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	04/23/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on medical record review, resident and staff interview, and the facility investigation record, it was determined that the facility staff failed to follow the physician's order or the resident's care plan to prevent a resident (Resident #25) from experiencing a fall that resulted in harm. This was evident for 1 (25) of 1 resident.The facility implemented effective and thorough corrective measures following this incident and prior to the start of this survey. The facility's plan and action were verified during this survey; therefore, this deficiency was found to be past noncompliance with a compliance date of 3/6/2026 The findings Include On 4/16/2026 10:50AM, during the initial interview, Resident #25 stated that GNA #41 had dropped me on the floor and broke my ankle. The resident then showed their pink lower leg cast. On 4/16/2026 9:05AM, during the initial medical record review, it was discovered that the resident had a physician's order for the use of a Hoyer lift with a 2 person assist with a start date of 11/29/2023 and the most recent care plan that stated the resident required a total mechanical and 2 person assist for transfers that was dated 11/30/2025On 4/17/2026 9:55 AM, during an interview with the Director of Nursing (DON), the surveyor asked what had occurred that caused Resident #25's broken ankle and was told GNA #41 on 3/1/2026 had not checked the Kardex for the resident's transfer status and consequently was unaware of the order for the resident to use the Hoyer Lift with a 2 person assist and had single handedly attempted to transfer the resident from the bed to a wheelchair. GNA #41 reported that the resident's leg got tangled with the wheelchair and they dropped the resident on the floor causing the resident's ankle fracture.On 4/17/2026 at 1:55 P.M. the DON provided the facility investigation documents that included a statement from Employee #41 stating they did not use the Hoyer while transferring the resident. The DON also provided the training that Employee#41 had received at the beginning of the employment on 12/19/2025 with Orchard Hill that included the proper procedure to transfer a resident using a Hoyer lift and how to use the Kardex to find the proper way that each individual resident needed to be transferred due to the physical and mental limitations. The documentation also stated that Employee #41 had been suspended at the time of the incident until a full investigation could be completed. The Employee opted to not return to their position and was terminated on 3/6/2026.The facility's investigation determined that Employee #41 had not checked the Kardex to determine Resident #25's transfer status and had inappropriately attempted to transfer the resident by themselves and had caused the resident to fall and break the ankle. In response to this incident, the facility re-educated all nursing staff on locating transfer status; types of abuse and failure to follow plan of care and terminated GNA #41. In determining the Past Non-Compliant status for this citation, Employees #12, 13, 14, 15, 16 and 26 were interviewed on whether they had training regarding finding the resident's transfer status and how to use a Hoyer Lift. All 6 stated they had received these trainings and were able to answer the surveyor's question regarding resident transfer. Based on the actions taken by the facility and verified by the surveyors on site, it was determined that the facility's deficient practice was past noncompliance with a compliance date of 3/6/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review, responsible person interview, and staff interview, it was determined that the facility failed to ensure care plans were reviewed and revised at least quarterly and updated to reflect residents' current needs. This is evident for 6 (Residents #2, #3, #4, #6, #107, and #113) of 9 residents reviewed for care plan review and revision.The findings include: 1.) On 04/17/2026 at 9:11 AM, during review of the electronic medical record, it was revealed that Resident #113's last documented care plan review was on 12/18/2025. At 9:30 AM, review showed that Resident #107's last documented care plan review was on 01/02/2026. At 9:37 AM, review showed that Resident #2's last documented care plan review was on 12/11/2025. At 9:39 AM, review showed that Resident #6's last documented care plan review was on 01/09/2026. At 9:42 AM, review showed that Resident #4's last documented care plan review was on 01/02/2026. These dates exceeded the required quarterly (at least every three months) review timeframe. On 04/21/2026 at 9:54 AM, an interview was conducted with Staff #7, who stated she handles care plans and confirmed that care plans should be completed quarterly. Staff #7 stated she was unsure if she was responsible for completing the quarterly reviews. Staff #7 was informed of the identified concern regarding the five residents with missed quarterly care plan reviews and stated she would ensure quarterly updates moving forward. 2.) 04/22/2026 11:46 AM During the initial interview with Resident #3's family member, identified concerns with the residents hydration stating that the nursing staff did not assist the resident with drinking consistently throughout the day. During observations during the survey the GNA's were observed assisting the resident with drinking water. The medical staff had ordered an IV for Resident #3's hydration. Resident #3's care plan dated 1/9/2026 did not identify hydration as a focus. It was mentioned as a goal for the potential for infection due to the midline catheter and there were no interventions to maintain or restore the resident's hydration. There was a provider's order for Resident #3's hydration.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on interviews with facility staff and review of employee files, it was determined that the facility staff failed to conduct required performance reviews of Geriatric Nursing Assistants (GNAs) at least once every 12 months. This was found to be evident for 5 (GNA #42, GNA #43, GNA #44, GNA #45, GNA #46) out of 5 GNA employee files reviewed during the facility's recertification survey. The findings include:Performance reviews are to be completed for each GNA at least every 12 months to identify specific, in-service education based on the outcome of those individual performance reviews. On 4/17/26 at 1:55 PM the surveyor requested the complete employee files including, but not limited to, health records, training records, evaluations, disciplines, et cetera for GNA #42, GNA #43, GNA #44, GNA #45, and GNA #46.On 4/22/26 at 9:31 AM in an interview with the Director of Nursing (DON) when asked if performance reviews were conducted for the GNAs she stated, yes. During the interview when asked how often she stated, It's supposed to be yearly. When asked