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 _____	**09/03/2020**

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 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of medical records and other pertinent documentation and interviews, it was determined that the facility failed to implement care plan interventions as evidenced by the failure to ensure that floor mats were utilized as indicated in the care plan for a resident with a history of falls. This was found to be evident for 1 out of 3 residents (Resident #4).reviewed for falls during the survey. The findings include: Review of Resident #4's medical record revealed the resident was admitted to the facility several years ago and whose diagnoes include, but are not limited to, dementia, [MEDICAL CONDITION], adult failure to thrive and has a history of falls. Review of complaint MD 661 revealed a report that the resident had fallen out of bed, however, the mats at bedside, to protect the resident in the event of a fall, were not in place. Review of the May 2020 Treatment Administration Record (TAR) revealed that, prior to a May hospitalization , there was an order in place for Low bed with mat on floor for safety every shift. Staff were documenting that the bilateral floor mats next to Resident #4's bed were in place every shift on the May treatment administration record (TAR). Review of the medical record revealed a care plan, initiated 5/13/2020, for High risk for falls related to confusion, gait/balance problems, incontinence, poor communication/comprehension and unaware of safety needs. Interventions initiated 5/13/2020 included: bilateral fall mats in place while resident is in in bed. On 9/3/2020, further review of the medical record failed to reveal an order, since May 2020, for the fall mats. Review of the TARs for June, July and August failed to reveal documentation regarding the presence of the fall mats. Further review of the medical record revealed a progress note, dated 7/24/2020 at 10:25 PM, that stated: Resident had a fall today. No apparent injuries noted. No pain or discomfort voiced this shift. Neuro checks in progress. Vital signs stable. Safety precautions maintained. This note failed to address what safety precautions were being maintained. Review of the concurrent review assessment, dated 7/24/2020, revealed the presence of a 2 x 2 cm hematoma (bruise) on top of the scalp and 2 left forehead contusions of 0.5 cm. Notification had been made to the responsible party as well as the primary care provider regarding a fall from bed. This assessment also revealed the following: At 0855 this a.m. was observed on the floor lying on (his/her) back with feet on the bed. Resident stated I rolled out of bed. On 9/3/2020, review of the Investigation Report completed by the unit nurse manager #3, which included written statements from GNA #10 and nurse #12, failed to reveal documentation regarding the presence of floor mats. Both written statements included documentation that the resident was on the floor with (his/her) feet on the bed. On 9/3/2020 at 1:44 PM, geriatric nursing assistant (GNA #10) reported that they do have floor mats that they use but that once the resident is up, they put the mats to the side. Regarding the 7/24/20 fall, the GNA reported that she had not found the resident, but that she had observed the resident, reporting the bed was low, the upper part of the resident was on the floor and the resident's legs were on the mattress. The GNA was unable to recall if the floor mats were in place when she observed the resident on the floor. On 9/3/2020 at approximately 4:50 PM, surveyor reviewed the concern with the Director of Nursing regarding failure to follow the care plan regarding the use of floor mats at the time of the July fall.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 medical record review, interview and observation, it was determined that the facility 1) failed to ensure that orders for needed services and interventions were put in place when a resident was readmitted to the facility after a hospitalization as evidenced by the failure to re-order oxygen as needed (Resident #5) and failure to have an order for [REDACTED].#4); and failure to obtain orthostatic blood pressures (Resident #6). These deficient practices were found to be evident for 4 out of 12 residents (Resident # 4, #5, #8 and #6) reviewed during the survey. The findings include: 1a) Review of Resident #5's medical record revealed that the resident's most recent re-admission from the hospital was in July 2020 and [DIAGNOSES REDACTED]. On 8/25/2020, resident was observed in bed with oxygen via a nasal cannula. Review of the physician History and Physical note, dated 7/21/2020, failed to reveal documentation regarding the use of oxygen. Review of the 7/23/2020 Nurse Practitioner note revealed the resient was seen for increased work of breathing, the resident's pulse ox was 98% on 2L of oxygen via nasal canula (NC) and the plan included an increase in the oxygen to 3L. Review of the 7/28/2020 nurse practitioner note revealed the resident's pulse ox was 98% on 2 L oxygen via NC. Further review of the orders, as well as the medication and treatment administration records for July and August 2020, failed to reveal documentation of the administration of the oxygen as indicated in the nurse practitioner notes. Review of the 7/31/2020 nurse practitioner note revealed that the resident was currently on room air (no supplemental oxygen). Review of the 8/14/2020 nurse practitioner note revealed that the resident was currently on room air and denied any shortness of breath. On 8/27/2020 at 7:45 AM, surveyor observed Resident #5 receiving oxygen via a nasal cannula (NC) at 3 L per minute. On 8/28/2020, review of Resident #5's medical record failed to reveal current orders for oxygen administration for this resident. On 8/28/2020 at 12:30 PM, the unit nurse manager #3 reported the resident was currently on continuous oxygen. Surveyor then reviewed the concern that no current order could be found for the use of the oxygen and that the most recent Nurse Practitioner notes indicated the resident was on room air. On 8/28/2020 at 1:00 PM, the unit nurse manager #3 reported that, when Resident #5 returned from a hospitalization , the resident was not on oxygen, however, they had been put on 2 L when on another unit. She confirmed that there was no current order for oxygen in the medical record, and stated it's getting in there. Further review of the medical record revealed an order, dated 8/28/2020 at 1:10 PM, for O2 via nasal cannula at 2L/min every 8 hours as needed. On 9/1/2020 at 11 AM, surveyor reviewed the concern regarding the administration of oxygen without an order with the Director of Nursing (DON). The DON reported that she thought that the order got dropped after the resident's most recent re-admission.The surveyor reviewed the concern that observation of the oxygen administration was at 3L but that the most recent order was for 2L. 1b) Failed to have an order for [REDACTED]. Review of the May 2020 Treatment Administration Record (TAR) revealed that prior to a hospitalization , there was an order in place for : chair alarm to chair. check placement and function every shift. Staff were documenting regarding this order every shift on the May TAR. Review of the medical record revealed a care plan, initiated 5/13/2020, for High risk for falls related to confusion, gait/balance problems, incontinence, poor communication/comprehension and unaware of safety needs. Interventions initiated 5/13/2020 included: Bed alarm to bed, check placement and function; chair alarm to chair, check function every shift. Observations of Resident #4 on 9/2/2020 at 4:20 PM revealed the resident was in bed with the alarm in place. On 9/2/2020 at approximately 4:30 PM, further review of the medical record failed to reveal an order, since May, for the chair/bed alarm. No documentation was found that the functionality of the alarms were being assessed. On 9/2/2020 at

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.

