can be identified and resolved through an interdisciplinary approach .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 12679 Based on observation, interview, and review of facility policies, the facility failed to ensure protective equipment (PPE) was available for laundry staff in one of one laundry rooms while sorting soiled resident clothing and bed linens. This had the potential to infect the staff and/or residents with pathogens which could potentially lead to the development of infectious diseases. Findings include: During a tour of the soiled laundry room on 08/09/24 at 8:41 AM, gloves were observed but no gowns. An immediate interview was conducted with Housekeeper 1, and she confirmed when she handled the soiled linens from the floors, she did not don (put on) a gown and only used gloves. The Director of Housekeeping/Laundry (DHL) was present during this interview and confirmed the same information. The DHL stated the laundry staff would retrieve the bagged soiled laundry from a bin and then place the bag open end first into the washing machine. The DHL stated there was no contact between the soiled laundry and the laundry staff. During an interview on 08/09/24 at 8:44 AM, Director of Nursing (DON) 1 confirmed the laundry staff only used gloves when handling soiled laundry. During an interview on 08/09/24 at 9:48 AM, the Infection Preventionist (IP) stated she did not go into the soiled laundry room and was not aware the laundry staff were not donning gowns while handling soiled linens. Review of a facility policy titled Laundry and Bathing, Soiled, dated 09/2022 indicated, . Soiled laundry/bedding shall be handled, transported and processed according to best practices for infection prevention and control . All used laundry is handled as potentially contaminated using standard precautions (e.g., gloves and gowns when sorting) .

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 12679 Based on interview, record review, review of the Centers for Disease Control and Prevention (CDC) guidelines, and facility policy review, the facility failed to offer eight of eight residents (Resident (R) R14, R21, R10, R32, R35, R2, R19, and R36) reviewed for immunizations and/or their representatives the opportunity for the resident to be vaccinated in accordance with nationally recognized standards out of a current facility census of 69. This practice had the potential to increase the risk for the residents to contract pneumonia. (Cross Reference F835 and F867) Findings include: Review of a facility policy titled Resident Immunization dated 11/08/23 indicated . The facility will offer residents immunization against vaccine-preventable diseases that may be encountered in the facility and as recommended by the CDC Advisory Committee for Immunization Practices . Upon admission or shortly thereafter, each resident's status for influenza, pneumococcal . will be determined and recorded in the medical record . Residents will be offered pneumococcal vaccine (PPV) using these criteria . Primary physician will be contacted for pneumococcal vaccine for information if not received upon admission . Review of the CDC website titled Pneumococcal Vaccination: Summary of Who and When to Vaccinate, effective 01/28/22, indicated . CDC recommends pneumococcal vaccination for all adults [AGE] years or older . For adults [AGE] years or older who have not previously received any pneumococcal vaccine, CDC recommends you . Give 1 dose of PCV [Pneumococcal Conjugate Vaccine] 15 or PCV20 . If PCV15 is used, this should be followed by a dose of PPSV 23 [Pneumococcal polysaccharide vaccine] at least one year later. The minimum interval is 8 weeks and can be considered in adults with an immunocompromising condition, cochlear implant, or cerebrospinal fluid leak . If PCV20 is used, a dose of PPSV23 is NOT indicated . For adults [AGE] years or older who have only received a PPSV23, CDC recommends you . May give 1 dose of PCV15 or PCV20 . The PCV15 or PCV20 dose should be administered at least one year after the most recent PPSV23 vaccination. Regardless of if PCV15 or PCV20 is given, an additional dose of PPSV23 is not recommended since they already received it. For adults [AGE] years or older who have only received PCV13, CDC recommends you . Give PPSV23 as previously recommended . For adults who have received PCV13 but have not completed their recommended pneumococcal vaccine series with PPSV23, one dose of PCV20 may be used if PPSV23 is not available. If PCV20 is used, their pneumococcal vaccinations are complete . For adults who received PCV13 at any age and PPSV23 after age [AGE] years . use shared clinical decision-making to decide whether to administer PCV20 . 