STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215227	A. Building B. Wing	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgeway Rehab Center	5743 Edmondson Avenue 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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 49148 Based on record review and interview with staff, it was determined that the facility failed to have a system in place to ensure that a copy of the resident's Advanced Directives documents had been obtained and maintained in the resident's medical record. This was evident for 1 (Resident #4) out of 3 residents reviewed for Advanced Directives. The findings include: Advance directive is a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated. Power of Attorney (POA) is a document that allows a person to appoint someone to act on their behalf with respect to certain matters, such as medical, financial, real estate, and business transactions. On 10/28/2024 at 11:01AM, a review of Resident #4's electronic medical record revealed no documentation of an Advanced Directives for the resident. On 10/29/2024 at 7:26AM, during a review of Resident #4's electronic medical record, the Surveyor discovered a Social Services note written on 5/28/2024 by Social Worker #40, which indicated that the Resident Representative was also the Power of Attorney (POA). Further review of the electronic medical record revealed an Admission Contract signed by the Resident Representative in a designated space for the POA to sign. The Admission Contract stated that if the resident had an Advance Directive, a copy should be given to the facility. On 10/29/2024 at 8:39AM, the Surveyor conducted an interview with Business Office Manager #27. During the interview, the Surveyor was informed that on admission Advanced Directives are reviewed with the resident and /or resident representative. If the resident has an advanced directive, the facility will request a copy of the document and then upload it into the resident's electronic medical record. The resident's profile will also be updated to reflect who has the authoritative title. The Surveyor requested a copy of Resident #4's Power of Attorney. On 10/30/2024, the Surveyor was informed that the facility did not have a copy of Resident #4's Power of Attorney.

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 B. Wing	11/06/2024

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48167 Based on observations and interviews with facility staff it was determined the facility failed to provide and maintain a safe, clean, and homelike environment for the residents. This was found to be evident when observations were made during tours of the building during the facility's survey. The findings include the following: An entrance tour was conducted on 10/27/24 at 9:15 AM and the following concerns were identified: Room # 200 was observed with marring noted on the wall Room # 201 was observed with marring noted on the wall behind each bed and near the door Room # 203 was observed with marring noted on the side of the walls Room # 204 was observed with marring noted on the walls, and the floor was dirty with a dark substance noted throughout the room Room # 205 was observed with marring noted on the side of wall around each bed and the wall near the door Room # 206 was observed with marring noted on the walls and around each of the beds Room # 208 was observed with a dirty floor with black substances noted on the floor. room [ROOM NUMBER] bathroom toilet was observed to have a water substance that was yellow in color around the base of the toilet, a wet dark brown in color stains on the floor starting at the base of the toilet and extended up onto the right side of the wall with flaking paint above the cove base. The bathroom was also noted to have a damp, strong harsh odor of ammonia. At 1:30 PM the Director of Nursing was made aware of the observation. A tour of the building was conducted with the Maintenance Director (Staff # 29) on 10/30/24 at 3:00 PM and he was made aware of all the concerns. He stated that the facility had recently had a high turnover of environmental staff. He stated that he would tour the entire hallway of the 200 hall and begin working on all the identified areas. The Administrative team was made aware of all concerns at the time of exit on 11/6/24 at 3:00 PM.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49148 Based on record review, review of facility reported incident (FRI), and interviews, it was determined that the facility failed to report an injury of an unknown source. This was evident for 1 (Resident #58) out of 11 residents investigated for allegations of abuse during the survey. The findings include: On 10/31/2024 at approximately 2:10PM during review of Resident #58's electronic medical record, the Surveyor discovered a Nurses Note written by Licensed Practical Nurse (LPN) #36, dated 9/23/2024 at 5:13AM, which stated that the resident was found in another resident's room and appeared to have bitten his/her lip, blood noted [on the resident's chin area]. There was no documentation of an assessment or change in condition note by LPN #36 in the resident's electronic medical record. On 10/31/2024 at approximately 2:17PM, the Surveyor reviewed the facility reported incident file of an alleged abuse for Resident #58. A review revealed that at 4:00AM the resident was found by Geriatric Nursing Assistant (GNA) #37, sitting in room [ROOM NUMBER] and his/her lip was bleeding. GNA #37 retrieved assistance from another GNA to get the resident back to his/her room and notified LPN #36 that the resident's lip was bleeding. Additional review of the FRI file revealed a statement from LPN #36, which stated that he asked Resident #58 if he/she bit his/her lip, and the resident nodded. LPN #36 also stated that he cleaned the resident's face and did no further assessment; he did not notify the family, physician, or administration, and did not write an incident report. On 10/31/2024 at approximately 2:25PM during an interview conducted with the Administrator, the Surveyor confirmed that LPN #36 should have immediately reported the injury of an unknown source to administration. According to the facility's Abuse Policy reviewed on 10/31/2024 at approximately 2:39PM, the Surveyor determined that injuries of an unknown source should be immediately reported to the Administrator, Director of Nursing, or the Charge Nurse. Administration should report injuries of an unknown source to the Office of Health Care Quality within 2 hours of knowledge of injury. On 10/31/2024 at approximately 2:50PM, the Surveyor discovered a Nurses Note written on 9/23/2024 at 1:47PM by LPN #38, which stated that the Resident #58 was transferred to the hospital via 911/EMT. Resident representative and Physician aware. A review of the hospital discharge summary on 10/31/2024 at 3:00PM revealed that Resident #58 suffered a laceration to his/her upper lip that was repaired using sutures and a sprained right knee.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50573 Based on staff interviews and record review, it was determined that the facility failed to include the resident care plan goals with the required documentation during a transfer. This was evident for 2 (#55 and #37) of 4 residents reviewed for hospitalization . The findings include: 1) On 10/30/24 at 07:30 AM, review of Resident #55's medical record revealed he/she was hospitalized on [DATE] and 9/24/24. On 10/30/24 at 09:05 AM, an interview with the Director of Nursing revealed that the care plans are not sent with the resident upon transfer from the facility. 2) On 10/30/24 at 07:35 AM, review of Resident #37's medical record revealed that he/she was hospitalized [DATE] and 10/25/24. On 10/30/24 at 09:05 AM, an interview with the Director of Nursing revealed that the care plans are not sent with the resident upon transfer from the facility. On 10/30/24 at 09:17 AM, an interview with Licensed Practical Nurse (LPN, Staff #12) and Licensed Practical Nurse (LPN, Staff #26) revealed the nurses go off of a transfer check list to know what to send with a resident. Further interview revealed they do not send the care plans with the resident during a transfer. LPN #12 provided the surveyor with a copy of a blank transfer checklist form. On 10/30/24 at 9:20 AM, review of the blank transfer checklist provided failed to reveal care plans as one of the documents to send with a resident during a transfer. On 11/06/24 at 2:50 PM, at the time of exit, the surveyor reviewed the concern regarding the failure to ensure care plans are sent with residents upon transfer.

