STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215352	A. Building B. Wing	07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coffman Nursing Home	1304 Pennsylvania Avenue Hagerstown, MD 21742

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. (continued on next page)

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.

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: 215352	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coffman Nursing Home	1304 Pennsylvania Avenue Hagerstown, MD 21742

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	Based on review of medical records and complaint 316958, and interviews it was determined that the facility failed to ensure a resident received care in accordance with professional standards of practice. This was found to be evident for one (Resident #23) of five residents reviewed for unnecessary medication.The findings include:1)Review of Resident #23's medical record on 7/17/25 revealed the resident has resided in the facility for more than 8 months. The resident was admitted with an implanted port in place and orders to access the port once a month to complete a flush with saline and heparin (a medication used to prevent blood clots). A port is a medical device that is surgically implanted under the skin that allows health care providers easy access to a vein. A port can be used for access to give medications, intravenous (IV) fluids, blood transfusions or for obtaining blood samples. Flushing the port lowers the risk of clots and blockages. Review of the nursing progress notes revealed that on 2/3/25 a nurse from the pharmacy completed the flush. This note was completed by the facility Nurse (Staff #1).Further review of the medical record revealed that in the beginning of March 2025 the order to flush the port once a month was still in place. However, review of the Licensed Nurse Administration Record (where the nurse's document the medications they administer to the resident) revealed a blank in the area for staff to document the flush when due on 3/3/25 and a notation that the order was discontinued on 3/3/25. Review of corresponding progress notes, completed by Nurse #1 revealed a notation: port flush changed to every 3 months, last flushed on 2/3/25. Further review of the medical record revealed an Implanted Port Infusion Protocol and Orders form, dated 3/3/25, that included orders to flush the port with saline and heparin once every 3 months. Nurse (#1) had signed the form. On 7/17/25 at 2:09 PM an interview with Nurse #1 revealed that an infusion nurse had completed a training with the staff in regard to completing the flush and referenced her note from February. Nurse (#1) went on to report that the nurse who conducted the training had recommended the flush be completed every 3 months rather than every month.No documentation was found to indicate the physician or nurse practitioner were notified of this recommendation when it was made in February. The surveyor discussed the concern with the DON on 7/22/25 at 4:53 PM, that the staff had received education in February but no documentation was found to indicate the physician was notified about the recommendation to change the order until the next month when Nurse #1 identified that the order should have been changed. Since a flush was completed on 2/3/25, and the order was changed in March to every three months then the next flush would be due in May. Further review of the Licensed Nurse Administration Record revealed a flush was completed on 4/3/25, which was a month before it was due.On 7/17/25 further review of the Licensed Nurse Administration Record revealed a current order was in place to complete the flush once every three months and that it was due to be administered on 7/3/25. In the area to document administration the nurse (Staff #9) documented a 9 which indicates Other/See Progress Notes.There was a corresponding progress note written by Nurse #9 on 7/3/25 at 11:28 PM. Review of this note revealed the nurse had attempted to access the port with the needle, but the needle would not fully access, there was no blood return and was unable to flush. The note also documented that the on-call nurse was made aware and that the night shift nurse had also attempted.Further review of the progress notes revealed a note completed by Nurse #10 on 7/3/25 at 11:44 PM. This note revealed the following: This RN attempted access without results. Resident screaming and waving [his/her] arms during access attempt. Attempts and educating resident and talking with resident were without results. DSD [dry sterile dressing] applied.On 7/17/25 further review of the medical record failed to reveal documentation to indicate the port flush was completed after the unsuccessful attempts on 7/3/25. No documentation was found to indicate the physician or nurse practitioner was notified that the nursing staff was unable to complete the flush as ordered.On 7/17/25 at 11:20 AM Nurse (Staff #12) reported she was aware the resident has a port and that staff flush it, but she was unsure how often and stated that she had never completed the flush. The surveyor then reviewed the concern that the record review revealed the flush was due on 7/3 but that progress notes indicated nursing staff could not access the port, no documentation was found to indicate any follow up or if the port has been flushed in the two weeks since. Nurse #12 stated: the doctor should have been notified.On 7/17/25 at 12:15 PM the surveyor informed the Director of Nursing (DON) that no documentation was found to indicate the port was flushed since it was due on 7/3/25. The DON indicated she would check if there was any documentation to indicate the port was flushed.On 7/17/2025 at 12:28 PM the DON confirmed there was no documentation to indicate the port was flushed or that the physician or nurse practitioner was notified. DON reported she was going to have staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215352	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2025
NAME OF PROVIDER OR SUPPLIER Coffman Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1304 Pennsylvania Avenue Hagerstown, MD 21742	

