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	05/30/2025

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. 45555 Based on interview, record review, and facility document and policy review, the facility failed to report an allegation of abuse to the state survey agency (SSA) for 1 (Resident #2) of 10 residents reviewed for abuse. Findings included: A facility policy titled, Abuse, Neglect and Exploitation, reviewed/revised 07/21/2021, indicated, VII. Reporting/Response A. The facility will have written procedures that include: 1. Reporting of all alleged violation to the Administrator, state agency, adult protective services and to all other required agencies (e.g. [exempli gratia, for example], law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. Resident #2's Admission Record indicated the facility admitted the resident on 02/14/2025. According to the Admission Record, the resident had a medical history that included diagnoses of hemiplegia and hemiparesis following a cerebral infarction (stroke) affecting the left non-dominant side, aphasia (language disorder), and dysphagia (difficulty swallowing). An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/20/2025, revealed Resident #2 had unclear speech and was rarely/never understood. The MDS indicated the resident had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. According to the MDS, the resident required substantial/maximal assistance from staff with rolling left and right in bed. A typed statement, initialed by the Director of Social Work (DSW) and dated 04/13/2025, indicated the DSW interviewed Resident #2 about an incident, and the resident reported, When the lady was washing me up at night. [sic] The table went boom and it hit my arm. The statement indicated the resident did not know if the incident was intentional or accidental. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215054	A. Building B. Wing	05/30/2025

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	During an interview on 05/29/2025 at 1:09 PM, the DSW stated that in 04/2025, Resident #2 told a therapy staff member that a geriatric nursing assistant (GNA) hurt their arm. She stated she went in and asked the resident about it and the resident vocalized sounds indicating impact (boom, bam) and demonstrated that they rolled over and impacted a bedside table with their arm. The DSW stated she thought the incident was an accident and not intentional. She stated she interviewed the GNA assigned to the resident, as well as other residents, and no concerns were identified. The DSW stated she turned the information she collected into the Administrator, but she did not know what happened after that. During an interview on 05/30/2025 at 9:10 AM, the Administrator stated the facility had not reported the allegation made by Resident #2, because the DSW determined that it was an accident; however, the Administrator indicated the facility had maintained what she referred to as a soft file related to the incident. She stated they did not want to report every time a resident made a negative statement, because it did not always mean abuse, and she did not want to send multiple reports to the SSA if it was not really an allegation of abuse. The Administrator then stated that since the resident did make the statement to the therapy staff member, they should have considered it an allegation of abuse and reported it. During an interview on 05/30/2025 at 9:37 AM, the Director of Nursing (DON) stated that anytime an allegation of abuse was made, it should be reported. She stated when the staff went in to speak with Resident #2 about the incident, the resident's story changed, and they thought it was an accident. During an interview on 05/30/2025 at 10:05 AM, the Director of Rehabilitation (DOR) stated that when Resident #2 told her about what happened in 04/2025, the resident reported that the staff was rough with them while changing them and hit their arm. The DOR stated the resident repeated this several times. She stated she immediately went to the DSW, and they went back into the room together, and the resident changed their story, saying they did not think the staff member meant to hit them. She stated the resident was holding their arm and vocalizing sounds indicating impact (boom, bam) and demonstrated by turning toward their table. She said it seemed that the resident hit their arm on the table. The DOR stated Resident #2 had aphasia, so she was not completely sure. She stated she reported the resident's allegation right away just like she was supposed to, and she did not know if it was reported to the state. During an interview on 05/30/2025 at 10:12 AM, the Administrator stated that after discussing the incident with their team and the Regional Consultant, they determined that Resident #2's allegation should have been reported.