where they were stored, she stated with HR (Human Resources). On 4/22/26 at 9:34 AM in an interview with Regional HR with the DON present, she verified and confirmed that the GNA performance reviews were stored in their employee files.On 4/22/26 at 10:07 AM review of GNA #42's employee file revealed she was hired on 4/17/13; however, failed to reveal a performance review from 2025.On 4/22/26 at 1:31 PM review of GNA #43's employee file revealed she was hired on 8/8/24; however, failed to reveal a performance review from 2025.On 4/22/26 at 2:03 PM review of GNA #44's employee file revealed she was hired on 3/20/25; however, failed to reveal a performance review from 2025.On 4/22/26 at 2:37 PM review of GNA #45's employee file revealed she was hired on 12/11/24; however, failed to reveal a performance review from 2025.On 4/22/26 at 2:51 PM review of GNA #46's employee file revealed he was hired on 12/27/23; however, failed to reveal a performance review from 2025.On 4/23/26 at 9:57 AM in an interview with GNA #35 when asked if he/she had ever had a performance review, he/she stated, No, I cannot remember having a performance review.On 4/23/26 at 11:10 AM in an interview with the DON the surveyor shared the concern that there were no 2025 performance reviews observed in the 5 GNA employee files reviewed. When asked about the GNA performance reviews she stated, I know from my years of Director of Nursing experience that they are completed annually. Let me check with HR because they're union employees and on top of things like that. When asked if she personally had conducted any GNA performance evaluations, she stated, I haven't done any. On 4/23/26 at 12:14 PM in an interview with the DON she stated, For the performance reviews, I didn't find any. The surveyor shared this was a concern and asked how the facility provided in-service education to GNAs that addressed areas of weakness identified in performance reviews if performance reviews were not conducted. The DON acknowledged the concerns, stated she understood, and offered no further comments at that time.On 4/23/26 at 12:51 PM review of the facility's policy entitled, Performance Evaluations, revealed the Policy Statement: The job performance of every employee is reviewed and evaluated at least annually. Further review revealed, The completed performance evaluation is sent by the director or supervisor to the director of human resources to be placed in the employee's personnel record. A copy is provided to the employee.Cross Reference F947

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and staff interview, it was determined that the facility failed failed to ensure that medication was secured in the pharmacy issued bubble packs. This was evident in 4 out of 4 medication carts observed during the survey.The findings Include: On 4/22/26, during the medication storage observation, it was observed that in all 4 Medication carts there were a large number of pills and capsules, approximately 2-3 dozen per cart, that had come loose from the bubble packs that the pharmacy provided the resident's medication in. The loose medications were collected and given to the DON for appropriate disposal and the DON was notified of the concern and indicated the facility did not have specific policy regarding medications that came out of the bubble packs but they had ordered 2 additional medication carts since it appeared that the crowding of the bubble packs seemed to cause the medication to be accidently pushed out.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations and staff interviews, it was determined that the facility failed to stock appropriate personal protective equipment (PPE) near resident rooms that were on enhanced barrier precautions (EBP). This was found to be evident in 2 (station 1 and station 2) of 4 unit stations reviewed during the recertification survey.The findings include: PPE refers to specialized clothing or equipment worn by healthcare workers to create a barrier against infectious materials, protecting themselves and residents from contamination. It consists of gloves, gowns/aprons, masks/respirators, face shields, and goggles.EBP is an infection control strategy for long-term care facilities, requiring staff to wear gowns and gloves during high-contact care for residents with MDROs, chronic wounds, or indwelling devices.On 4/16/2026 at 8:48 AM, the following resident rooms on Station 2 were observed to have EBP posters placed on entrance doorways: Rooms 202, 203, 204, 206, 207, 208, 209, 210, 211, 212, and 213. Station 2 had two PPE dispensers hanging from walls located in the hallway that were observed at 8:57 AM. Neither PPE dispensers had gowns stocked. Additional observations inside rooms with EBP posters on Station 2 did not reveal PPE stocked inside the rooms.On 4/16/2026 at 8:54 AM, Licensed Practical Nurse (LPN) #6 was interviewed and stated that the overnight supervisor is responsible for stocking PPE dispensers if they are empty during night shift.On 4/16/2026 at 8:56 AM, Registered Nurse (RN) #5 was interviewed and stated that gowns are kept in PPE dispensers in hallways, and it is expected that they should be stocked.On 4/16/2026 at 9:18 AM, the following resident rooms on Station 1 were observed to have EBP posters placed on entrance doorways: Rooms 101, 103, 104, 105, 110, 112, 113, and 115. Station 1 had two PPE dispensers hanging from walls located in the hallway that were observed at 9:20 AM. Neither PPE dispensers had gowns stocked. Additional observations inside rooms with EBP posters on Station 1 did not reveal PPE stocked inside rooms.The Director of Nursing was made aware of surveyor concerns on 4/16/2026 at 11:44 AM.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on record review and staff interview, it was determined that the facility failed to ensure the resident or representative were informed of the risks and benefits of a medication prior to initiation. This is evident for 1 (Resident #2) of 2 residents reviewed for unnecessary medications.The findings include:On 04/20/2026 at 11:05 AM, review of Resident #2's electronic medical record revealed that on 02/13/2026, Resident #2 was ordered Lorazepam Injection 1 mg intramuscularly every 24 hours as needed for breakthrough seizures for a duration of 6 months. There was no documented diagnosis of seizures for the resident and no evidence of seizure activity that would support the use of this medication.On 04/23/2026 at 10:27 AM, interview with Staff #17, the provider that wrote the order, revealed the medication was ordered as a precaution due to EEG findings during a prior hospitalization; however, the provider was unable to identify a supporting diagnosis for seizures. Staff #17 was asked if the resident was informed of the risks and benefits of the Lorazepam and s/he stated Yes'.On 04/23/2026 at 10:52 AM, the surveyor requested the Director of Nursing (DON) provide documentation that the resident had been informed of the risks and benefits of Lorazepam prior to the initiation of the medication.On 04/23/2026 at 11:09 AM, documentation was provided which stated, Diagnosis, prognosis, treatment plan, risk, benefits, alternatives, side effects and adverse reactions of treatment were discussed with client. Informed consent for all medications and treatments was obtained. with a date of service of 04/20/2026, which was after the medication order date of 02/13/2026.