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	215227	A. Building B. Wing	11/06/2024

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50573 Based on record review and interviews with staff, it was determined that the facility failed to notify the resident or resident representative in writing of the reason for transfer to the hospital. This was found to be evident for 4 (Resident #55, # 37, # 41, #58) of 4 residents reviewed for hospitalization s during the investigative portion of the survey. The findings include: 1) On 10/30/24 at 07:30 AM, review of Resident #55's medical record revealed he/she was hospitalized on [DATE] and 9/24/24. On 10/30/24 at 11:25 AM, an interview with the [NAME] President of sister company (Staff #21) revealed they are unable to provide a copy of the written transfer form from the 9/21/24 hospitalization . On 10/30/24 at 11:39 AM, an interview with the Business Office Manager (Staff #27) revealed that the written transfer form is not sent to the family and if the resident would like to see it, they can request it from the office but that it is verbal and not automatically provided to them. On 11/06/24 at 2:50 PM, at the time of exit, the surveyor reviewed the concern regarding the failure to ensure written notification of transfer is provided to the resident and or resident representative upon transfer. 2) On 10/30/24 at 07:35 AM, review of Resident #37's medical record revealed that he/she was hospitalized [DATE] and 10/25/24. On 10/30/24 at 11:25 AM, an interview with the [NAME] President of sister company Azria Healthcare (Staff #21) revealed they are unable to provide a copy of the written transfer form from the 6/2/24 hospitalization . On 10/30/24 at 11:39 AM, an interview with the Business Office Manager (Staff #27) revealed that the written transfer form is not sent to the family and if the resident would like to see it they can request it from the office but that it is verbal and not automatically provided to them. On 11/06/24 at 2:50 PM, at the time of exit, the surveyor reviewed the concern regarding the failure to ensure written notification of transfer is provided to the resident and or resident representative upon transfer. 49148 3) On 10/30/2024 at 8:05AM, a review of Resident #41's electronic medical record revealed that the resident was transferred to the hospital on 8/29/2024. Additional review of the electronic medical record failed to reveal a Notice of Facility Initiated Transfer document and further documentation to indicate that Resident #41 had been notified in writing of the reason for transfer to the hospital. (continued on next page)

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	215227	A. Building B. Wing	11/06/2024