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	05/30/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 45555 Based on interview, record review, and facility document and policy review, the facility failed to ensure an investigation into an allegation of abuse was submitted to the state survey agency (SSA) and failed to ensure documentation of the facility's investigation reflected a thorough investigation for 1 (Resident #2) of 10 residents reviewed for abuse. Findings included: A facility policy titled, Abuse, Neglect and Exploitation, reviewed/revised 07/21/2021 indicated, V. Investigation of Alleged Abuse, Neglect and Exploitation A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation or reports of abuse, neglect or exploitation occur. The policy specified, B. Written procedures for investigations included, 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations and 6. Providing complete and thorough documentation of the investigation. Resident #2's Admission Record indicated the facility admitted the resident on 02/14/2025. According to the Admission Record, the resident had a medical history that included diagnoses of hemiplegia and hemiparesis following a cerebral infarction (stroke) affecting the left non-dominant side, aphasia (language disorder), and dysphagia (difficulty swallowing). An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/20/2025, revealed Resident #2 had unclear speech and was rarely/never understood. The MDS indicated the resident had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. According to the MDS, the resident required substantial/maximal assistance from staff with rolling left and right in bed. A typed statement, initialed by the Director of Social Work (DSW) and dated 04/13/2025, indicated the DSW interviewed Resident #2 about an incident, and the resident reported, When the lady was washing me up at night. [sic] The table went boom and it hit my arm. The statement indicated the resident did not know if the incident was intentional or accidental. During an interview on 05/29/2025 at 1:09 PM, the DSW stated that in 04/2025, Resident #2 told a therapy staff member that a geriatric nursing assistant (GNA) hurt their arm. She stated she went in and asked the resident about it, and the resident vocalized sounds indicating impact (boom, bam) and demonstrated that they rolled over and impacted a bedside table with their arm. The DSW stated she thought the incident was an accident and not intentional. She stated she interviewed the GNA assigned to the resident (GNA #2), as well as other residents, and no concerns were identified. The DSW stated she turned the information she collected into the Administrator, but she did not know what happened after that. (continued on next page)

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	05/30/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/30/2025 at 9:10 AM, the Administrator stated the facility had not reported the allegation made by Resident #2 to the SSA, because the DSW determined that it was an accident; however, the Administrator indicated the facility had maintained what she referred to as a soft file related to the incident. She stated they did not want to report every time a resident made a negative statement, because it did not always mean abuse, and she did not want to send multiple reports to the SSA if it was not really an allegation of abuse. The documents referred to by the Administrator as their soft file included a typed statement from the DSW dated 04/13/2025 that provided details of the interview they conducted with Resident #2 regarding the allegation, a typed statement from the GNA assigned to the resident at the time of the allegation (GNA #2), and documentation that five additional residents were interviewed on 04/13/2025 and reported no concerns. There was no documentation to indicate the facility interviewed or obtained statements from the therapy staff member the resident originally reported the allegation to or other staff members who may have had knowledge of the alleged incident. During an interview on 05/30/2025 at 9:37 AM, the Director of Nursing (DON) stated that anytime an allegation of abuse was made, it should be reported and investigated. During an interview on 05/30/2025 at 10:05 AM, the Director of Rehabilitation (DOR) stated that when Resident #2 told her about what happened in 04/2025, the resident reported that the staff was rough with them while changing them and hit their arm. The DOR stated the resident repeated this several times. She stated she immediately went to the DSW, and they went back into the room together, and the resident changed their story, saying they did not think the staff member meant to hit them. She stated the resident was holding their arm and vocalizing sounds indicating impact (boom, bam) and demonstrated by turning toward their table. She said it seemed that the resident hit their arm on the table in their room. The DOR stated Resident #2 had aphasia, so she was not completely sure. She stated she reported the resident's allegation right away just like she was supposed to. The DOR further stated the facility had just asked her to provide a statement regarding the resident's 04/2025 allegation. A typed statement, signed by the DOR and dated 05/30/2025, revealed the DOR entered Resident #2's room on 04/13/2025 to initiate physical therapy. The DOR's statement indicated that the resident had expressive aphasia, and was clearly upset. The resident reported, The lady was rough with [the resident] while changing [him/her] and hit [his/her] arm. Per the statement, Resident #2 repeated this several times, and the DOR immediately went to the DSW to report the information alleged by the resident, and they both spoke with the resident about the allegation further. During an interview on 05/30/2025 at 10:12 AM, the Administrator stated that after discussing the incident with their team and the Regional Consultant, they determined that Resident #2's allegation should have been reported. She stated they did get statements from other residents that GNA #2 was assigned to care for, and skin checks were conducted for the residents that were cognitively impaired. The Administrator confirmed the facility did not interview or obtain statements from any other staff members.