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 _____	09/03/2020

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** - Some	(continued... from page 1) 4:35 PM, unit nurse manager #3 confirmed that the resident had a bed/chair alarm. Surveyor reviewed the concern with the unit manager and the Director of Nursing that the alarm could be considered a restraint and that no order was found for the use of the alarm since May. On 9/3/2020 at 1:44 PM, GNA #10 confirmed they have been using an alarm since Resident #4 was moved to the current unit. Further review of the medical record revealed that resident had been moved prior to 7/24/2020. 2) Failure to have an order specifying the rate and total amount of IV fluid to be infused. Review of Resident #4's medical record revealed a nurse's note, on 4/30/2020 at 6:21 PM, that revealed IV placement was completed and that normal saline was being administered via the IV. No documentation was found of an order for [REDACTED]. Further review of the medical record failed to reveal nursing documentation regarding the completion of the IV fluid administration. On 9/3/2020 at approximately 4:50 PM, surveyor reviewed with the DON the concern with the failure to have an order for [REDACTED]. On 8/31/2020, review of Resident #8's Minimum Data Set Assessment, dated 5/14/2020, revealed the resident was totally dependent on staff for bed mobility, dressing, eating and personal hygeine. Review of the Skin Grid Non-Pressure assessment, dated 7/15/2020, revealed the resident had a wound on the pubis since March of 2020 that was being treated with medi-honey daily. This note was completed by the wound nurse. Further review of the medical record revealed this wound was suspected of being a neoplasm, which is an abnormal mass of tissue that may or may not [MEDICAL CONDITION]. During an interview on 8/25/2020 at 2:50 PM, the wound nurse reported that she does the dressing changes for the residents on Monday/Tuesday/Thursday and Friday. She indicated the regularly assigned nurse would complete any dressing changes that needed to be completed on the other days of the week (Saturday/Sunday/Wednesday). Review of the 8/11/2020 wound physician note revealed the pubis wound was more than a year old, was 1.3 x 1.3 cm in size with light serous drainage and the treatment plan consisted of Leptospermum honey apply once daily for 30 days. Leptospermum is the primary component in [MEDICATION NAME] dressings. Review of the Skin Grid Non-Pressure assessment, dated 8/25/2020, revealed the wound on the pubis continued to have a small amount of serous drainage and the current treatment orders consisted of medi-honey daily. The wound nurse completed this note. Further review of the medical record failed to reveal orders for treatment to the pubis wound since 7/16/2020. Review of the Treatment Administration Record (TAR) revealed documentation of the medi-honey once daily for 7/1 thru 7/16, but no documentation was noted that this dressing change was being completed after 7/16/2020. On 9/1/2020 at 12:25 PM, the DON reported that the wound physician orders [REDACTED]. The DON went on to report that the wound nurse's notes indicated she was completing the [MEDICATION NAME] dressing change every day. Surveyor reviewed the concern that wound nurse only does the dressing changes Monday/Tuesday/Thursday/Friday and that there was no documentation that the treatment was provided as indicated by the other nurses assigned to care for the resident. 4) Failure to follow physician orders. 4a) On 8/25/2020 at 12:20 PM, during observation of incontinence care for Resident #4, surveyor observed GNA #4 apply [MEDICATION NAME] cream to the resident's buttocks. [MEDICATION NAME] is a [MEDICATION NAME] based barrier cream. On 8/25/2020 at approximately 2:30 PM, review of Resident #4's medical record revealed an order in place since 8/20/2020 for Zinc Oxide Cream apply to buttocks after each incontinence episode. At 2:50 PM, the wound nurse #8 confirmed that Zinc Oxide Cream was different than [MEDICATION NAME] and that the zinc oxide was kept on the treatment cart (a locked cart that nurses have access to). After reviewing the order, the wound nurse confirmed that the nurse should have brought in the Zinc Oxide Cream and applied it to the resident's buttocks during the incontinence care. On 8/25/2020 at 3:00 PM, surveyor reviewed the concern with the Unit Nurse Manager #3 regarding the GNA's use of the [MEDICATION NAME] and the failure of the nurse to apply the zinc oxide as ordered during incontinence care. This concern was also reviewed with the DON on 9/3/2020. 4b) On 8/25/2020, review of Resident #4's medical record revealed an order in place since 7/27/2020 for Nectar consistency (of fluids). Review of the Meal Tracker information from the kitchen also revealed documentation that the resident was to receive Nectar thickened liquids. On 8/25/2020 at 4:15 PM, the therapy director confirmed the order should be for Nectar think liquids. On 8/26/2020 at 4:00 PM, the RD #6 reported that the resident currently receives Ensure and magic cup (frozen nutritional treat) mixed together three times a day. Review of the medical record revealed an order for [REDACTED].#5 who reported she would give the resident some Ensure. At approximately 9:00 AM, nurse #5 reported she had provided the Ensure this morning, she went on to report that she does not thicken the Ensure and was unable to verbalize if the resident's fluids needed to be thickend stating that she provides medications in applesauce. The nurse also denied having mixed the Ensure with the frozen nutritional treat, indicating that was provided seperately. On 8/27/2020 at 9:20 AM, the speech therapist #9 confirmed that Ensure needs to be thicked to nectar thick. Surveyor then informed the speech therapist of the nurse's report that she did not thicken the ensure. The speech therapist indicated she would address the issue. On 8/27/2020 at 11:50 AM, surveyor reviewed the concern regarding the administration of non-thckened Ensure with the Administrator. On 9/2/2020 at 9:25 AM, surveyor then reviewed the concern with the RD and the DON that staff have not been combining the Ensure with the frozen nutritional treat as ordered, but rather administering the two items seperately. On 9/2/2020 at 10:10 AM, the unit nurse manager #3 confirmed that the Ensure and the frozen treat were not being mixed together as ordered. The unit manager reported that the frozen nutritional treat is too hard to mix with the Ensure so staff were thickening the Ensure and giving the frozen treat seperately. Surveyor reviewed the concern that staff were documenting that the items are being mixed and given together. On 9/3/2020, further