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4) On 10/30/2024 at 8:15AM, a review of Resident #58's electronic medical record revealed that the resident was transferred to the hospital on 9/23/2024. Additional review of the electronic medical record failed to reveal documentation to indicate that the resident or his/her representative had been notified in writing of the reason for transfer on 9/23/2024. During an interview conducted on 10/30/2024 at 9:02AM with the Director of Nursing (DON) #2, the Surveyor expressed the concern that Resident #41's and Resident #58's electronic medical record failed to reveal documentation that the resident and/or their representative had been notified in writing for the reason of transfer to the hospital. During an interview conducted on 10/30/2024 at 9:23AM with the Business Office Manager #27, the Surveyor confirmed that the residents and/or resident representatives are not sent any notification in writing for the reason of discharge or transfer from the facility.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49148 Based on record review and interview with staff, it was determined that the facility failed to have system in place to ensure the residents and/or resident representatives are notified in writing of the bed hold policy at the time of discharge/transfer to the hospital. This was found to be evident for 3 (Resident #41, #55, and #37) out of 4 residents reviewed for hospitalization s during the survey. The finding include: 1) On 10/30/2024 at 8:05AM, a review of Resident #41's electronic medical record revealed that the resident was transferred to the hospital on 8/29/2024. Additional review of the electronic medical record failed to reveal documentation to indicate that Resident #41 had been notified in writing of the facility's bed hold policy upon transfer to the hospital. During an interview conducted on 10/30/2024 at 9:02AM with the Director of Nursing (DON) #2, the Surveyor expressed the concern that Resident #41's electronic medical record failed to reveal documentation that resident and/or their representative had been notified in writing of the bed hold policy upon transfer to the hospital. During an interview conducted on 10/30/2024 at 9:23AM with the Business Office Manager #27, the Surveyor confirmed that the residents and/or resident representatives are not sent notification in writing of the facility's bed hold policy upon discharge or transfer from the facility. 50573 2) On 10/30/24 at 07:30 AM, review of Resident #55's medical record revealed he/she was hospitalized on [DATE] and 9/24/24. On 10/30/24 at 11:25 AM, an interview with the [NAME] President of sister company (Staff #21) revealed they are unable to provide a copy of the written bed hold policy form from the 9/21/24 hospitalization . On 10/30/24 at 11:30 AM, review of the written bed hold policy from the 9/24/24 hospitalization revealed a witness signature but failed to reveal a signature from the resident or any indication that the resident was informed. On 10/30/24 at 11:39 AM, an interview with Business Office Manager (Staff #27) revealed that the written bed hold policy form was not sent to the resident representative and if the resident would like to see it they can request it from the office but that it was verbal and not automatically provided to them. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3) On 10/30/24 at 07:35 AM, review of Resident #37's medical record revealed that he/she was hospitalized [DATE] and 10/25/24. On 10/30/24 at 11:25 AM, an interview with the [NAME] President of sister company (Staff #21) revealed they are unable to provide a copy of the written bed hold policy form from the 6/2/24 and 10/25/24 hospitalization . On 10/30/24 at 11:39 AM, an interview with Business Office Manager (Staff #27) revealed that the written bed hold policy form was not sent to the family and if the resident would like to see it they could request it from the office but that it was verbal and not automatically provided to them. On 11/06/24 at 2:50 PM, at the time of exit, the surveyor reviewed the concern regarding the failure to ensure the written bed hold policy was provided to the resident and or resident representative upon transfer.

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	215227	A. Building B. Wing	11/06/2024

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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** 30440 Based on medical record review and interviews with facility staff it was determined the facility failed to ensure that the coding of the resident assessment by the Minimum Data Set (MDS) Coordinator accurately reflected the resident status at the time the assessment was done. This was found to be evident for 1 (Resident # 12) of 1 residents reviewed for Activities of daily living (ADL's) during the investigation stage of the survey. Findings include: The MDS is a federally mandated assessment tool used by nursing home staff to gather information on each resident's strengths and needs. The information collected drives resident care planning decisions. MDS assessments need to be accurate to ensure each resident receives the care they need. On 10/28/24 at 10:31 AM Resident # 12 medical record was reviewed. Resident # 12 was admitted with the following but not limited to diagnosis: Hemiplegia (paralysis on one side of the body) and Hemiparesis (weakness to one side of the body) and history of Malignant Neoplasm of Larynx. A review of the MDS assessment that was completed on 06/14/24 Section GG for Functional Status; Toileting was coded (03) requiring partial assistance of staff. Further review of the next quarterly assessment dated [DATE] revealed the resident functional status with a decline in Toileting and was coded (01) requiring dependence on staff for assistance. A telephone interview was conducted with the MDS Coordinator (Staff # 28) on 11/1/24 at 11:15 AM and she was asked if she could explain the resident decline for toileting in which the resident went from partial assistance (03) to total dependence (01). She stated that the facility recently had a change in ownership and that she needed to review information in the old system to determine the decline. During a follow-up telephone conversation with staff # 28 on 11/6/24 at 2:04 PM she acknowledged that the coding did not accurately reflect the resident functional status on the quarterly assessment dated [DATE] that showed a decline for resident # 12 for toileting. She stated that the resident fluctuates from requiring minimum assistance to requiring maximum assistance and she coded the resident somewhere in the middle. She stated that moving forward she will ensure the resident is coded accurately based on the resident's actual assessment. The Administration team was made aware of all concerns at the time of exit on 11/6/24 at 3:00 PM.