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record review and staff interview, it was determined that the facility failed to ensure residents were free from unnecessary medications by failing to ensure a PRN psychotropic medication was ordered with an adequate indication, supporting diagnosis, and within the required 14-day time-limited duration without documented clinical justification for extended use. This is evident for 1 (Resident #2) of 2 residents reviewed for unnecessary medications.The findings include:Psychotropic medications are drugs that affect brain function and alter mood, behavior, or cognition; in long-term care, they must be supported by a specific clinical indication, appropriate monitoring, and time-limited use when ordered on an as-needed basis.Lorazepam is a benzodiazepine psychotropic medication commonly used for anxiety, agitation, or acute seizure activity, but it carries risks such as sedation, respiratory depression, and dependence, and requires clear clinical justification. On 04/20/2026 at 11:05 AM, during review of Resident #2's electronic medical record it was revealed the resident was ordered Lorazepam Injection 1 mg intramuscularly every 24 hours as needed for breakthrough seizures for a duration of 6 months. This order was placed on 2/13/2026. Further review showed no documented diagnosis of seizures and no evidence of seizure activity to support the use of this medication. Additionally, PRN or as needed psychotropic medications are required to have a time-limited duration of 14 days unless there is a documented clinical justification and supporting rationale for continued use. The extended 6-month PRN order for lorazepam lacked documented justification consistent with this requirement.On 04/23/2026 at 10:27 AM, interview with Staff #17, the ordering provider, revealed the medication was ordered as a precaution due to EEG findings during a prior hospitalization; however, the provider was unable to identify a supporting diagnosis for seizures. Staff #17 stated that Resident #2 was on seizure precautions and this order was part of a protocol for seizures.On 04/23/2026 at 10:32 AM, review of physician orders revealed no seizure precautions in place, only an order to monitor for seizure activity.At 12:04 PM, the Director of Nursing (DON) the surveyor shared the concerns about the lorazepam order length of 6 months and the lack of adequate indication, documented justification, or a supporting diagnosis. The DON stated that PRN or as needed psychotropic medications may be ordered longer when used for other clinical conditions such as seizure management; however, no supporting documentation or policy was provided at the time of exit.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record and interview with facility staff, it was determined that the facility failed to complete a Significant Change in Status Assessment (SCSA) within 14 days of the resident's enrollment and discontinuation in hospice services. This was evident for 1 (Resident #1) out of 1 residents reviewed for hospice during the facility's recertification survey. The findings include:A Significant Change in Status Assessment (SCSA) is a comprehensive assessment that must be completed within 14 days after the Interdisciplinary Team (IDT) has determined that a resident meets the guidelines for significant change for either major improvement or decline. A SCSA is required when a resident: enrolls in a hospice program, changes hospice providers and remains in the facility, discontinues hospice services, or experiences a consistent pattern of changes, with either two or more areas of decline or two or more areas of improvement, from their baseline.On 4/17/26 at 12:03 PM review of Resident #1's medical record revealed an order, Admit to [NAME] Hospice Primary DX (diagnosis): Interstitial Lung Disease, Secondary DX: COPD, Pulmonary Fibrosis, Chronic Respiratory Failure, Dysphagia that was ordered on 11/13/25. Further review revealed Resident #1's primary physician discontinued the 11/13/25 hospice order on 11/18/25. Continued review revealed a second hospice order, Admit to [NAME] Hospice dx (diagnosis): Interstitial lung disease that was ordered on 3/30/26. Additionally, review of Resident #1's medical record revealed a SCSA was completed on 11/20/25; however, further review revealed that on 11/25/25 at 5:22:28 PM Section O0110. Special Treatments, Procedures, and Programs: K1. Hospice care was documented as No. This was the only SCSA completed for Resident #1; therefore, the facility did not complete a SCSA within 14 days of when the resident enrolled in hospice on 11/13/25, was discharged from hospice services on 11/18/25, or when the resident enrolled in hospice on 3/30/26. On 4/20/26 at 12:39 PM in an interview with the Regional MDS (Minimum Data Set) Coordinator #11 when asked when a SCSA must be completed she stated within 14 days if a resident had 2 or more ADL (activities of daily living) changes, was put on hospice or discharged from hospice. The surveyor shared the concern that a SCSA was not completed when Resident #1 enrolled in hospice services on 11/13/25 or 3/30/26 or when the resident was discontinued from hospice services on 11/18/25. The Regional MDS Coordinator #11 confirmed and verified that a SCSA should have been completed within 14 days of each of these three dates and that none were completed and acknowledged understanding of the concerns.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. Based on review of Minimum Data Set (MDS) assessment records, MDS validation reports, and interview with facility staff, it was determined that the facility failed to transmit MDS assessments within 14 days of completion of the assessment. This was evident for 2 (Resident #84, #106) of 2 residents reviewed for resident assessment.The findings include:On 04/22/2026 at 11:12 AM, review of MDS records revealed Resident #84 was discharged from the facility on 11/30/2025 and Resident #106 was discharged on 12/09/2025. A review of the MDS validation report showed that discharge assessments for both residents had not been transmitted within the required timeframe.On 04/22/2026 at 11:36 AM, Staff #8 stated that both MDS discharge assessments were completed but had not been transmitted, and copies were requested by the surveyor for review.On 04/23/2026 at 9:12 AM, review of the MDS 3.0 Final Validation Report confirmed that the discharge assessments for both residents were transmitted on 04/22/2026 after surveyor inquiry identified concerns, indicating transmission occurred well beyond the required 14-day timeframe.