review of the medical record revealed that the order to mix the Ensure and frozen nutritional treat had been discontinued on 9/2/20. New orders had been implemented on 9/2/20 to provide the Chocolate Ensure (8oz) mixed with thickener (nectar) in morning, afternoon and evening snack and a separate order for the frozen nutritional snack to be given three times a day. The concern regarding the failure to thicken the Ensure and the failure to ensure the staff were providing the supplements as ordered was reviewed with the DON on 9/3/2020 at approximately 4:50 PM. 4c) Orthostatic (relating to or caused by an upright posture) blood pressures measure a person's blood pressure both while lying or sitting and while standing and the measurements are compared. Orthostatic blood pressure (BP) monitoring can identify orthostatic [MEDICAL CONDITION], a form of low blood pressure that happens when standing up from sitting or lying down, can cause dizziness or lightheadedness and can contribute to falls. On 9/1/20 at 10:00 AM, a review of Resident #6's electronic medical record (EMR) and closed paper medical record revealed the resident had a history of [REDACTED]. Review of Resident #6's physician orders [REDACTED]. Review of Resident #6's July 2020 Medication Administration Record [REDACTED]. There was no documentation in the MAR indicated [REDACTED]. Continued review of the medical record failed to reveal evidence that Resident #6 was being monitored for orthostatic blood pressures as ordered. The Director of Nurses was made aware of these findings on 9/1/20 at 1:41 PM.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, interview and observation, it was determined that the facility failed to: a) provide adequate nutrition to support wound healing and skin integrity as evidenced by failing to provide needed protein via daily [DEVICE] feeds; b) prevent additional skin damage as evidenced by the deveopment of a wound related to incontinence brief usage and trauma to the skin from dressing used for a stage 4 pressure ulcer (Resident #5); c) prevent the deveopment of pressure area on the buttocks of a resident dependent on staff for bed mobility and on a [DEVICE] for nutrition. This was found to be evident for 2 out of 3 residents (Resident #5 and #8) reviewed for pressure ulcers. The findings include: 1) On 8/26/2020, review of Resident #5's medical record revealed that the resident had a history of [REDACTED]. Due to the COVID dx, the resident had an extended hospitalization prior to returning to the facility in June 2020. The resident was readmitted with a [DEVICE], although eating by mouth at the time of re-admit, with orders for the [DEVICE] to be flushed with water multiple times a day. The resident has had a stage 4 pressure ulcer on the right upper thigh for more than a year. This wound was followed weekly by a wound specialist. Review of the medical record revealed that, on 7/1/2020, a Dietary Nutritional Assessment was completed. This assessment revealed the resident was eating between 75 - 100% of meals daily and acknowledged the presence of the right upper thigh pressure ulcer The resident's weight was 222.5 lbs (100 kgs). The total energy estimated needs was 2300 - 2500 calories per day with a total protein need of 100 - 120 gms/day. The resident was assessed to be at nutritional risk for malnutrition related to acute illness and skin breakdown as evidenced by calculated need for wound healing and [DIAGNOSES REDACTED]. According to the(NAME)website, 30 ml of ProMod provides 100 calories and 10 gms of protein. Further review of the medical record revealed that this supplement was provided until the resident was hospitalized in July 2020. The Minimum Data Set (MDS) Resident Assessment Instrument (RAI) Version 1.17.1, released during October 2019, provides a definition for Nutrition or Hydration Intervention to Manage Skin Problems as dietary measures received by the resident for the purpose of preventing or treating specific skin conditions, (including) . high calorie diet with added supplementation to prevent skin breakdown, (and) high-protein supplementation for wound

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 _____	09/03/2020

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 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) healing. In July 2020, during a brief hospitalization , the resident was found to have a swallowing problem. The resident was readmitted in July with a NPO (nothing by mouth) order and [DEVICE] feedings were initiated. Review of the 7/15/2020 Dietary Nutritional Assessment revealed the resident was now NPO. The resident's weight was documented as 225.2 lbs (101 kg) and the resident's IBW was documented as 166 lbs (75 kg). The total energy estimated needs was 1818-2020 calories per day with a total protein need of 90-105 gms/day (1.2 - 1.4gm/IBW). The [DEVICE] feeding orders found in this assessment and in corresponding orders in effect until 8/8/2020 were [MEDICATION NAME] 1.5 at 65 ml (and hour) x 20 hours or until 1300 ml infuse. Further review of the 7/15/2020 Dietary Nutritional Assessment form revealed documentation that the 1300 ml of [MEDICATION NAME] 1.5 per day would provide 83 gms of protien per day, providing 85% of the estimated protein needs of the resident (based on the 1.2 gms/IBW). On 8/28/2020 at 9:01 AM, the RD #6 reported that she used Ideal Body Weight (IBW) to calculate the protein and fluid needs when assssing the needs for the resident once the resident became NPO, stating that she wanted to make sure they were giving the resident just what s/he needed. When asked if she took the presence of the wound into account, the RD reported that was why she calculated 1.4 gms of protein per kg of IBW (this would be 105 gms of protein per day). After reviewing the 7/15/2020 Dietary Nutritional Assessment with the RD, she confirmed that the resident was only receiving 83 gms of protein per day based on [MEDICATION NAME] 1.5 at 65 ml x 20 hours. At 9:30 AM on August 28, 2020, surveyor reviewed the concern with the RD and the Director of Nursing that, based on the RD's assessment and documentation, the [DEVICE] feeding ordered and administered failed to meet the residents protein needs. On 7/20/2020, the resident's weight was 226 lbs. Review of the 7/21/2020 wound physician note revealed the presence of a stage 4 pressure wound of the right posterior upper thigh, measuring 15 cm in length by 10 cm in width by 4 cm in depth. The wound had been present for more than one year. The wound progression was noted to be improved. This note also documented a new wound on the right hip measuring 7 cm x 0.5 cm with no depth and a notation From rubbing diaper. On 7/27/2020, the resident's weight was 219.6. Review