STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215094	A. BUILDING _____ B. WING _____	06/24/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WESTMINSTER HEALTHCARE CENTER	1234 WASHINGTON BOULEVARD WESTMINSTER, MD 21157

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 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record and interview with facility staff, it was determined the facility staff failed to ensure that an order was correctly transcribed resulting in the administration of 4 doses of a respiratory medication being administered via nebulizer rather than an inhaler as indicated in the medical providers note, and failed to follow a physician's orders [REDACTED].#5) and 1 of 13 residents(Resident #8) selected for focused COVID-19 infection control review. The findings include: 1. Review of facility monitoring documentation revealed the first COVID positive cases were identified in early April 2020. Review of Resident #5's medical record revealed the resident had multiple medical conditions including [MEDICAL CONDITION] (lung disease). Review of the facility's census documentation for 4/8/2020 revealed the resident was residing in a room with two roommates. Review of the 4/9/2020 Concurrent Review (nursing assessment documentation), revealed that, on 4/9/2020 at 3:34 AM, the resident had an elevated temperature of 101.8 and labored breathing, and a medical provider (Nurse Practitioner #9) was notified at 3:41 AM. Review of the Telehealth physician progress notes [REDACTED].#9 on 4/9/2020 at 3:41 am revealed the following: Verbal order for [MEDICATION NAME] inh (inhaler) 4 puffs q2hrs PRN (as needed) SOB (shortness of breath)/Wheezing . The note also included orders for Droplet precautions and to Discontinue nebulizer therapies ([MEDICATION NAME]). If resident previously on nebulizer therapies, transition to dose equivalent MDI (multidose inhaler). Further review of the 4/9/2020 Concurrent Review revealed the following: new orders .[MEDICATION NAME] neb q2h (nebulizer every two hours) . [MEDICATION NAME] is a medication used to treat wheezing and shortness of breath. It can be administered via an inhaler or via a nebulizer. A nebulizer turns the medication into a fine mist that is inhaled into the resident's lungs. Nebulizer treatments are considered an aerosol-generating procedure (AGP). Review of a nursing note, written on 4/9/2020 at 8:03 AM, revealed the following: .NP (nurse practitioner) notified and gave new orders . [MEDICATION NAME] via neb q4 . Review of the Medication Administration Record [REDACTED]. No documentation was found on the MAR indicated [REDACTED]. Review of the Medication Administration Record [REDACTED]. On 6/19/20 at 10:49 AM, the Director of Nursing confirmed that the 4/9/20 Telehealth provider note indicated that an inhaler, not a nebulizer, was ordered. Surveyor then reviewed the concern that the order entered into the electronic health system, and administered, was different than what was actually ordered by the provider, resulting in multiple nebulizer treatments being administered. As of time of exit on 6/24/2020 at 9:00 AM, no additional documentation or other information had been provided regarding this concern. 2. Resident #8's medical record was reviewed on 6/22/20 at 10:00 AM. A physicians' order was written on 6/6/20 for vital signs Q(every) 4 hours temp above 99.0 notify MD (physician). Further review of the record, on 6/24/20 at 8:20 AM, revealed that Resident #8's TAR (Treatment Administration Record) included the physicians VS (vital signs) order as written and also included every shift. The TAR provided space to record and sign off Resident #8's vital signs once each shift labeled Day Eve and Night. Space was not provided on the TAR to sign off or document vital signs every 4 hours which would have been 6 times per day. Further review of the Electronic Medical Record (EMR) reflected that vital signs were also documented in the Vital Signs section of the electronic medical record. A comparison of the Vital Signs record and the TAR revealed that some vital signs were recorded on the vital sign record, some were recorded and signed off on the TAR and many were documented on both records. However, the records failed to reveal that Resident #8's vital signs were checked every 4 hours as ordered from 6/6/20 to 6/24/20. The Administrator was made aware of these findings by telephone on 6/24/20, and was asked if she could provide documentation to reflect that Resident #8's vital signs were obtained every 4 hours as per the physicians order. At 8:45 AM, a telephone interview was conducted with the Administrator, Staff #6 (Assistant Director of Nursing) and Staff #7 (Unit Manager). They indicated that the resident was not always cooperative and refused vital signs. When asked where the vital sign refusals were documented, they indicated in the progress notes. The progress notes from 6/6/20 - 6/24/20 were reviewed and revealed that 6 notes were written - 6/7/20 at 4:48 AM, 6/8/20 at 6:31 AM and 11:00 AM, 6/14/20 at 12:24 AM, 6/20/20 at 2:28 PM and 6/21/20 at 1:37 AM indicating Resident #8 refused vital signs assessments. These refusal notes did not account for all of the missing vital signs. No documentation was found to indicate that Resident #8's vital sign were assessed every 4 hours as ordered by the physician.