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined that the facility failed to ensure Minimum Data Set (MDS) assessments were accurately coded to reflect residents' clinical status. This is evident for 2 (Residents #1 and #3) of 2 residents reviewed for MDS accuracy.The findings include: The Minimum Data Set (MDS) is a federally mandated, standardized assessment tool used to comprehensively evaluate a resident's functional, medical, psychosocial and cognitive status. It is administered to all residents at admission, quarterly, annually, and whenever a significant change in an individual's condition occurs. It is the foundation for creating an individualized care plan and ensures the appropriate care and services are provided to each resident. MDS assessments must be accurate to ensure each resident receives the personalized and resident specific care they need. A Significant Change in Status Assessment (SCSA) is a comprehensive assessment that must be completed within 14 days after the Interdisciplinary Team (IDT) has determined that a resident meets the guidelines for significant change for either major improvement or decline. A SCSA is required when a resident: enrolls in a hospice program, changes hospice providers and remains in the facility, discontinues hospice services, or experiences a consistent pattern of changes, with either two or more areas of decline or two or more areas of improvement, from their baseline. 1.) On 4/17/26 at 12:03 PM review of Resident #1's medical record revealed an order, Admit to [NAME] Hospice Primary DX (diagnosis): Interstitial Lung Disease, Secondary DX: COPD, Pulmonary Fibrosis, Chronic Respiratory Failure, Dysphagia that was ordered on 11/13/25. On 4/20/26 at 10:30 AM review of Resident #1's medical record revealed an assessment entitled, Interim Skin Check .2 – V1 dated 11/20/25. In Section A: Head to Toe Skin Check and Evaluation, it documented Are there any skin impairments noted? and yes was recorded. The next question, Is this a new skin impairment? was also documented yes. For type of skin impairment, it documented Pressure injury and the site was documented sacrum. Further review of the medical record revealed a note from the Wound Nurse Practitioner #10 also dated 11/20/25 which documented a Stage 3 pressure ulcer. On 4/20/26 at 12:24 PM review of Resident #1's medical record revealed a SCSA MDS was completed. Further review revealed that on 11/25/25 Section O0110. Special Treatments, Procedures, and Programs: K1. Hospice care was documented as No. Continued review revealed that on 11/25/25 Section M0210. Unhealed Pressure Ulcers/Injuries: Does this resident have one or more unhealed pressure ulcers/injuries? was documented as No. On 4/21/26 at 10:40 AM in an interview with the Regional MDS Coordinator #11, a dual observation of Resident #1's Interim Skin Check .2 – V1 and the progress note from Wound Nurse Practitioner #10 both dated 11/20/25 was conducted. When asked if the pressure ulcer should have been captured and coded on the 11/20/25 SCSA, the Regional MDS Coordinator #11 stated, yes. During the interview she also verified and confirmed that, We did not mark hospice on the 11/20/25 assessment. The surveyor shared these were both concerns for inaccurate coding and the Regional MDS Coordinator #11 acknowledged and verbalized understanding of the concerns. 2.) A record review was completed for Resident #3 on 4/22/2026 at 10:30 AM. The review noted that Resident #3 was re-admitted to the facility on [DATE] after a hospitalization that included surgery (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for an above the knee amputation (AKA) of his/her right leg. The resident's discharge to the hospital had been reported to the MDS with the notation that return was anticipated. His/her readmission was also reported with the initial MDS for the readmission completed. On the quarterly assessment, the facility inaccurately answered the question regarding had the resident had surgery within the last 100 days. The quarterly assessment was dated 4/8/2026 and the resident had the AKA surgery on 2/19/2026 which made the assessment completed 39 days after the surgery. The regional director (Employee #11) was interviewed regarding this assessment and they acknowledged that there was an error made.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review and staff interview, it was determined that the facility failed to ensure comprehensive care plans were developed and updated timely to reflect residents' current conditions. This is evident for 2 (Residents #1 and #3) of 2 residents reviewed for care planning. Findings include: A care plan is a guide that outlines a person's healthcare needs, treatment goals, and the specific interventions required to meet those goals, ensuring personalized and consistent care. The facility is required to have care plans developed and revised by an interdisciplinary team including: the attending physician, a registered nurse, a nursing aide, a representative from dietary services, the resident, and the resident's representative (as practicable). The care plan is used to plan, assess, and evaluate the effectiveness of the resident's care they receive in a facility. A pressure ulcer also known as pressure sore, bed sore, or decubitus ulcer is any lesion caused by unrelieved pressure that results in damage to the underlying skin. Pressure ulcers are staged according to their severity from Stage I (area of persistent redness), Stage II (partial thickness loss of skin presenting as a shallow open ulcer), Stage III (full thickness skin loss involving damage to subcutaneous tissue presenting as a deep crater), Stage IV (full thickness skin loss with exposed tendon, muscle or bone) to Unstageable (the depth of tissue damage cannot be determined due to the presence of slough or eschar (both are types of dead skin that prevent healing). Consistent care is essential for treating and preventing pressure ulcers. Inconsistent care can lead to severe complications, including infection and worsening of the wound. 1. On 04/21/2026 at 1:14 PM during a medical record review for resident # 3 it was discovered that the last care update in the resident's e-chart was dated 1/9/2026. Since that date, the resident was discharged from the facility on 2/19/2026 to the hospital where the resident underwent an above the knee amputation. They were discharged from the hospital on 3/10/2026 and returned to the facility. The facility update the Minimal Data Set(MDS) with the resident's discharge and re-admission. The care plan was not updated for the re-admission. The care plan from 1/9/2026 had some addendum added but still contained care areas that did not reflect the resident's change in condition. This included care for an wound on the great toe of the leg that had been amputated. There was nothing in the care plan regarding care for the amputation site.In an interview with the social services assistant, Employee #11, while trying to establish who was responsible for ensuring care plans were completed in a timely fashion, Employees #7, #11 and #2 were interviewed before it was established that the DON was responsible for care plans. Employee #11 stated that they sent out invitations to the care plan meetings and had the sign-in sheets. Sign in sheets were reviewed and it was noted that few of the staff participated in the care plan meeting. 