of the 7/28/2020 wound physician note revealed that the stage 4 wound on the right thigh had no change, the wound of the right hip had Improved. On 7/31/2020, the resident's weight was 212 lbs. Further review of the medical record revealed a Dietary Progress note with an effective date of 7/31/2020, but a created date of 8/5/2020, which stated: Reviewed weight loss of 6# in one week with IDT (interdisciplinary team). Spoke with nursing about tube feeding regimen - stated resident has been receiving (his/her) full amount and not pulling out the tube feeding while infusing Tube feeding of [MEDICATION NAME] 1.5 at 65ml x 20 hours, flushes 200 ml q (every) 4 hours; provides1330 ml TV (total volume), 1950 cal, 83 gm proten, and 2188 ml fluids including flushes. Provides 100% of estimated nutritional needs. No intolerance to tube feeding. Will continue to observe weight trends and alter interventions as indicated. followed for wounds on right posterior upper thigh, right hip and left buttocks (right buttocks resolved). Based on the review of the 7/15/2020 Dietary Assessment, the tube feeding of [MEDICATION NAME] 1.5 at 65 ml x 20 hours was not providing 100% of the estimated nutritional needs as indicated in the 7/31 RD progress note. On 8/3/2020, a care plan was initiated for trauma to the left buttock r/t fragile skin. Review of the 8/4/2020 wound physician note revealed the presence of a new wound of the left buttocks measuring 9 cm x 4cm x 0.1 cm with a notation: from pulling of tape. Observation of the dressing change on 8/27/2020 revealed this wound was adjacent to the stage 4 pressure ulcer. Further review of the 8/3/2020 care plan for the trauma to the left buttock revealed interventions that included: Identify potential causative factor and eliminate/resolve when possible; and keep skin clean and dry, use lotion on dry scaly skin. No documentation was found in this care plan to indicate the trauma was related to the dressing for the stage 4 pressure ulcer. On 8/7/2020, the resident's weight was 206.6 lbs. On 8/7/2020, the RD wrote a Dietary Progress Note in which she recommended increasing the tube feeding to 75 ml/hr x 20 hours or until 1500 ml infuses. This note included the following: Tube feeding will provide 2250 cal (24 kcal/kg), 95 gm protein (1gm/kg) Meeting 100% of estimated nutritional needs. Based on review of the protein needs established in the 7/15 dietary assessment and confirmed by the RD interview on 8/28/20, the resident's protein needs were 105 gms/day. The increased feeding failed to provide the needed protein per day required by the resident. During an interview on 8/26/2020 at 3:25 PM with the Registered Dietitian (RD #6), she stated that she did not need to re-adjust the tube feeding orders until she saw the weight loss. She also reported that the wound nurse had noted that the wounds were not really healing. Review of the 8/11/2020 wound physician note revealed No Change to any of the three documented wounds: stage 4 to the right thigh; wound of the right hip or the wound to the left buttocks. On 8/14/2020, the RD wrote a Dietary Progress Note which stated: Discussed with IDT wound healing- wounds are stable. Recommendations to add prosource 30 ml once per day for wound healing via [DEVICE]. Will add 100 calories. 16 gms of protein. Further review of the medical record revealed an order for [REDACTED]. Review of the 8/25/2020 wound physician note revealed No Change to the stage 4 wound to the right thigh; Improved for the wound of the right hip; and Deteriorated for the wound of the left buttock. On 9/3/2020 at approximately 4:50 PM, surveyor reviewed the concerns with the Director of Nursing regarding the failure to provide adequate nutrition to promote wound healing based on the RD's assessment of the resident's protien needs, as well as the development of the wounds related to use of the incontinent brief and the injury related to the pressure ulcer dressing. 2) On 8/31/2020, review of Resident #8's Minimum Data Set Assessment, dated 5/14/2020, revealed the resident was totally dependent on staff for bed mobility, dressing, eating and personal hygeine. The resident had a [DEVICE] for nutrition. Review of a 7/9/2020 Dietary Nutritional Review note revealed the resident was NPO (nothing by mouth) which indicated that all nutrition was via the [DEVICE]. On 8/26/2020 at 3:25 PM, the RD #6 reported that she was present in the facility 3 days a week, usually Monday/Wednesday/Fridays. On 6/8/2020, the resident's weight was 139 lbs. On 7/1/2020, the resident's weight was 139.5 lbs. On 8/31/2020, review of the Skin Grid Pressure assessment, dated 7/29/2020, revealed a new facility acquired pressure wound. The wound was located on the right buttock and was 0.5cm length x 0.5cm width x 0.1 depth. A corresponding order was found to clean the open area to the right buttock with normal saline, pat dry, apply [MEDICATION NAME] and a dry dressing daily until healed every day shift. Review of the Treatment Adminsitration Record revealed that this dressing change was occurring daily since 7/30/2020. On 8/8/2020, the resident's weight was 124.2 lbs. 8/8 was a Saturday. Review of the progress notes revealed that, on 8/10/2020 at 3:21 PM, the RD #6 wrote a Weight Change Note: Pending re-weight to confirm significant weight loss. On 8/10/2020 at 5:35 PM, the resident's weight was 127 lbs. This 12 lb weight loss represents a severe loss of more than 8% in one month. Further review of the medical record failed to reveal documentation that the primary care physician was made aware of the confirmed weight loss on August 10, 11, 12 or 13, 2020. No documentation was found to indicate that the RD followed up regarding the re-weight until Friday August 14. Review of the 8/14/2020 Weight Change Note completed by RD #6 revealed documentation regarding the significant weight loss of 9.2% x 30 days, 8.6% x 90 days, that the weight loss unintentional, the existence of the right buttock wound and that the RD was recomending an increase in the tube feeding. Review of the Treatment Administration Record revealed that the resident's tube feeding was increased as recommended starting on 8/14/2020. This was six days after the significant weight loss was first identified on Saturday 8/8/2020, and more than a week after the pressure area was identified on the resident's buttocks. On 8/31/2020 at 3:54 PM, unit nurse manager #3 reported that the resident had two small areas on the buttocks; but those areas had healed up. On 9/3/2020 at approximately 4:50 PM, surveyor reviewed the concern with the Director of Nursing regarding the development of a pressure ulcer for a dependent resident and failure to address the resident's weight loss in a timely manner.
