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	10/23/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on medical record review, documentation review, and interview, it was determined the facility staff failed to notify the resident's responsible party of the addition of a medication and an increase in an anti-anxiety medication. This was evident for 1 (Resident #3) of 4 residents reviewed during a complaint survey.The findings include: On 10/22/25 at 8:40 AM a review of Resident #3's medical record revealed that Resident #3 was admitted to the facility in September 2025 with diagnoses that included but were not limited to metabolic encephalopathy, unspecified dementia with other behavioral disturbances, anxiety disorder, depression, and altered mental status.Review of a 10/2/25 at 14:00 (2:00 PM) change in condition note documented that Resident #3 was noted with increased anxiety and restlessness and required frequent redirection due to impulsive behaviors, including repeated attempts to ambulate without assistance. Resident #3 was evaluated by psychiatry, and Buspar 5 mg. was ordered twice per day for management of anxiety. Resident #3's caregiver was notified and authorized the medication.Review of a 10/9/25 psychiatry note documented the resident was seen for, complaints of ongoing yelling and agitation. The psychiatrist documented that the nurse manager and floor nurse collaborated that Resident #3 had, moderate aggression and anxiety. Resident #3 was observed to be restless, verbally aggressive, and irritable. Resident #3's affect was intense with ongoing agitation and behavioral dysregulation; possible exacerbation of underlying psychiatric condition. Resident #3's Buspar was increased to 7.5 mg. twice per day and was to be started on, Hydroxyzine 10 mg. BID (twice per day) as needed x 14 days for escalating anxiety and agitation. Hydroxyzine is an antihistamine that is prescribed for the short-term relief of anxiety.There was no documentation found in the medical record that Resident #3's responsible party was notified of the increase in the anti-anxiety medication and the addition of the Hydroxyzine.On 10/23/25 at 12:26 PM the Director of Nursing (DON) was informed that family notification was not found related to the increase in the anti-anxiety medication and the addition of Hydroxyzine. The DON stated that the Assistant Director of Nursing (ADON) told someone verbally but could not say who the ADON spoke to.On 10/23/25 at 1:20 PM the DON and the Nursing Home Administrator (NHA) gave the surveyor a signed timeline of events and documented on 10/10/25 the family member (caregiver name) was notified by the ADON in regard to the change in medication. The form was signed by the ADON. The form was not created until 10/22/25, when the surveyor was investigating the issue. There was no documentation in the medical record that the caregiver was notified and had approved the medication increase and addition of the other medication.

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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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. Based on medical record review and staff interview it was determined the physician progress notes were not in the resident medical records the day the resident was seen. This was evident for 1 (Resident #3) of 4 residents reviewed during a complaint survey.The findings include:On 10/23/25 at 7:30 AM a review of Resident #3's medical record was conducted and revealed the physician's notes were not in the electronic medical record on the day the resident was seen. There were physician visit notes dated 9/6/25, 9/11/25, 9/14/25, and 9/17/25, that were not signed until 9/24/25 and were not uploaded into the resident's medical record until 9/24/25. A 9/22/25 physician's note was not signed and uploaded until 9/27/25.On 10/23/25 at 9:32 AM Physician #12 was interviewed and stated that he typically got his notes in the system within 24 hours and that the notes that were referenced here were not his notes.On 10/23/25 at 11:27 AM the concern was discussed with the Nursing Home Administrator (NHA). The NHA confirmed the findings.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. Based on medical record review and staff interview, it was determined the facility failed to ensure a resident's drug regimen was free from an unnecessary drug as evidenced by a PRN (when necessary) medication that was given routinely and lack of documented behavior monitoring. This was evident for 1 (Resident #3) of 4 residents reviewed during a complaint survey. The findings include: On 10/22/25 at 8:40 AM a review of Resident #3's medical record revealed that Resident #3 was admitted to the facility in September 2025 with diagnoses that included but were not limited to metabolic encephalopathy, unspecified dementia with other behavioral disturbances, anxiety disorder, depression, and altered mental status.Review of a 10/2/25 at 14:00 (2:00 PM) change in condition note documented that Resident #3 was noted with increased anxiety and restlessness and required frequent redirection due to impulsive behaviors, including repeated attempts to ambulate without assistance. Resident #3 was evaluated by psychiatry, and Buspar 5 mg. was ordered twice per day for management of anxiety. Resident #3's caregiver was