2. A review of Resident #1's medical record on 4/20/26 at 10:30 AM revealed an assessment entitled, Interim Skin Check .2 – V1 dated 11/20/25 which revealed a new, sacral pressure injury. Further review revealed a progress note from the Wound Nurse Practitioner #10 also dated 11/20/25 which documented a Stage 3 pressure ulcer. A review was conducted of Resident #1's medical record on 4/21/26 at 11:26 AM that revealed a care plan for a bilateral coccyx Stage 3 pressure ulcer; however, it was initiated on 2/2/26 10 weeks after the pressure ulcer was identified and documented on by a facility nurse and Wound Nurse Practitioner (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#10. On 4/21/26 at 11:38 AM in an interview with the Director of Nursing (DON), On 4/21/26 at 11:38 AM in an interview with the Director of Nursing (DON), when asked if the expectation was for a resident with a Stage 3 pressure ulcer to have a care plan, she stated, Yes, I would expect the resident to be care planned. Everyone should have an at risk of pressure ulcer care plan and if the resident has a pressure ulcer, we will update the care plan. When asked when the care plan should be updated, she stated, It should be updated when it is found the resident has a wound. During the interview, a dual observation of the Interim Skin Check .2 – V1 and progress note from the Wound Nurse Practitioner #10 which documented a Stage 3 pressure ulcer both dated 11/20/25 was conducted. The surveyor shared the concerns that the pressure ulcer was noted on 11/20/25; however, a care plan for Resident #1's pressure ulcer was not created until 2/2/26. The DON acknowledged and confirmed understanding of the concerns.

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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. Based on review of medical records and interviews with facility staff, it was determined the facility failed to order and implement the treatment of a Stage 3 pressure ulcer timely. This was evident for 1 (Resident #1) out of 1 residents reviewed for pressure ulcers during the during the facility 's annual recertification survey.The findings include:A pressure ulcer also known as pressure sore, bed sore, or decubitus ulcer is any lesion caused by unrelieved pressure that results in damage to the underlying skin. Pressure ulcers are staged according to their severity from Stage I (area of persistent redness), Stage II (partial thickness loss of skin presenting as a shallow open ulcer), Stage III (full thickness skin loss involving damage to subcutaneous tissue presenting as a deep crater), Stage IV (full thickness skin loss with exposed tendon, muscle or bone) to Unstageable (the depth of tissue damage cannot be determined due to the presence of slough or eschar (both are types of dead skin that prevent healing). Consistent care is essential for treating and preventing pressure ulcers. Inconsistent care can lead to severe complications, including infection and worsening of the wound. On 4/20/26 at 10:30 AM review of Resident #1's medical record revealed an assessment entitled, Interim Skin Check .2 - V1 dated 11/20/25. In Section A: Head to Toe Skin Check and Evaluation, it documented Are there any skin impairments noted? and yes was recorded. The next question, Is this a new skin impairment? was also documented yes. For type of skin impairment, it documented Pressure injury and the site was documented sacrum. Further review of the medical record revealed a progress note from the Wound Nurse Practitioner (NP) #10 also dated 11/20/25 which documented a Stage 3 pressure ulcer with four treatment recommendations.On 4/20/26 at 10:36 AM review of Resident #1's orders revealed the following order, Coccyx-cleanse with NSS, calcium alginate border foam gauze daily and prn (as needed). The order date was 1/30/26. Further review failed to reveal a wound treatment order prior to 1/30/26. On 4/21/26 at 11:38 AM in an interview with the Director of Nursing (DON), when asked about the wound team, she stated there is a wound doctor, wound NP, and wound nurse. When asked when she would expect interventions to be put in place for a resident identified with a pressure ulcer, she stated, I would expect interventions to be put in place immediately for a resident found to have a pressure ulcer. During the interview, a dual observation of the Interim Skin Check .2 - V1 and progress note from the Wound Nurse Practitioner #10 which documented a Stage 3 pressure ulcer both dated 11/20/25 was conducted. The surveyor shared the concerns that the pressure ulcer was noted on 11/20/25; however, there was no wound treatment ordered until 1/30/26. The DON acknowledged and confirmed understanding of the concerns. On 4/21/26 at 12:36 PM review of the facility's policy entitled, Pressure Ulcers/Skin Breakdown-Clinical Protocol revealed, The physician will authorize pertinent orders related to wound treatments, including wound cleansing and debridement approaches, dressings (occlusive, absorptive, etc.) and application of topical agents if indicated for type of skin alterations. Further review revealed, The physician will help identify medical interventions related to wound management.On 4/21/26 at 12:53 PM in an interview with the DON she stated, I did not see any wound treatment orders prior to 1/30/26. Cross reference F710