F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, interview and observation, it was determined that the facility failed to ensure that residents maintained acceptable parameters of nutritional status as evidenced by significant weight loss identified in a resident dependent on [DEVICE] feedings for all nutritional intake; failure to implement supplements as indicated in the registered dietitian's assessment and care plan ; failure to have an effective system in place to notify primary care provider and responsible party of weight loss and RD recommendations in a timely manner; failure to ensure weights were obtained as ordered; and failure to revise a resident's care plan for nutrition when a the resident had a significant weight loss. This was found to be evident for 4 out of 6 residents (Resident #5, #9, #4 and #6) reviewed for weight loss during the survey.The findings include: 1) On 8/26/2020, review of Resident #5's medical record revealed the resident had a history of [REDACTED]. Due to the COVID dx, the resident had an extended hospitalization prior to returning to the facility in June. The resident was readmitted with a [DEVICE], although eating by mouth at the time of re-admit, with orders for the [DEVICE] to be flushed with water multiple times a day. The resident has had a stage 4 pressure ulcer on the right upper thigh for more than a year. This wound was followed weekly by a wound specialist. Review of the medical record revealed that, on 7/1/2020, a Dietary Nutritional Assessment was completed. This assessment revealed that the resident was eating between 75 - 100% of meals daily and acknowledged the presence of the right upper thigh pressure ulcer The

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 _____	09/03/2020

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 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) resident's weight was 222.5 lbs (100 kgs). The total energy estimated needs was 2300 - 2500 calories per day with a total protein need of 100 - 120 gms/day. The resident was assessed to be at nutritional risk for malnutrition related to acute illness and skin breakdown as evidenced by calculated need for wound healing and [DIAGNOSES REDACTED]. According to the(NAME)website 30 ml of ProMod provides 100 calories and 10 gms of protein. In July 2020, during a brief hospitalization , the resident was found to have a swallowing problem. The resident was readmitted in July with a NPO (nothing by mouth) order and [DEVICE] feedings were initiated. Review of the 7/15/2020 Dietary Nutritional Assessment revealed the resident was now NPO. The resident's weight was documented as 225.2 lbs (101 kg) and the resident's IBW was documented as 166 lbs (75 kg). The total energy estimated needs was 1818-2020 calories per day with a total protein need of 90-105 gms/day (1.2 - 1.4gm/IBW). The [DEVICE] feeding orders found in this assessment and in corresponding orders in effect until 8/8/2020 were [MEDICATION NAME] 1.5 at 65 ml (and hour) x 20 hours or until 1300 ml infuse. Further review of the 7/15/2020 Dietary Nutritional Assessment form revealed documentation that the 1300 ml of [MEDICATION NAME] 1.5 per day would provide 83 gms of protien per day, providing 85% of the estimated protein needs of the resident (based on the 1.2 gms/IBW). During an interview on 8/28/2020 at 9:01 AM the RD #6 reported that she used Ideal Body Weight (IBW) to calculate the protein and fluid needs when asssing the needs for the resident once the resident became NPO, stating that she wanted to make sure they were giving the resident just what s/he needed. When asked if she took the presence of the wound into account, the RD reported that is why she calculated 1.4 gms of protein per kg of IBW (this would be the 105 gms of protein per day). After reviewing the 7/15/2020 Dietary Nutritional Assessment with the RD she confirmed that the resident was only receiving 83 gms of protein per day based on [MEDICATION NAME] 1.5 at 65 ml x 20 hours. At 9:30 AM surveyor reviewed the the concern with the RD and the Director of Nursing that, based on the RD's assessment and documentation, the [DEVICE] feeding ordered and administered failed to meet the residents protein needs. On 7/20/2020 the resident's weight was 226.0 lbs On 7/27/2020 the resident's weight was 219.6 lbs. Review of the Policies and Standard Procedures for Resident Weight, with a review date of 5/29/2019, revealed A plus/minus of 5 pounds of weight in one week will result in: i) Reweight within 24 hours 1) Validation with nurse for accurate weight 2) Notify IDT team/doctor/family, if indicated. Further review of the medical record failed to reveal documentation that a re-weight was obtained for more than 3 days. No documentation was found to indicate the primary care provider was made aware of the significant weight loss. The facility provided documentation that a 6 lb wieht loss x 1 week was addressed at the risk meeting held on 7/31/2020 and attended by the medical director. This documentation indicates a re-evaluation of the tube feeding was to occur. On 7/31/2020 the resident's weight was 212.0 lbs. A significant weight loss is 5% in one month or 7.5 % in 3 months, or 10% in 6 months. A severe weight loss occurs when the loss is greater than 5% in one month or 7.5 % in 3 months, or 10% in 6 months No document was found that the continued weight loss of more than 7 lbs identified on the day of the risk meeting (7/31) was addressed at the meeting. This represents a severe weight loss of more than 6% in less than two weeks. Further review of the medical record revealed a Dietary Progress note with an effective date of 7/31/2020, but a created date of 8/5/2020, which states: Reviewed weight loss of 6# in one week with IDT (interdisciplinary team). Spoke with nursing about tube feeding regimen - stated resident has been receiving (his/her) full amount and not pulling out the tube feeding while infusing Tube feeding of [MEDICATION NAME] 1.5 at 65ml x 20 hours, flushes 200 ml q (every) 4 hours; provides1330 ml TV (total volume), 1950 cal, 83 gm proten, and 2188 ml fluids including flushes. Provides 100% of estimated nutritional needs. No intolerance to tube feeding. Will continue to observe weight trends and alter interventions as indicated. followed for wounds on right posterior upper thigh, right hip and left buttocks (right buttocks resolved). On 8/26/2020 at 3:25 PM the Registered Dietitian (RD #6) confirmed that the weight loss had been addressed at the risk meeting held on 7/31/2020 but that she did not write the note until she was back in the building (created date was 8/5/2020). Based on the review of the 7/15/2020 Dietary Assessment, the tube feeding of [MEDICATION NAME] 1.5 at 65 ml x 20 hours was not providing 100% of the estimated nutritional needs as indicated in the 7/31 RD progress note. This note also failed to address the continued weight loss that was identified on 7/31, despite the fact that the note was written 5 days later on August 5. Further review of the medical record failed to reveal documentation to indicate the primary care provider was made aware of the continued weight loss prior to 8/7/2020. On 8/7/2020 the resident's weight was 206.6 lbs. This represents a severe weight loss of more than 8% in less than a month. On 8/7/2020 the RD wrote a Dietary Progress Note inwhich she recommends increasing the tube feeding to 75 ml/hr x 20 hours or until 1500 ml infuses. This note includes the following: Tube feeding will provide 2250 cal (24 kcal/kg), 95 gm protein (1gm/kg) Meeting 100% of estimated nutritional needs. Based on review of the protein needs established in the 7/15 dietary assessment and confirmed by the RD interview on 8/28 the resident's protein needs were 105 gms/day. The increased feeding continued to fail to provide the needed protein per day required by the resident. During an interview with the RD #6 on 8/26/2020 the RD indicated they waited another week prior to addressing the weight loss because of concern over the accuracy of the weights. She reported they discussed the weight process with nursing and provided education regarding obtaining weights. On 8/14/2020 the RD wrote a Dietary Progress Note which states: Discussed with IDT wound healing- wounds are stable. Recommendations to add prosource 30 ml once per day for wound healing via [DEVICE]. Will add 100 calories. 