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a record review, observations, and interviews, it was determined that the facility failed to serve residents meals according to a predetermined menu that reflected their preferences. This was evident in four out of four dining observations during the survey.The findings include:1) A review of the facility's food committee meeting notes was done. The notes revealed that the residents voiced concerns and grievances, including the dietary staff consistently not serving their meals according to their preferences on the meal tickets.A dining observation on 7/17/2025 at 5:35 PM, in the 300 Hall, showed Resident #56 eating dinner in the room. On the Resident's meal tray was a ticket that listed all the food items to be on the tray: sloppy joe on Bun, xplain potato chips, steamed corn, salt and pepper, chocolate pudding, 2% milk, Ice water, vanilla ice cream. However, continued observation failed to show that Resident #56's tray contained vanilla ice cream, salt, and pepper. The Resident's Representative was present and said, We don't always get everything on the ticket. 2) An observation of dinner in the 300 Hallway included Resident #11, eating dinner in his/her room. The observation noted from the Resident's meal ticket was that s/he was to receive a red inner lip plate, a sloppy joe on a bun, mashed potatoes, cream-style corn, salt and pepper, chocolate pudding, ice water, cranberry juice, chocolate ice cream, 2% milk, and low-fat yogurt.However, the observation failed to show that Resident #11 received milk and low-fat vanilla yogurt on his/her tray. The resident stated that s/he did not receive milk or yogurt and added that s/he had requested cottage cheese with his/her meals but did not receive it at times.In an interview on 7/17/2025 at 6:05 PM, staff #17, a dietary aid, confirmed concerns about missing food items on the trays for Residents #56 and #11. And added that missing food items on the residents' trays were dependent on which dietary staff member loaded the meal cart.3) An observation of breakfast on 7/18/2025 at 8:00 AM showed that Resident #40 was eating breakfast in the room. The resident's tray contained corn flakes, scrambled eggs, hash brown patty, special cup, special spoon and fork, special yellow plate, dry wheat toast, butter, salt and pepper, grape jelly, creamer, cranberry juice, 2% milk, coffee, and Prune juice. However, the Resident's meal ticket listed the following items: corn flakes, scrambled eggs, hash brown patty, [NAME] anti-spill cup, small built-up utensils, yellow-lipped plate, dry wheat toast, butter, salt and pepper, grape jelly, creamer, cranberry juice, 2% milk, coffee, Prune juice, and banana. The Resident stated, They missed my banana.4) While observing the dinner tray line on 7/22/2025 at 5:15 PM, the surveyor requested a test tray. The tray contained a meal ticket for Resident #52, which listed the following food items to be served: Manicott Alfredo, Spinach with garlic butter, Wheat roll, butter, salt, pepper, chocolate pudding, 2% milk, Ice water, and a Chocolate ice cream cup.However, continued observation failed to show that Resident #52's tray contained chocolate pudding. The dietary manager was present and was made aware of the concern that Resident #52's tray did not contain chocolate pudding, and he confirmed the concern.In an interview on 7/23/2025, at 11:12 AM, the dietary manager confirmed the concerns and verbalized understanding.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215352	A. Building B. Wing	07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coffman Nursing Home	1304 Pennsylvania Avenue Hagerstown, MD 21742

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 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a record review, observation, and interviews, it was determined that the facility failed to provide an assistive device for eating to a Resident. This was evident in one of four dining observations during the survey.The findings include:On 7/15/25, at 8:14 AM, a review of a report provided by the dietary manager for Residents who require special utensils during meals was completed. The review showed that Resident #40 required “a [NAME] anti-spill cup, a yellow-lipped plate, and small built-up utensils [special fork and spoon with built-up handles to aid people with a weakened grip]” for every meal. However, during dinner observation on 7/17/25, at 5:35 PM, Resident #40 was eating dinner in his/her room and did not have his/her weighted utensils. Staff #6, a geriatric nurse aid, was present and stated that she had given Resident #40 regular utensils because the weighted utensils had not been received from the dietary staff. In an interview on 7/17/25 at 6:05 PM, Staff #17, a dietary aid, confirmed that Resident #40 did not receive his/her weighted utensils on the meal tray and stated that she would notify her supervisor of the concern. During an interview on 7/21/2025 at 8:11 AM, Staff #19, an occupational therapist, reported that Resident #40’s weighted utensils were to help limit spillage and gather food during meals due to decreased fine motor strength and coordination. However, earlier observations failed to show that staff provided utensils to the resident during mealtime.