| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 215227 | A. Building<br>B. Wing | 10/16/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Ridgeway Rehab Center | 5743 Edmondson Avenue<br>Catonsville, MD 21228 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>Based on staff interviews and record review, it was determined that the facility failed to follow up on a resident's statement of possible abuse during another investigation for abuse. This was evident for 1 (Resident #1 ) out of 1 resident reviewed for medical records during this complaint survey. The findings include:On October 14th, 2025, at 2 PM, during the review of records for Resident #11's facility-reported incident, it was found that Resident # 1 had stated yes to all the questions asked on the Resident Interview form for abuse. No comments were added, nor any additional information to the claim.On October 15th, 2025, at 1:15 PM, the DON was questioned about the reported incident and if she knew that there was a resident who responded that they thought abuse was occurring in the facility during that investigation. The acting DON stated that she was unaware of the resident's claim and that the prior DON was present during this investigation and would have asked the questions to the residents. The acting DON made the surveyors aware that the resident was still at the facility.At 2:55 PM, the surveyor went to find Resident #1, but they were not in their room. The acting DON stated that Resident #1 can be found in the rehabilitation center, working with physical therapy. The surveyor interviewed Resident #1 at that time. The resident was asked if s/he remembered the situation back in May 2025, when s/he reported that they felt as though staff had abused them in any way, physically or verbally. Resident #1 stated that s/he remembered and that the staff member who was the problem was no longer working at the facility. The resident was asked if they felt as though any of their personal property was used or taken without permission. Resident #1 stated, no. The resident was asked if they had seen any abuse at the facility. Resident #1 stated, yes, but the staff was no longer working at the facility. The resident was asked if they had any concerns or problems with a roommate or other resident. Resident # stated, not anymore. The resident was asked if s/he felt safe at the facility or if anyone was abusing resident. Resident #1 stated that they liked it at the facility and denied any abuse at this time. At 3:15 PM, the surveyor notified the acting DON of the findings and that Resident #1 had no concerns at this time; however, all possible abuse statements must be investigated completely. The acting DON acknowledged that she understood. |

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 |
|---|---|---|---|
| | 215227 | A. Building<br>B. Wing | 10/16/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Ridgeway Rehab Center | 5743 Edmondson Avenue<br>Catonsville, MD 21228 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>Based on record review and staff interview, it was determined that the facility failed to ensure care plans were reviewed and revised at least quarterly and as necessary to address changes in residents' conditions. This deficient practice was evident for 2 of 2 residents reviewed (Residents #1 and #2) during a complaint survey.The findings include:On 10/14/25 at 12:13 PM, record review for Resident #2 revealed the most recent care plan was dated 3/18/25. On 10/14/25 at 12:22 PM, record review for Resident #1 revealed the most recent comprehensive care plan was dated 4/9/25. During an interview with the Director of Nursing at 12:37pm, it was confirmed that the quarterly care plans were significantly past due for Residents #1 and #2. |