1. Review of a facility provided document titled Profile Face Sheet indicated R21 was admitted to the facility on [DATE]. The resident was over the age of 65 at the time of their admission. Review of a facility provided document for R21 titled Consent for Immunization, dated 10/03/22, indicated a section titled Pneumococcal Vaccine. Under this section were blank (incomplete) areas which would identify if the resident received, was offered, or declined the opportunity to be vaccinated with PCV20. Review of a facility provided document titled Immunization Report for Residents indicated R21 received a PCV13 on 10/05/22. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. Review of a facility provided document titled Profile Face Sheet indicated R10 was admitted to the facility on [DATE]. The resident was over the age of 65 at the time of their admission. Review of a facility provided document titled Consent for Immunization, dated 10/26/23, indicated a section titled Pneumococcal Vaccine. Under this section were blank areas which would identify if the resident received, was offered, or declined the opportunity to be vaccinated with PCV20. Review of a facility provided document titled Immunization Report for Residents indicated R10 was not offered the opportunity to be vaccinated with PCV20 and had not received any prior pneumococcal vaccinations. 3. Review of a facility provided document titled Profile Face Sheet indicated R36 was admitted to the facility on [DATE]. The resident was over the age of 65 at the time of their admission. Review of a facility provided document titled Consent for Immunization, dated 09/25/23, indicated a section titled Pneumococcal Vaccine. Under this section, revealed R36's representative consented to the pneumococcal vaccine. The consent did not identify which pneumococcal the resident's representative was offered. Review of a facility provided document titled Immunization Report for Residents dated 02/01/21 indicated R36 received the PPSV23 vaccination. There was no other evidence the resident was provided the opportunity to be offered the PCV20. 4. Review of a facility provided document titled Profile Face Sheet indicated R35 was admitted to the facility on [DATE]. he resident was over the age of 65 at the time of their admission. Review of a facility provided document titled Consent for Immunization dated 09/26/23 indicated a section titled Pneumococcal Vaccine. Under this section, revealed R35's representative consented to the pneumococcal vaccine. The consent did not identify which pneumococcal the resident's representative was offered. Review of a facility provided document titled Immunization Report for Residents dated 08/12/20 indicated R35 received the PPSV23 vaccination. There was no other evidence the resident was provided the opportunity to be offered the PCV20. 5. Review of a facility provided document titled Profile Face Sheet indicated R14 was admitted to the facility on [DATE]. The resident was over the age of 65 at the time of their admission. Review of a facility provided document titled Immunization Report for Residents indicated R14 received PCV13 on 07/20/18 and the PPSV23 on 07/10/08. There was no other evidence, in the clinical record, to show R14 and/or her representative was offered the PCV20. There was no evidence in the clinical records, which indicated shared clinical decision making was conducted by the medical provider with the resident and/or their representative. 6. Review of a facility provided document titled Profile Face Sheet indicated R19 was admitted to the facility on [DATE]. The resident was over the age of 65 at the time of their admission. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of a facility provided document titled Consent for Immunization dated 05/05/22 indicated R19's representative consented to the resident to be vaccinated with the pneumococcal vaccine. This document revealed the resident received an unknown pneumococcal on 10/18/18. Review of a facility document titled Immunization Report for Residents indicated R19, received the PCV13 vaccine on 10/18/18. There was no other evidence, in the clinical record, to show R19 and/or her representative was provided the opportunity to be offered the PCV20 or PPSV23. 7. Review of a facility provided document titled Profile Face Sheet indicated R2 was admitted to the facility on [DATE]. The resident was over the age of 65 at the time of their admission. Review of a facility provided document titled Consent for Immunization dated 09/25/23 indicated R2's representative consented to a pneumococcal vaccine. The consent failed to identify which pneumococcal was offered. Review of a facility provided document titled Immunization Report for Residents indicated R2 received the PCV13 on 02/02/15 and the PPSV23 on 10/01/09. There was no other evidence, in the clinical record, to show R2 and/or her representative was offered the PCV20. There was no evidence in the clinical records, which indicated shared clinical decision making was conducted by the medical provider with the resident and/or their representative. 