16 gms of protein. Further review of the medical record revealed an order for [REDACTED]. at 9:00 AM and again at 10:00 AM. On 8/28/2020 at 9:30 AM surveyor reviewed the concerns with the Director of Nursing and RD #6 regarding the fact that the RD assessment indicated the resident's protein requirements were between 90-105 gms/day but the ordered [DEVICE] feeding only provided 83 gms/day; the re-weights were not obtained the next day as indicated in the facility's policy when a difference of more than 5 lbs was identified; no documentation to indicate the primary care physician had been made aware of the significant weight loss until more than a week after it was first identified and confirmed by the 7/31 weight. 2) Review of Resident #9's medical record revealed [DIAGNOSES REDACTED]. The resident's weight on 5/5/2020 was 178 lbs and on 5/8 was 179. Further review of the medical record revealed a Dietary - Nutritional assessment dated [DATE] and completed by registered dietitian (RD#13). This note revealed the resident was willing to have supplement to aide in skin integrity, glucerna (8oz) x1 . One can of glucerna per day would provide an additional 220 calories with 10 grams of protein. This note also indicated the RD would be monitoring weekly weights to gather baseline for the resident. Further review of the medical record failed to reveal documentation that the primary care physician was made aware of the RD's recommendation for Glucerna during the month of May. Further review of the medical record revealed a care plan, initiated 5/16/2020, for the potential for imbalanced nutrition related to poor skin integrity, need for therapeutic diet and dx of diabetes, high blood pressure, and chronic heel ulcer. One of the goals was to accept and tolerate supplement by consuming more than 50% at offering. No order for a supplement was found for the month of May 2020. Review of the Policies and Standard Procedures for Resident Weight, with a review date of 5/29/2019, revealed that residents should be weighed within 24 hours of admission and that weekly weights should be obtained x 4 weeks for a baseline; and that if there is more than a 5 lb weight diference in one week then the resident should be re-weighed within 24 hours with validation by the nurse. The resident was hospitalized in May with a re-admission date of [DATE]. The re-admission orders [REDACTED]. No weights were found for 5/16 thru 5/31. On 6/1/2020, the resident weighed 164.5 lbs. No reweight was found to confirm this more than 10 lb weight loss in less than one month. Further review of the medical record revealed a Dietary Nutritional Assessment, dated 6/3/2020, which addressed the weight loss identified on 6/1 and included a recommendation for Glucerna two times a day. No documentation was found to indicate the weight loss was addressed by the primary care physician until 6/9/20 when an order for [REDACTED].#13 confirmed that the assessment was started on the 3rd, locked on the 4th but that nothing was implemented until the 9th. On 8/31/2020 at approximately 5:00 PM, RD #6 and RD #13 both confirmed that the process for documentation of changes was to record the information on a recommendation sheet, which is)given to the unit nurse manager, as well as the nurse assigned to the resident. The DON also reported that she gets a copy of the recommendations the next morning, and RD #6 confirmed that she was providing this information to the DON as well. Further review of the medical record failed to reveal documentation of the resident's weight from 6/2/2020 thru 7/9/2020. Further review of the medical record revealed a Dietary Progress Note written by RD #6 on 6/25/2020. This note addressed the 14 lb weight loss in one month and stated will observe weight trends and wound healing. This note failed to address the fact that weekly weights were not being obtained as ordered. On 9/3/2020 at approximately 4:50 PM, surveyor reviewed the concern with the DON regarding the failure to implement the supplement in May as indicated by the RD note and the care plan, failure of the physician to address the significant weight loss for more than one week in June, despite the RD note indicating a need for twice a day supplements and failure to obtain weekly weights as ordered and required in the facility policy. 3) Review of Resident #4's medical record revealed that the resident was admitted to the facility several years ago whose [DIAGNOSES REDACTED]. On 8/26/2020 at 4:00 PM, the RD reported that between 6/8/20 to 7/8/20, the resident had lost 9 lbs and that the resident currently received Ensure and magic cup (frozen nutritional treat) mixed together three times a day. Review of the medical record

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 _____	09/03/2020

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 0692 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 4) revealed an order for [REDACTED]. On 7/8/20, the resident's weight was documented as 89.4 lbs with a reweight two hours later of 89.2. Both of the weights recorded on 7/8 had been entered into the electronic health record by the Registered Dietitian (RD #6). There was a Care Conference Note, dated 7/14/2020, which revealed the interdisciplinary team, including the responsible party, met to discuss current goals and interventions. This note revealed that the responsible party expressed concern regarding resident's food intake. No documentation was found in this note addressing the significant weight loss that had been documented the week prior on 7/8/2020. Further review of the medical record failed to reveal any nursing, RD, physician, or nurse practitioner notes addressing the significant weight loss prior to 7/15/2020. Review of Concurrent Review note completed by the nurse on 7/15/2020 revealed a new recommendation from nutritional therapy to increase frozen nutritional treat and chocolate Ensure BID (two times a day) to TID (three times a day) 7/15/2020. This note indicated that the primary care physician and the resident's responsible party were made aware of this recommendation on 7/15/2020 at 9:45 PM. The RD wrote a corresponding Weight Change Note on 7/17/2020 in which she addressed the 9 lb wieght loss in one month and the recommendation to increase the frozen treat and Ensure