STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215054	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Towson Rehabilitation and Healthcare Center	509 East Joppa Road Towson, MD 21286

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 40927 Based on record review and staff interview it was determined that the facility failed to ensure that all allegations of abuse were reported to the State Agency (SA) within the required timeframe. This was evident for 1 (MD00209677) of 2 facility reported incidents reviewed. The findings include: A review of the facility's investigation file for the facility reported incident #MD00209677 on 10/08/2024 at 1:03 PM revealed an incident report that was dated 9/10/24 at 12:44 PM. The report read that during Resident #1's care plan meeting s/he reported an allegation of abuse that occurred on 9/7/24. Review of the facility's initial report to the SA the facility documented that Registered Nursed (RN) #2 was made aware of the allegation of abuse on 9/10/24 at 12:45 PM and it was reported to the Administrator at 12:50 PM. Review of the email confirmation for the initial report to the SA revealed it had not been sent until 9/10/24 at 3:15 PM. The Nursing Home Administrator and Director of Nursing were made aware at the time of exit 10/10/24 at 1:40 PM. They offered no rationale for the late reporting.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. 40927 Based on observation, record review, and staff interview it was determined that the facility failed to turn and reposition a resident who was at risk for pressure injury. This was evident for 1 (#72) of 4 residents reviewed for pressure ulcers. The findings include: An observation on 10/9/24 at 8:45 AM of Resident #72, revealed s/he was sitting up in the bed for breakfast. When the geriatric nursing assistant (GNA) left the room, the resident remained laying on his/her back. The resident was observed to have a few inches on each side of the mattress. A second observation on 10/9/24 at 11:21 AM revealed the resident was laying on his/her back. An interview on 10/9/24 at 9:07 AM with GNA #1, who was Resident #72's assigned GNA, revealed she was aware that s/he was to be turned and repositioned every 2 hours. On 10/10/24 at 7:58 AM an observation was made of Resident #72 laying on his/her back. The resident was in the same position 10/10/24 at 8:12 AM, and 10/10/24 at 10:13 AM. On 10/10/24 at 10:26 AM an interview with the resident's assigned GNA #2 revealed she reportedly turned and repositioned the resident every 2 hours by placing a pillow under the resident's shoulder. GNA #2 was asked to demonstrate to the surveyor how she was placing the pillow to turn the resident. She demonstrated placing the pillow under the right shoulder and back area. When asked to check to see if the placement of the pillow had relieved the pressure on the resident's bottom she felt under the resident and stated it had not. She also reported that the resident did not have much room in the bed, and she was afraid to turn and reposition the resident because she feared s/he would fall. However, she failed to report this concern to the nurse. During an interview with Licensed Practical Nurse (LPN) #1 on 10/10/24 at 10:21 AM, she reported that Resident #72 should be turned and repositioned every 2 hours. She stated that it seemed the resident was always on his/her back, so she would add another pillow. A review of Resident #72's medical record on 10/9/24 at 8:55 AM, while observing the resident revealed the resident was obese and had Hidradenitis suppurativa (HS - a chronic skin disease. It causes painful, boil-like lumps that form under the skin. The lumps become inflamed and painful. Medlineplus.gov). According to the minimum data set (MDS) with the assessment reference date of 9/9/24 the resident required maximum to full dependence on staff for moving around in bed. An interview with the Wound Care Nurse Practitioner (NP) #1 on 10/10/24 at 11:11 AM revealed Resident #72 currently had an outbreak of HS. She reported the resident had no pressure wounds at this time. When asked if it was important to turn and reposition the resident, she stated that the wounds that developed from the HS had the potential to become pressure wounds. She reported the resident had one area on the sacrum (boney area located above the tailbone) and on the back. Reviewed the observations with her and she reported she had given education to staff to watch those areas and report changes when necessary. She was visiting the resident once a week. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The concerns were reviewed with Registered Nurse (RN) #2, the Unit Manager, on 10/10/24 at 12:06 PM. She was asked if she was aware that staff were afraid to turn and reposition the resident due to the fear of him/her falling, she stated she had not been aware. The Nursing Home Administrator and Director of Nursing were made aware at the time of exit 10/10/24 at 1:40 PM.