STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215069	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Orchard Hill Rehabilitation and Healthcare Center	111 West Road Towson, MD 21204

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. Based on review of facility documentation and staff interview, it was determined the facility failed to provide documentation that allegations of neglect were thoroughly investigated. This was evident for 1 (#3) of 5 residents reviewed for facility reported incidents reviewed during a complaint survey.The findings include: On 1/20/26 at 9:47 AM a review of facility reported incident 2697242 was conducted and revealed the facility's Regional Director received a call about potential neglect for Resident #3 after the resident had been sent to the hospital. Review of the facility's investigation revealed a summary that documented the Director of Nursing (DON) had interviewed nursing staff that had provided care to Resident #3 for the 72 hours prior to transfer to the hospital. Review of the facility's investigation revealed the geriatric nursing assistant (GNA) that provided care for Resident #3 the morning of transfer to the hospital was interviewed and wrote a statement that was included in the packet. There were no further statements or interviews of staff from the previous 72 hours. On 1/21/26 at 1:30 PM an interview was conducted with the Nursing Home Administrator (NHA). The investigation was reviewed with the NHA, and she confirmed the lack of interviews with other staff that took care of the resident leading up to transfer to the hospital. The NHA stated she looked through the previous DON's files and could not find any interviews. The NHA confirmed that the staff from the previous shifts should have been interviewed.

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based interview and observed smell of resident's room, the facility failed to provide bedpan or change resident as requested. This was evident for 1 out of 1 resident reviewed.The findings include: On 1/20/26 at 11 am Resident #6 was heard outside of their room requesting to be changed. There were two nurses observed outside the room. Staff # 4 was the resident's assigned nurse. Staff # 4 stated to resident, you just put on your call bell, give us a chance to get there. Resident #6 continued to call out for help. There was a strong odor of urine coming from the resident's room. During the interview with resident Resident # 6 at the time of the observation, they complained about not being changed on a timely basis. Resident # 6 stated the last time I was changed was in the middle of the night and its now 11 am and I haven't been changed. Surveyor interviewed Resident #6 later in the day at 1PM and resident stated they were changed about 1 hour later or about 12 noon. The Director of Nursing was made aware of the observation and said, ok.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, medical record review, and interview, it was determined the facility failed to provide respiratory services in accordance with professional standards of practice. This was evident for 1 (#3) of 9 residents reviewed during a complaint survey.The findings include: On 1/20/26 at 11:30 AM observation was made of Resident #3 lying in bed. Resident #3 was receiving oxygen via nasal cannula. Observation was made of the oxygen concentrator that was sitting next to the bed. The setting of the amount of oxygen being delivered was 4 L (liters) per minute. There was no date written on the humidification water bottle or the oxygen tubing. The date would have indicated when the humidification water bottle was opened and when the oxygen tubing was applied.Review of Resident #3's medical record revealed a 1/18/26 physician's order for oxygen to be administered at 2L/min.On 1/20/26 at 11:41 AM the Director of Nursing (DON) accompanied the surveyor in Resident #3's room. The DON confirmed the oxygen was set at 4L/min. The DON stated she would check with the nurse and review the physician's orders.Further review of Resident #3's medical record revealed a 1/19/26 at 13:59 (1:59 PM) respiratory therapy note that documented, patient was found on non-rebreather, diaphoretic and breathing fast. A non-rebreather mask is a medical device that delivers high concentrations of oxygen to patients in respiratory distress. It features a face mask with a reservoir bag.There was no further documentation in the medical record about Resident #3's trouble breathing and use of a non-rebreather mask.On 1/20/26 at 1:07 PM an interview was conducted with Respiratory Therapist (RT) #14. RT #14 stated that the Nurse Practitioner (NP #7) had summoned someone to find her. RT #14 stated NP #7 was with the resident. Resident #3 was on the non-rebreather. I went over some breathing techniques such as purse lip breathing, link in with me with your eyes, and touch. RT #14 stated the NP was on 1 side of the bed and she was on the other side and they both did some touch therapy and the Assistant Director of Nursing (ADON) also came in and supported from the end of the bed. RT #14 stated that because of those things they were able to bring the resident's rate of breathing back down and relax the resident and no further intervention was needed.On 1/20/26 at 1:25 PM NP #7 was interviewed and stated that she was called to the resident's room yesterday because the resident was having problems breathing and the oxygen saturation was low, so she put Resident #3 on a non-rebreather mask and gave Resident #3 a breathing treatment of Ipratropium because his/her lungs sounded junky. Ipratropium is a prescription anticholinergic bronchodilator used as an inhaler or nasal spray to relax airway muscles. NP #7 was asked if she documented what happened in the medical record and that she saw the resident. NP #7 just looked at the surveyor and said, no, but I will go document it now. The surveyor asked NP #7 if she should have documented the interaction with the resident related to trouble breathing and the administration of a breathing treatment with medication. NP #7 stated, yes, I will go do that right now.On 1/21/26 at 1:30 PM the concern was discussed with the Nursing Home Administrator (NHA). The NHA concurred with all of the findings.

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. Based on interview and medical record review, the facility failed to make an appointment for Resident # 6. that was to see an outside physician. This was evident for 1 out of 1 resident reviewed.The Findings include:Medical record review on 1/20/26 for Resident #6 revealed that on 11/23/25 the Doctor for Resident #6 requested the resident get an appointment to see a gynecologist for symptoms and possible infection. The request was sent over to Staff # 5 who arranges appointments and transportation for residents that need to go out of the facility. Staff # 5 could not make an appointment for resident because all gynecologist that facility uses would not accept the resident because the large stretcher needed by resident that would not fit through the office door. Staff member # 5 stated in her interview on 1/20/26 at 11 AM, that resident's daughter makes all the appointments. Resident #6's daughter stated in an interview on 1/20/26 at 12:30PM that she was unaware that resident needed an appointment with gynecologist and she would be able to get an appointment. Per interview with DON on 1/20/26, she stated she would look into this, however the doctor was never notified the resident had not gotten an appointment yet.