to three times a day. Review of the MAR/TAR revealed that the chocolate ensure mixed with frozen nutritional treat at morning; afternoon and evening was changed to three times a day starting 7/16/20. On 9/2/2020 at 9:25 AM, interview with RD #6 confirmed that, on 7/8/20, there was a 8+ lb weight loss. The RD reported they got a re-weight and she later ordered an increase in the Ensure mixed with the frozen nutritional treat to three times a day. Surveyor reviewed the concern that the physician had not been informed of the significant weight loss at the time it was confirmed, and that there was a 7 day delay in the implementation of an intervention. On 9/2/2020 at 4:08 PM, the RD reported that the primary care provider had not been notified of the weight loss, but the loss was discussed at the risk meeting. The concern regarding the failure to address the resident's weight loss and implement interventions for one week was addressed with the DON on 9/3/2020 at approximately 4:50 PM. 4) On 9/2/20 at 10:00 AM, a review of Resident #6's medical record was conducted and revealed the resident was admitted to the facility on [DATE] following an acute hospital stay. Review of Resident #6's June 2020 MAR (medication administration record) revealed an order for [REDACTED].#6's June 2020 MAR indicated [REDACTED]. Review of Resident #6's weight summary in the resident's EMR (electronic medical record) revealed there were a total of two recorded weights: a weight of 165.2 lbs. (pounds) was recorded on 6/24/20 and a weight of 152.2 lbs. was recorded on 7/10/20. Continued review of the medical record failed to reveal documentation that a Resident #6's weight was obtained on admission and failed to reveal evidence that weekly weights had been obtained as ordered. Current professional standards of practice recommend weighing the resident on admission or readmission (to establish a baseline weight), weekly for the first 4 weeks after admission and at least monthly thereafter to help identify and document trends such as slow and progressive weight loss Resident #6's weight summary in the resident's EMR documented two recorded weights: a weight of 165.2 lbs. (pounds) was recorded on 6/24/20 and a weight of 152.2 lbs. was recorded on 7/10/20, indicating a 13 lb. weight loss between 6/24/20 and 7/10/20. Resident #6's significant weight loss, that was captured in the EMR weight summary on 7/10/20, was not addressed by the dietician until 7/17/20. On 7/17/20 at 2:43 PM, in a Weight Change Note, with the text Weight Warning, the dietician indicated that, on 7/10/20 at 9:11 AM, the resident's weight value was 152.2 lbs., which was a 7.5 % weight variation which indicatied the resident lost 13 lbs. in 15 days. The dietician documented the resident's weight loss was related to diuretics (water pill) (promotes increased production of urine) and indicated the resident's oral intake was improved over the past 5 days and indicated that the resident's weight trends would be observed. Continued review of Resident #6's medical record failed to reveal evidence that Resident #6 had fluid retention and/or [MEDICAL CONDITION] (excess fluid trapped in the body's tissues) which resolved from the use of the diuretic and failed to reveal evidence that Resident #6's significant weight loss was intentional as the result of diuretics. Resident #6's July 2020 MAR (medication administration record) documented the resident received [MEDICATION NAME] ([MEDICATION NAME]) (diuretic) by mouth daily for hypertension (high blood pressure). On 6/17/20 at 3:10 PM, in a hospital discharge summary, the PA-C (physician assistant, certified) wrote that Resident #6 had no lower extremity [MEDICAL CONDITION]. On 6/18/20, in an Admission Observation Tool, the section Most recent weight and scale used was left blank, indicating the resident's weight was not obtained on admission, and the nurse documented Resident #6 did not have [MEDICAL CONDITION] present. On 6/25/20 in a Nutritional Assessment, the dietician documented that the resident was currently on diuretics which can cause weight changes due to fluid shifts. No [MEDICAL CONDITION] noted on admission. Further review of Resident #6's medical record failed to reveal that further weights had been obtained on Resident #6 following the resident's significant weight loss. Review of Resident #6's nutrition plan of care was reviewed and revised when Resident #6 was identified to have an actual significant weight loss. There was no evidence in the medical record to indicate that Resident #6's attending physician had been notified of the resident's significant weight loss and there was no evidence in the medical record that Resident #6's responsible party had been notified of the resident's significant weight loss. During an interview on 9/2/20 at 9:07 AM, the Registered Dietician #6 was made aware of the above concerns. At that time, the Dietician confirmed that a weight was not obtained on admission, that weekly weights were not obtained and stated that normally a reweight is usually done following a significant weight loss. The Dietician stated that care plans are updated when there is a change in a resident's condition and confirmed that Resident #6's nutrition plan of care had not been updated to reflect the resident's significant weight loss. On 9/2/20 at 4:08 PM, the dietician confirmed that the resident's attending physician had not been made aware of Resident #6's weight loss. Failure of the facility staff to immediately assess and notify the physician of the weight loss delayed interventions that the physician could have put in place at the first sign of weight loss.
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, It was determined that the facility failed to ensure that a resident's medication regimen was free from an unnecessary [MEDICAL CONDITION] medication by failing to adequately monitor a resident for behavior, side effects or adverse consequences related to [MEDICAL CONDITION] medication. This was evident for 1 (Resident #7) of 3 residents reviewed for activities of daily living. The findings include: On 9/3/20 at 10:30 AM, Resident #7's medical record was reviewed. On 7/28/20 in a psychiatry note, the CRNP (Certified Registered Nurse Practitioner) documented that Resident #7 had a history of [REDACTED].#7's current psychiatric medications included [MEDICATION NAME] (anti-anxiety) by mouth 3 times a day and [MEDICATION NAME] ([MEDICATION NAME]) (antipsychotic) by mouth, 2 times a day. The CRNP's recommendations included monitor for any acute change in mood and/or behavior. Review of Resident #7's August 2020 MAR (medication administration record) revealed documentation that Resident #7 received [MEDICATION NAME] by mouth two times a day for [MEDICAL CONDITION] and [MEDICATION NAME] (anti-anxiety) by mouth three times a day for anxiety every day in August. Continued review of Resident #7's medical record failed to reveal evidence the facility staff monitored Resident #7 for the resident specific behavior that necessitated the use of the prescribed [MEDICAL CONDITION] medications or monitored the resident for the potential side effects related to the use of [MEDICAL CONDITION] medication. On 9/3/20 at 10:55 AM, during an interview, nurse #8 confirmed the above findings. The DON was made aware of these findings on 9/3/20 at 11:00 AM.