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observations, and interviews, it was determined that the facility failed to provide additional nourishment for a resident as ordered by a physician. This was found to be evident in 1 (Resident #55) of 40 residents reviewed during the recertification survey.The findings include:Magic Cups most commonly refer to high-calorie, nutrient-dense frozen nutritional desserts often used in health settings.During an interview on 4/16/2026 at 10:43 AM, Resident #55 stated that their meals are often missing items they expect to receive.Resident #55's medical record was reviewed on 4/20/2026 at 12:30 PM. The resident was admitted on [DATE] and had a diet order placed by a physician on 4/2/2026 that stated, Magic Cup with meals for risk of malnutrition or equivalent 4 oz. TID and Health shakes with meals for risk of malnutrition 4 oz. TID.On 4/21/2026 at 8:56 AM, Resident #55's breakfast meal was observed. No Magic Cup or health shake were observed on the meal tray and the resident's meal ticket did not include Magic Cup and health shake on listed items to receive. Resident #55 stated they had been admitted to the facility for several weeks and never received Magic Cups or health shakes.On 4/21/2026 at 9:09 AM, Resident #55's care plan meeting notes from 4/15/2026 were reviewed. Under the concerns section it was written, [Resident#55] also stated that [he/she] has not been receiving Health Shakes or Magic Cup at every meal as ordered.Review of Resident 55's Medication Administration Record (MAR) on 4/21/2026 at 9:09 AM showed that facility staff had been documenting administering health shakes and Magic Cups at every meal since the diet order was placed.Review of Resident #55's MAR on 4/21/2026 at 12:30 PM showed that Magic Cup and health shake were administered for breakfast on 4/21/2026.Resident #55 stated during an interview on 4/21/2026 at 12:40 PM that they had not received the Magic Cup and health shake for breakfast or anytime afterwards.On 4/21/2026 at 1:26 PM, Resident #55's lunch tray was observed. No Magic Cup or health shake were on the meal tray, and the lunch meal ticket did not have either item listed.On 4/21/2026 at 1:29 PM, Licensed Practical Nurse (LPN) #20 was interviewed and informed that Resident #55 did not have a Magic Cup and health shake on their breakfast and lunch tray. LPN #20 stated that they went to the facility kitchen and got them for the resident at breakfast. LPN #20 was informed that Resident #55 stated to surveyor multiple times that they did not receive them today and no observations by the surveyor during the day revealed Magic Cup and health shakes being served. LPN #20 was also shown Resident #55's MAR which showed documentation that the Magic Cup and health shake were administered for lunch even though the resident had not received either item. LPN #20 was asked if it was standard practice to document Magic Cup and health shakes as administered before resident received and they replied, not really.The Director of Nursing (DON) was made aware of surveyor concerns on 4/21/2026 at 1:50 PM. The DON stated that they will make sure Resident #55's meal ticket would be updated to include both Magic Cup and health shakes for meals.

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. Based on review of medical records and interviews with facility staff, it was determined the facility failed to ensure that a resident's primary care provider(s) assessed and monitored his/her pressure ulcer. This was evident for 1 (Resident #1) out of 1 residents reviewed for pressure ulcers during the facility 's annual recertification survey.The findings include:A pressure ulcer also known as pressure sore, bed sore, or decubitus ulcer is any lesion caused by unrelieved pressure that results in damage to the underlying skin. Pressure ulcers are staged according to their severity from Stage I (area of persistent redness), Stage II (partial thickness loss of skin presenting as a shallow open ulcer), Stage III (full thickness skin loss involving damage to subcutaneous tissue presenting as a deep crater), Stage IV (full thickness skin loss with exposed tendon, muscle or bone) to Unstageable (the depth of tissue damage cannot be determined due to the presence of slough or eschar (both are types of dead skin that prevent healing). Consistent care is essential for treating and preventing pressure ulcers. Inconsistent care can lead to severe complications, including infection and worsening of the wound. On 4/20/26 at 10:30 AM review of Resident #1's medical record revealed a nursing skin assessment that documented a new, sacral pressure ulcer on 11/20/25. Further review revealed a progress note from Wound Nurse Practitioner (NP) #10 also dated 11/20/25 which documented a Stage 3 pressure ulcer.On 4/21/26 at 11:57 AM review of Resident #1's medical record revealed a physician's note from Resident #1's primary care provider, Medical Doctor (MD #40), dated 11/21/25 that read in part: Chief Complaint/Reason for this Visit: Readmission and Note: The patient's care plan including but not limited to imaging, labs and medications being ordered have been discussed in detail with the care providing nursing staff. Further review of the note failed to reveal the identification and/or assessment of the resident's Stage 3 pressure ulcer in the Physical Examination, Assessment and Plan, or Diagnoses sections of the note. Continued review of the medical record revealed progress notes from MD #40 on 11/22/25, 11/27/25, 11/28/25, 12/5/25, 12/15/25, 12/17/25, 12/31/25, 1/7/26, 1/28/26, 2/18/26, 3/11/26, 3/23/26, 4/1/26; however, the medical provider failed to identify and/or assess Resident #1's Stage 3 sacral pressure ulcer from her visits. Additionally, the facility's Nurse Practitioner (NP #17) failed to identify and/or assess Resident #1's pressure ulcer from her visits on 11/25/25, 1/8/26, 2/17/26, 3/5/26, or 3/19/26. On 4/21/26 at 12:36 PM review of the facility's policy entitled, Pressure Ulcers/Skin Breakdown-Clinical Protocol revealed, The nursing staff and Attending Physician will assess and document an individual's significant risk factors for developing pressure sores; for example, immobility, recent weight loss, and history of pressure ulcer(s). Further review revealed, During resident visits, the physician will evaluate and document the progress of wound healing-especially for those with complicated, extensive, or non-healing wounds.On 4/21/26 at 12:53 PM in an interview with the Director of Nursing (DON) when asked if there was one provider who was responsible for the overall care of the resident, she stated his/her primary care provider who was [MD #40's name]. The surveyor shared the concern that after Resident #1's Stage 3 pressure ulcer was identified by facility nursing staff and Wound NP #10 on 11/20/25, the resident was seen 14 times from 11/21/25-4/1/26 by Resident #1's primary care provider, MD #40, and 5 times from 11/25/25-3/19/26 by NP #17; however, both medical providers failed to identify and/or assess the resident's Stage 3 pressure ulcer. The DON acknowledged and confirmed understanding of the concern.An interview was conducted with the facility's NP #17 on 4/21/26 at 10:15 AM when asked what residents she was responsible for, she stated, I see everyone. During the interview she stated she was in the facility 5 days a week. On 4/21/26 at 2:26 PM in an interview with the facility's NP #17 when asked if Resident #1 had any wounds, she stated he/she was being followed weekly by the wound team for a pressure ulcer. When asked if she had ever assessed the wound she stated, No, I haven't seen it to be honest since he/she's being followed by the wound team, they usually take care of that. When asked if she was this resident's primary care provider and responsible for the resident's care she stated, Yes, I am one of the resident's primary (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care provider and he/she's followed by the Wound NP who is more of an expert in that area. The surveyor shared this was a concern. NP #17 stated, I've seen it (pressure ulcer) once when they said the person has a wound. I looked at it and said let's have the wound team see the patient. When asked if that was documented, NP #17 stated, I can check and see if I did. It looks like I captured the rash but did not capture the wound. No, I do not see it. When asked why there was no documentation of an assessment or mention of Resident #1's pressure ulcer, she stated, Well, since he/she was followed by Wound NP #10, I just didn't include it in my notes. I should have included it. It's an oversight. The surveyor shared the concerns and NP #17 acknowledged the concerns and offered no further comments at that time. Cross reference F686