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, it was determined that the facility failed to have a system in place to ensure that newly admitted residents were kept in isolation during a 14 day observation period as evidenced by housing residents of unknown COVID status in a room together during the observation period, thus potentially exposing a resident to the [MEDICAL CONDITION]; and failed to ensure that vitals signs were being monitored on a daily basis as part of the COVID 19 screen. This was found to be evident for four out of the six (Resident #9, #10, #11 and #12) newly admitted residents selected for review; and 3 out of 3 residents (Residents #1, #3 and #13) reviewed for daily COVID 19 screening. The findings include: 1. Consistent with guidance from both the CDC and CMS, on 4/24/20, the State of Maryland Health Secretary issued an order requiring facilities to, designate a room, series of rooms, or floor of the nursing home as a separate observation area where newly admitted or readmitted residents are kept for 14 days on contact and droplet precautions while being observed every shift for signs and symptoms of COVID-19. The CDC guidance regarding Droplet Precautions includes the following: Ensure appropriate patient placement in a single room if possible. In long-term care and other residential settings, make decisions regarding patient placement on a case-by-case basis considering infection risks to other patients in the room and available alternatives. The CDC guidance regarding testing includes the following: Testing residents upon admission could identify those who are infected but otherwise without symptoms and might help direct placement of asymptomatic [DIAGNOSES REDACTED]-CoV-2-infected residents into the COVID-19 care unit. However, a single negative test upon admission does not mean that the resident was not exposed or will not become infected in the future. On 6/15/2020, the surveyor completed an onsite visit. During this visit, the Administrator reported that the facility had designated three resident areas: Red for COVID positive; Yellow for residents under observation, and Green for residents who were negative. 1a) Neither Resident #9 nor Resident #10 were isolated for 14 days after admission. On 6/18/2020, review of Resident #9's medical record revealed that the resident was admitted on [DATE] after a hospitalization . The resident had a COVID 19 test on 5/22 which was negative. However, per CDC guidance, Resident #9's COVID status remained unknown due to possible exposure prior to this admission. No documentation was found to indicate that Resident #9 had ever been COVID positive or that any additional COVID testing had occurred. On 6/18/2020, review of Resident #10's medical record revealed that the resident was admitted on [DATE], after a hospitalization , to the same room as Resident #9. Further review, on

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) 6/18/2020, of Resident #10's medical record failed to reveal documentation that a COVID 19 test had been ordered or completed either at the hospital or the facility. On 6/18/2020 at 3:42 PM, during an interview, the Infection Control Nurse indicated that Resident #10 was tested for COVID-19 shortly after admission and the results were still pending. On 6/15/20, Resident #9 had been in the facility 14 days. However, because newly admitted Resident #10 was placed into the same room with Resident #9 on 6/5/20, 14 days had not passed since Resident #9's possible exposure from Resident #10. Further as noted above, test results for Resident #10 had not yet been obtained. Nonetheless, on 6/15/20, Resident #9 was moved off the observation unit and to the green COVID negative unit. On 6/19/2020 at 9:45 AM, the infection control nurse indicated that calls had been made to the health department in attempts to obtain the results of Resident #10's COVID test, but the results had not yet been obtained. Later that day, review of the medical record revealed that the results of the COVID test had been uploaded to the electronic health record on 6/19/2020. Review of the report revealed that the date of the specimen was 6/8/2020 and that the results had been received by the health department on 6/11/2020. This test was noted to be negative. Further review of the medical record failed to reveal any documentation regarding attempts to obtain the COVID test results prior to 6/19/2020. 1b) Neither Resident #11 nor Resident #12 were isolated for 14 days after admission. Resident #12 was newly admitted on [DATE] with a negative COVID test from 5/16/2020. However, per CDC guidance, Resident #12's COVID status remained unknown due to possible exposure prior to this admission Resident #11 was newly admitted on [DATE] to the same room as Resident #12. Resident #11 had a COVID negative test on 5/27/2020, however, per CDC guidance, Resident #11's COVID status remained unknown due to possible exposure prior to this admission. Further review of Resident #11's medical record revealed a [DIAGNOSES REDACTED]. An ambulatory resident with dementia increases the risk of the spread of [MEDICAL CONDITION]. Resident #11 and Resident #12 were not kept in isolation for 14 days, but rather shared the same room beginning on 6/2/20. On 6/16/20, both resident #11 and Resident #12 were moved from the yellow observation area to the green COVID negative area. No documentation was found to indicate any of these 4 residents (#9, #10, #11, and #12) had previously been admitted to the facility. Review of the census data for 6/14/2020 revealed at least one empty room in the designated Yellow unit. Additionally, there were other empty resident rooms in the facility. On 6/19/2020 at 9:45 AM, a phone interview was conducted with the Administrator, Director of Nursing and the infection control nurse. The Administrator reported that if a resident is asymptomatic and there is a negative COVID test from the hospital, they are admitted to the yellow unit and cohorted with a resident of same status. A resident with a negative test may have been exposed and may then test positive for up to 14 days after exposure. During the 6/19/2020 9:45 AM phone call, surveyor reviewed the concern regarding cohorting newly admitted residents of unknown COVID status in the same room. On 6/19/2020 at 4:00 PM, Administrator indicated they were continuing to work on a plan to address new admissions. On 6/22/2020 at 1:43 PM, the Administrator reported new admissions were being placed in any private room on the isolation (yellow) unit. When asked for clarification regarding what would happen when there were no empty rooms on the Yellow unit, the Administrator reported she was not sure yet, but indicated that she was not taking in any more admissions until a process was in place. 