F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, it was determined that the facility failed to ensure that medications were stored in

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 _____	09/03/2020

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 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 5) locked compartments as evidenced by the observation of a [MEDICATION NAME] filled syringe on a resident's window sill; and observation of an opened package of medication from the pharmacy at an unattended nurses station. These observations were found to be evident on 2 out of the 2 nursing units observed during the survey. The findings include: 1) On 8/27/2020 at 7:45 AM, surveyor observed a unopened sealed prefilled syringe containing [MEDICATION NAME] on the window sill next to Resident #5's bed. At 7:50 AM, Nurse #1 confirmed the observation of the [MEDICATION NAME] on the resident's window sill and removed the medication from the resident's room. [MEDICATION NAME] is an anticoagulant medication used to prevent the formation of blood clots. A [MEDICATION NAME] flush is used to in IV lines to prevent blockages after an IV infusion. Review of Resident #5's medical record failed to reveal an order for [REDACTED].#3 of the observation of the [MEDICATION NAME] on the window sill. The unit nurse manager responded that she did know why that (medication) would be there since the resident does not have an IV. 2) On 9/3/2020 at 9:07 AM, surveyor observed an opened pharmacy delivery bag, accessible from the hallway, at the Unit 2 nursing station. No nursing staff was observed at the nursing station or within eyesight of the bag of medication. Surveyor continued to observe the unattended bag of medications until 9:10 AM at which time the Director of Nursing (DON) was observed in the hallway. The DON confirmed the surveyor observation of the unattended pharmacy bag and took possession of the bag of medication. The concern regarding unattended medications was reviewed with the DON on 9/3/2020 at 4:50 PM
F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **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 ensure that medical records were kept in professional standards as evidenced by: 1) staff documentation of an assessment having been completed during a time frame when that staff member was not working; 2) failed to ensure that primary care physician notes were documented in a timely manner as evidenced by notes being electronically signed more than a week after the visit occurred 3) staff documenting vital signs, assessments and medication administration for a resident who was hospitalized at the time 4) documentation of notification of responsible party for orders that had not actually been written or implemented for that resident. This was found to be evident for 3 out of 12 residents (Resident #5, #4 and #6) reviewed during the survey. The findings inlude: 1) On 8/27/2020, review of Resident #5's medical record revealed that nurse #11 had documented on 6/20/2020 between 9:44 PM - 9:49 PM the completion assessments (GG Admission Evaluation (8 Hr)) with the following dates/times: 6/19/2020 at 12:28 PM 6/19/2020 at 8:28 PM 6/20/2020 at 4:28 AM 6/20/2020 at 12:28 PM 6/20/2020 at 8:28 PM Review of Punch Detail report for Nurse #11 failed to reveal documentation that the nurse was working on 6/19 at 12:28 PM or on 6/20 at 12:28 PM. The nurse had worked the evening and night shift on 6/19; and 7:00 PM to 7:00 AM shift on 6/20. On 8/27/2020 at 11:15 AM, the Director of Nursing (DON) reported that all of the assessments were completed on the lock date (6/20/2020 between 9:44-9:49). She went on to report that the system automatically opens the assessments and they should be completed during the shift. Surveyor then reviewed the concern that the nurse had completed 5 assessments at one time; some of which were for a time when the nurse was not working. This concern was reviewed with the Administrator on 8/27/2020 at 11:50 AM. 2) On 9/3/2020, review of Resident #5's medical record revealed a note electronically signed by the primary care provider on 8/31/2020 for a visit that occurred on 8/18/2020. A nurse practitioner note was electronically signed on 8/7/2020 for a visit that occureed on 7/31/2020. Review of Resident #4's medical record revealed a note electronically signed by the primary care provider on 8/25/2020 for a visit that occurred on 7/31/2020. 3) Review of Resident #4's medical record revealed the resident was not in the facility on May 9, 10 or 11, 2020, having been discharged to the hospital earlier that month. On 9/3/2020, review of the resident's medical record revealed [REDACTED]. Values for temperature, pulse, respiration and blood pressure were recorded between 9:15 - 9:36 AM; and again at 7:36 PM. The 7:36 PM documention also included a pulse ox value. Further review of the vital sign documentation also revealed recorded temperature on 5/10 at 1:33 PM and a respiratory rate recorded on 5/11 at 11:30 AM. The concern regarding the documentation of vital signs values for a resident who was not physically in the facility was reviewed with the DON and the unit nurse manager #2 on 9/3/2020 at 12:23 PM. Further review of the Medication Administration Record [REDACTED]. This documentation included the administration of [MEDICATION NAME] injection on 5/9 at 9:57 PM to the RLQ (right lower quadrant) of the abdomen and on 5/10/2020 at 9:00 am to the LLQ (left lower quadrant) of the abdomen. Staff also documented having completed COVID assessments on 5/9 day and evening shift including temperature and pulse ox values. 4) On 9/1/20 at 10:00 AM, Resident #6's electronic medical record (EMR) and paper medical record was reviewed. Review of Resident #6's progress notes revealed on 7/10/20 at 5:57 PM, in a notification note, the nurse wrote that the resident had a new order for insulin sliding scale (the insulin dose is based on a person's blood sugar level) at bedtime for 1 week, [MEDICATION NAME] (insulin [MEDICATION NAME]) (long acting insulin) 5 units at hour of sleep and HgA1c (blood test that measures a person's average blood sugar levels over the past 3 months) on 7/14/20. The nurse's documentation indicated that Resident #6's responsible party was notified of the resident's new orders. Review of Resident #6's July 2020 physician orders [REDACTED].#6. Further review of the Resident #6's medical record failed to reveal physician documentation that correlated with nurse's documentation that the resident had new orders for insulin or an order for [REDACTED].#6 and the notification note was documented in error.