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on record review and staff interview, it was determined that the facility failed to ensure that the pharmacist performed an accurate medication regimen review and identify a medication without a matching diagnosis. This is evident for 1 (Resident #2) of 2 residents reviewed for medication regimen review.The findings include:On 04/20/2026 at 11:05 AM, a review of the electronic medical record for Resident #2 revealed an order for Lorazepam Injection 1 mg intramuscularly every 24 hours as needed for breakthrough seizures for a duration of 6 months. The order was written by Staff #17 on 02/13/26. Review of Resident #2's documented medical diagnoses revealed no documented diagnosis of seizures and no evidence of seizure activity to support the use of this medication. Monthly medication regimen reviews completed on 02/27/26 and 03/29/26 documented No medication irregularities noted at this time. The pharmacist failed to identify or report that the medication lacked a documented supporting diagnosis.On 04/23/2026 at 10:27 AM, during an interview with Staff #17, the surveyor shared the concern of the lack of a medical diagnosis of seizures in the electronic medical record for Resident #2. Staff #17 stated that the lorazepam order was part of a seizure protocol and that she ordered it because the resident was on Keppra. Staff #17 was unable to identify a supporting diagnosis for seizures. At 12:04 PM, the Director of Nursing (DON) was made aware of the concerns with the medications lacking a diagnosis and a request for any further documentation regarding the concerns was made. At the time of exit, there was no further documentation provided regarding the identified concerns.

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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 record review and staff interview, it was determined that the facility failed to ensure medications were ordered with an adequate indication and supporting diagnosis and failed to ensure appropriate parameters for a psychotropic medication ordered on an as-needed basis, resulting in an unnecessary medication. This is evident for 1 (Resident #2) of 2 residents reviewed for unnecessary medications.The findings include: Lorazepam is a benzodiazepine psychotropic medication commonly used for anxiety, agitation, or acute seizure activity, but it carries risks such as sedation, respiratory depression, and dependence, and requires clear clinical justification. Levetiracetam (Keppra) is an anticonvulsant used to prevent or control seizures and should be supported by a documented seizure disorder or related neurological condition.On 04/20/2026 at 11:05 AM, during review of Resident #2's electronic medical record it was revealed the resident was ordered Lorazepam Injection 1 mg intramuscularly every 24 hours as needed for breakthrough seizures for a duration of 6 months. This order was placed on 2/13/2026. Further review showed no documented diagnosis of seizures and no evidence of seizure activity to support the use of this medication.On 04/23/2026 at 10:27 AM, interview with Staff #17, the ordering provider, revealed the medication was ordered as a precaution due to EEG findings during a prior hospitalization; however, the provider was unable to identify a supporting diagnosis for seizures. Staff #17 stated that Resident #2 was on seizure precautions and the addition of the lorazepam order was part of a protocol. Staff #17 stated that since the resident was on Keppra that lorazepam should be added. The surveyor also inquired about the lorazepam order having an empty checkbox for Reassessment required, indicating that if the medication were to be given to the resident, reassessment would not be performed. Staff #17 agreed lorazepam is a medication requiring reassessment and did not respond when asked if the box should indeed be checked.At 10:32 AM, review of physician orders revealed no seizure precautions in place, only an order to monitor for seizure activity. Further review showed that Resident #2 was ordered levetiracetam 250mg for seizure. This medication also lacked a matching medical diagnosis.At 12:04 PM, the Director of Nursing (DON) was interviewed and the concerns with the medications lacking a diagnosis were shared by the surveyor. A request for any further documentation regarding the two medication orders was made. The surveyor also requested copies of any policies or related information about the seizure medication protocol mentioned by Staff #17. The DON stated she did not think there was a written policy but would follow up on the concern. At the time of exit, there was no further documentation provided regarding the identified concerns.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and medical record review, it was determined that the facility failed to maintain and document accurate medical records. This was found to be evident in 1 (Resident #44) of 1 resident reviewed for dialysis during the recertification survey.The findings include:On Thursday, 4/16/2026 at 11:08 AM, Resident #44 was interviewed after returning from hemodialysis (HD) and stated that they receive HD 3 times a week on Tuesdays, Thursdays, and Saturdays at 6:00 AM.Resident #44's medical records were reviewed on 4/20/2026 at 8:20 AM and showed that the resident was admitted to the facility on [DATE]. Review of Resident 44's active medical orders revealed an order placed on 1/9/2026 that stated, Dialysis on [NAME] M, W, F as per schedule, every day shift every Mon, Wed, Fri. A nephrology consult dated 4/16/2026 was reviewed that stated under assessment and plan, ESRD on hemodialysis, dialyzes T/Th/Sat via tunneled catheter with stable post-HD returns, continue T/Th/Sat HD.Resident #44's Treatment Administration Record (TAR) was reviewed for the months of January, February, March, and April 2026, which revealed documentation on every Monday, Wednesday, and Friday for HD since Resident 44's admission. The TAR was either documented with