8. Review of a facility provided document titled Profile Face Sheet indicated R32 was admitted to the facility on [DATE]. The resident was over the age of 65 at the time of their admission. Review of a facility provided document titled Resident Vaccination dated 09/17/20 that R32 gave consent to receive a pneumococcal vaccination. Review of a facility provided document titled Immunization Report for Residents indicated R32 received the PCV13 on 01/08/15 and the PPSV23 on 07/30/12. There was no other evidence, in the clinical record, to show R32 and/or her representative was offered the PCV20. There was no evidence in the clinical records, which indicated shared clinical decision making was conducted by the medical provider with the resident and/or their representative. During an interview on 08/07/24 at 10:17 AM, the Consultant Pharmacist stated she called the facility's pharmacy to verify if PCV20 vaccines were ordered by the facility. The Consultant Pharmacist stated there were no orders placed by the facility for the PCV20. During an interview on 08/07/24 at 8:35 AM, the Infection Preventionist (IP) reviewed the residents' immunization records and stated she would assume if they were offered and administered the PCV20, it would be reflected in the immunization records and confirmed it was not. The IP stated the Admission Coordinators went over the vaccination consents with all new admissions, uploaded, and scanned and placed in the electronic medical records (EMR). The IP stated then a physician's order would be obtained. (continued on next page)

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 08/07/24 at 12:34 PM, the Admission Coordinator confirmed she obtained vaccination consents. The Admission Coordinator stated once the consent has been obtained, the document was uploaded into the resident's EMR. The Admission Coordinator stated she was unaware if the uploaded consent would alert nursing to obtain a physician's order for a pneumococcal vaccination. During this interview, the Admission Coordinator stated the information on the pneumococcal vaccine was included in the facility's Admission Packet. During this interview, the Admission Coordinator presented the educational piece for the Pneumococcal vaccine and confirmed this was the educational document provided to each resident and/or their representative. A review of the facility's admission packet contained a document titled Pneumococcal polysaccharide vaccine (PPSV23) dated 04/24/15. During an interview on 08/07/23 at 12:42 PM, the Medical Director stated he was aware of the PCV20 vaccination and stated this was the standard for long-term care to offer and to administer. During an interview on 08/07/24 at 1:17 PM, the Director of Nursing (DON) 2 for a sister facility stated there were no triggers to alert clinical staff to obtain a physician order for the pneumococcal vaccine when it was scanned into the EMR. During an interview on 08/09/24 at 12:10 PM, DON2 stated the facility missed identifying the need for the PCV20 vaccine.

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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 43050 Based on record review, interview, and policy review, the facility failed to ensure five staff (Geriatric Nursing Assistant (GNA) 4, GNA5, and GNA6); (Licensed Practical Nurse (LPN) 9) and (Registered Nurse (RN) 3) of five random nursing staff reviewed for staffing were trained in the facility's Quality Assurance Performance Improvement (QAPI) Program. Findings include: Review of a facility policy titled Staff Development Program, dated May 2019, indicated All personnel must participate in initial orientation and regularly scheduled in-service training classes . The primary objective of our facility's staff development program is to ensure that staff have the knowledge, skills and critical thinking necessary to provide excellent resident care . Required training topics include the following: Elements and goals of the facility QAPI program . Review of documents provided by the facility titled Relias [an on-line training program] revealed the following: 1. CNA4's date of hire was 11/02/23 and her training failed to address the facility's QAPI program. 2. CNA5's date of hire was 03/02/23 and her training failed to address the facility's QAPI program. 3. CNA6's date of hire was 06/27/24 and her training failed to address the facility's QAPI program. 4. LPN9's date of hire was 02/07/24 and her training failed to address the facility's QAPI program. 5. RN3's date of hire was 10/03/23 and his training failed to address the facility's QAPI program. During an interview on 08/08/24 at 3:59 PM, Director of Nursing (DON) 1 confirmed the staff were not yet trained on the facility's QAPI program. The DON stated, We were ready to implement the QAPI training to staff when COVID hit the facility, and it went by the wayside. My goal is to have QAPI included in the yearly Relias Training that is completed online.