notified and authorized the medication.Review of a 10/9/25 psychiatry note documented the resident was seen for, complaints of ongoing yelling and agitation. The psychiatrist documented that the nurse manager and floor nurse collaborated that Resident #3 had, moderate aggression and anxiety. Resident #3 was observed to be restless, verbally aggressive, and irritable. Resident #3's affect was intense with ongoing agitation and behavioral dysregulation; possible exacerbation of underlying psychiatric condition. Resident #3's Buspar was increased to 7.5 mg. twice per day and was to be started on, Hydroxyzine 10 mg. BID (twice per day) as needed x 14 days for escalating anxiety and agitation. Hydroxyzine is an antihistamine that is prescribed for the short-term relief of anxiety.Review of Resident #3's October 2025 Medication Administration Record (MAR) documented the Hydroxyzine was started on 10/11/25 and was being administered twice per day at 9:00 AM and 5:00 PM instead of when needed. Further review of Resident #3's October MAR documented that behavior monitoring was being done each shift, however the nurses were only putting check marks in the box and not describing the behaviors that the resident was displaying.On 10/23/25 at 11:57 AM an interview was conducted with Staff #19, the psych nurse practitioner, who stated that he was told Resident #3 was, fidgety, restless, had agitation and was yelling. Staff #19 stated, I recommended the 10 mg. of Hydroxyzine as a PRN. Staff #19 was informed that Resident #3 was receiving the medication twice per day versus PRN. Staff #19 stated, I intended for it to be given PRN.On 10/23/25 at 12:11 PM an interview was conducted with the Director of Nursing (DON) who confirmed it was a transcription error, that the Hydroxyzine should have been PRN and not twice per day. The DON also confirmed that the staff was not documenting what behaviors the resident was having and only that behaviors were sometimes occurring.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on medical record review and interview, it was determined the facility failed to maintain complete and accurate medical records in accordance with accepted professional standards. This was evident for 1 (Resident #3) of 4 residents reviewed during a complaint survey.The findings include. A medical record is the official documentation of a healthcare organization. As such, it must be maintained in a manner that follows applicable regulations, accreditation standards, professional practice standards, and legal standards. All entries to the record should be legible and accurate. On 10/22/25 at 8:40 AM a review of Resident #3's medical record revealed Resident #3 had a fall on 9/26/25 at 20:12 (8:12) PM. The change in condition note documented the resident sustained a hematoma on the face with discoloration to the left side of the eye. The change in condition note documented that the writer was unable to notify the physician. There was no further documentation in the medical record that the physician had been notified.On 10/22/25 at 1:51 PM an interview was conducted with the Medical Director (MD). The MD stated he was notified but he initially could not tell the surveyor when he was notified.On 10/23/25 at 7:30 AM the Director of Nursing (DON) and the Nursing Home Administrator (NHA) brought the surveyor an email from the MD that documented he was notified on 9/26/25 about the fall, however there was no time of notification. The email stated that Physician #12 evaluated Resident #3 the following morning in person. The NHA and the DON confirmed the incomplete documentation in the medical record of the physician being notified.Further review of the medical record revealed Physician #12's progress note dated 9/25/25 in the miscellaneous section of the electronic medical record. There was no progress note dated 9/27/27, the day after Resident #3's fall. The note was dated 9/25/25, however it documented, and a new left periorbital hematoma noted on 9/27/25. There was no addendum written on the note with the date 9/27/25. On 10/23/25 at 9:32 AM Physician #12 was interviewed about when he saw Resident #3. Physician #12 stated he saw Resident #3 on 9/27/25. The surveyor informed him his note was dated 9/25/25 and was wondering how he could have written a note on 9/25/25 that spoke about a hematoma on 9/27/25. Physician #12 stated that he did not change the date on the note but that it was for 9/27/25. He stated that the template does not automatically save, and he should have changed the date before he started the note. Further review of Physician #12's note about the hematoma on 9/27/25 documented that STAT (immediate) labs were needed due to the hematoma. The surveyor informed Physician #12 that STAT labs were not found in the medical record. Physician #12 stated, the patient was clinically stable so we observe, do neuro checks for 48 hours and can tell if there was clinical deterioration. STAT was an error. The resident was stable, and the hematoma was mild, so the labs could have been done on the normal lab draw day. The vital signs drive the labs. Physician #12 again said, my note should not have said STAT. On 10/23/25 at 11:27 AM a discussion occurred with the NHA about the medical record accuracy with physician documentation and notification. The NHA confirmed the surveyor's findings.