a check mark (administered), NA (not applicable), or 22 (drug/treatment not administered). There was no documentation on the TAR for any month reviewed for Tuesday, Thursday, Saturday HD.On 4/20/2026 at 9:33 AM, Resident 44's dialysis communication binder was reviewed with the Director of Nursing (DON). The dialysis communication forms between the nursing facility and dialysis center revealed that the resident had been receiving HD on Tuesdays, Thursdays, and Saturdays since their admission to the nursing facility. The DON was made aware of surveyor concern that Resident 44's medical order and TAR documentation did not accurately address the resident's dialysis schedule. The DON stated they would have the order change to reflect the correct HD schedule.An additional review of Resident 44's medical record was conducted on Tuesday, 4/21/2026 at 9:25 AM. A nurse progress note dated 4/21/2026 at 6:00 AM stated, Resident alert and responsive. Left for her HD section at 6am in stable condition. Review of Resident's 44 medical orders showed the resident still had an active order for Monday, Wednesday, Friday HD.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interviews with facility staff, review of employee files, and review of pertinent documentation, it was determined that the facility failed to ensure the nurses' aides had continuing education that included dementia management training and addressed areas of weakness as determined in nurse aides' performance reviews. This was found to be evident for 2 (GNA #44 and GNA #45) of 5 GNA employee files reviewed during the facility's recertification survey. The findings include:Performance reviews are to be completed for each GNA at least every 12 months to identify specific, in-service education based on the outcome of those individual performance reviews. Relias is an online training provider that offers continuing education (CE) for healthcare, senior care, and disabilities professionals. Relias's CE library covers a wide range of topics and is accredited by many national and state licensing boards. Relias's courses are designed to help healthcare workers improve patient care, grow, and provide high-quality care.On 4/22/26 at 7:55 AM in an interview with the Director of Nursing (DON) when asked if there was a Staff Educator, she stated they lost the Staff Educator last month and the Clinical Managers (Director of Nursing, Assistant Director of Nursing, and Unit Managers) were providing education currently. When asked who the best person was to direct questions regarding education, she stated herself or the Assistant Director of Nursing (ADON). On 4/22/26 at 9:21 AM in an interview with the DON when asked about all ways staff was provided with education she stated upon hire, there was an onboarding. During the interview, she also stated there is a 3 day orientation on the floor for clinical staff, on going in services, such as if there was an allegation of abuse, and Relias. On 4/22/26 at 9:34 AM in an interview with Regional HR (Human Resources) with the DON present, she stated that employees' Relias transcripts can be pulled as needed. The surveyor requested the Relias transcripts for GNA #42, GNA #43, GNA #44, GNA #45, and GNA #46.On 4/22/26 at 10:05 AM the ADON provided the facility's in service and education binders. There were 3 binders: 1) In Service/Education, 2) Staff Education Volume 2 2024-2025, and 3) Staff Education Volume 3 2025. At this time, in an interview with the DON and the ADON present, the DON verified and confirmed this was all the evidence of education for 2025 except maybe some education related to facility self reports.On 4/22/26 at 10:20 AM review of all attendance sheets in the 3 Education binders failed to reveal dementia training. On 4/22/26 at 2:03 PM review of GNA #44's employee file revealed she was hired on 3/20/25; however, failed to reveal a performance review from 2025.On 4/22/26 at 2:37 PM review of GNA #45's employee file revealed she was hired on 12/11/24; however, failed to reveal a performance review from 2025.An interview was conducted with the Director of Nursing on 4/23/26 at 11:10 AM. At this time, the surveyor shared the concern that there were no 2025 performance reviews observed in the GNA employee files reviewed. An interview was conducted with the DON on 4/23/26 at 12:14 PM. During the interview, she stated, For the performance reviews, I didn't find any. The surveyor shared this was a concern and asked how the facility provided in-service education to GNAs that addressed areas of weakness identified in performance reviews if performance reviews were not conducted. The DON acknowledged the concerns, stated she understood, and offered no further comments at that time.On 4/23/26 at 10:50 AM in an interview with the DON she verified and confirmed there was no dementia training associated with the facility self-reported incidents. During the interview, she stated the training was related to abuse and policies and procedures. The surveyor requested a copy of the material covered in the 2025 Skills Fair and the time duration.On 4/23/26 at 11:09 AM in an interview with the DON she stated, For the 2025 Skills Fair, I have to eat that one because I do not have any material to provide on what was covered. During the interview she confirmed dementia training was not part of the 2025 Skills Fair and that for dementia training, that is covered in orientation and the documentation is in the employee's file.On 4/23/26 at 11:10 AM in an interview with the DON when asked about her understanding of the requirements for annual GNA training/education, she stated there should be an (continued on next page)

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	04/23/2026

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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	annual in service, but the facility goes by Relias. On 4/23/26 at 11:35 AM in an interview with the DON the surveyor shared the concern that review of all 3 staff binders failed to reveal any dementia training. The Director of Nursing acknowledged understanding of the concern. On 4/23/26 at 12:51 PM in an interview with the DON, a dual observation was conducted of the New Hire Orientation checklist where Day 2 lists Hand in Hand Dementia Modules. The surveyor shared the concern that the dementia training from orientation was Hand in Hand Modules; however, the surveyor failed to observe that documentation in any of the GNA employees' files reviewed. During the interview, a second dual observation was conducted of GNA #44 and GNA #45's Relias transcript. The DON verified and confirmed that neither of the 2 GNAs had dementia training on their Relias transcript. The surveyor shared the concern that the in service training for GNAs must include dementia management training. The DON confirmed that the facility did not have such education documentation and validated the surveyor's concern.