2) On 4/29/20, the State of Maryland Health Secretary issued an order which included the following: As the clinical status of individuals infected with COVID-19 may change quickly and nursing home residents may have an atypical presentation of the infection, each nursing home resident shall be evaluated daily to check for COVID-19 by the nursing home's clinical staff. The evaluation shall include vital signs as well as the identification of new or worsening signs or symptoms. An atypical presentation of COVID-19 infection may include: lower temperature (<100.0 F); muscle aches; nausea; vomiting diarrhea; abdominal pain; headache; runny nose; or fatigue. Vital signs include: temperature, pulse rate, respiratory rate and blood pressure. They provide information on the body's most basic functions. On 6/15/2020 at approximately 3:15 PM, nurse manager #8 reported that residents receive an assessment at least once per shift and that if there is an increase in temperature or a low pulse ox (saturation %) then a COVID evaluation is completed with increased assessments to every 4 hours. On 6/16/2020 at 2:08 PM, the Director of Nursing (DON) reported that, if a resident has a fever of 99 or above, they then do a COVID symptoms evaluation. Review of Resident #1, #3 and #13's medical records revealed documentation in the June Medication Administration Record [REDACTED]. This documentation consisted of the nurse's initials that the assessment had been completed and documentation of a temperature, O2 saturation, and a response to whether the resident was experiencing respiratory symptoms. Some staff were documenting a respiratory rate while others documented N or no, indicating no respiratory signs or symptoms. Further review of the medical records for these three resident's failed to reveal consistent daily assessment of blood pressure or pulse. On 6/22/2020 at 1:23 PM, interview with the Director of Nursing revealed that the current daily COVID assessment only consisted of temperature, oxygen saturation and respiratory status. The DON confirmed that no blood pressure or pulse assessments were completed as part of the COVID assessment. The DON then reported that BP and pulse were only obtained on a regular basis if there was a specific order to do so, for example, if needed to monitor the use of a cardiac medication. The concern regarding the facility's failure to ensure that a set of vital signs were being completed as part of the daily COVID 19 screen was addressed with the Administrator and the Assistant Director of Nursing at time of exit on 6/24/2020 at 9:03 AM.
F 0885 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	Based on interview and review of documentation, it was determined that the facility failed to have an effective system in place to ensure that residents, their representatives and families were notified by 5:00 PM the next calendar day following the identification of a confirmed COVID + resident. This was found to be evident for 3 out of the 3 resident's (#1, #3 and #13) reviewed for notification. The findings include: On 6/15/2020 at approximately 12:15 PM, the Administrator reported that the facility provides a weekly letter with updates with documentation in the medical record of when the letters were sent out. Surveyor requested a copy of the two most recent letters. Review of the letters, dated 6/2/2020 and 6/9/2020 failed to reveal any documentation specific to this facility. On 6/17/2020 at 3:20 PM, interview with the Social Service worker revealed that the update letter that was recently sent out was written by the corporate medical director. On 6/15/2020 at 2:45 PM, the Administrator reported that the facility was utilizing robo calls to inform family of new cases and stated that they have not had any new cases recently. On 6/22/2020, review of Resident #8's medical record revealed that the resident had been identified as COVID positive in June. On 6/22/2020 at 12:19 PM, interview with the Infection Control nurse revealed that the facility was made aware of the positive COVID 19 test on 6/6/2020, and the resident was immediately placed on isolation precautions. On 6/23/2020, the Administrator reported that the most recent robo calls were made at the end of May and indicated that a letter went out after the identification of the new case on 6/6/2020. On 6/23/2020, surveyor reviewed additional letters provided by the Administrator regarding notification to residents and family members. Although these letters did mention the facility by name, they failed to include a cumulative update information. Also, two of the letters provided failed to include a date to indicate when they may have been sent out. On 6/24/2020 at 7:30 AM, review of Resident's #1, #3 and #13's medical records for documentation of notification regarding the identified case on 6/6/20 failed to reveal documentation of a robo call or a letter being sent out prior to 6/11/2020. This was more than 4 days after the identification of the new COVID + case.