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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. 49148 Based on record review and interview with staff it was determined that the facility failed to develop and implement a person-centered care plan for a resident who wanders and was at risk for elopement. This was evident for 1 (Resident #56) out of 5 residents investigated for accidents during the survey. The findings include: Wandering behavior is when a person becomes confused about their surroundings and stray from where they are supposed to be. Elopement risk describes an individual's behavior of leaving an area without permission or supervision. On 10/29/2024 at approximately 1:30 PM, a review of Resident #56's electronic medical record revealed a skilled progress note written on 9/23/2024 at 4:56 AM that stated the resident was walking up and down the hallways and in and out of various resident rooms. The resident refused redirection and aimlessly wandered. The resident stated that he/she wanted to go home. During further review of Resident #56's electronic medical record, the Surveyor discovered an Elopement Evaluation note with an elopement score of 3, indicating the resident was a high risk for elopement. Review of the resident's care plans failed to reveal a care plan for wandering and risk for elopement. On 10/30/2024 at 8:00 AM, during a review of the facility's Wandering and Elopements policy, if a resident is identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety. During an interview conducted on 11/6/2024 at 11:00 AM with the Director of Nursing (DON) #2 and Corporate Designee #3, the Surveyor confirmed that Resident #56 did not have a care plan initiated for wandering and elopement and that a resident who was at risk for wandering and elopement should have a care plan implemented in their electronic medical record.

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50573 Based on review of medical records, interviews and other pertinent documentation, it was determined that the facility failed to have an effective system in place to ensure accurate documentation of resident code status regarding Cardiopulmonary resuscitation (CPR). This was evident for 1 of 24 residents (Resident #37) reviewed. The findings include: Code Status refers to the level of medical interventions a person wishes to have started if their heart or breathing stops. Cardiopulmonary resuscitation (CPR) refers to any medical intervention used to restore circulatory and/or respiratory function that has ceased. MOLST (Maryland Orders for Life Sustaining Treatment) refers to a portable and enduring medical order form covering options for cardiopulmonary resuscitation and other life-sustaining treatments. The medical orders are based on a patient's wishes about medical treatments. When the MOLST form is updated, the MOLST form shall be voided and a new MOLST form prepared when there is a change to any of the orders. If modified, the physician, NP, or PA shall void the old form and complete, sign, and date a new MOLST form. 1) On [DATE] at 09:50 AM, a review of Resident #37's EHR revealed a MOLST form dated [DATE] which indicated the resident's code status order was to Attempt CPR. Further review of the nursing station MOLST binder at the same time revealed a paper MOLST form for Resident #37 dated [DATE] that indicated the resident's code status orders as No CPR, Option B, Palliative and Supportive Care / Do Not Resuscitate (DNR). On [DATE] at 9:54 AM, review of Resident #37's medical records failed to reveal that the MOLST form dated [DATE] was voided when a new one was created on [DATE]. On [DATE] at approximately 1:00 PM, a surveyor interview with the Director of Nursing (DON) revealed that the facility did not have hard paper charts and that staff are to refer to the Electronic Health Record (EHR) system for resident MOLST forms and code status. Further interview revealed that the facility also had a binder labeled Hard Copy MOLSTs at the nurses' station where they kept all resident MOLST forms alphabetically on paper. On [DATE] at 10:11 AM, an interview with the Director of Nursing (DON) revealed that MOLST forms can be found in 1) nursing station MOLST binder 2) Social Worker MOLST binder and 3) the EHR. Further interview with the DON on [DATE] at 10:11 AM revealed that if the MOLST form of various documentation did not reflect one another, the expectation was for staff to go by the most recent MOLST form. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215227	A. Building B. Wing	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 10:17 AM, the surveyor provided a copy of Resident #37's MOLST form dated [DATE] from the MOLST binder to the DON and she indicated to the surveyor that the resident's code status orders were No CPR, Option B, Palliative and Supportive Care / DNR During the same interview, the surveyor requested the DON look up the EHR MOLST form dated [DATE] on her laptop at the time of the interview which indicated that the MOLST form had the resident's code status orders as being a full code. An interview with the DON on [DATE] at 10:29 AM revealed if a new MOLST form was created for a resident, a copy should be kept in the MOLST binder, uploaded into the EHR and that they should reflect one another. During the same interview, the DON indicated that the process for voiding MOLST forms was when a new one was created, the expectation was that the old MOLST form should be voided. She further indicated that the outdated MOLST forms for both residents should have been voided and that she would educate the staff on what the expectation was.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215227	A. Building B. Wing	11/06/2024

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

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. 50573 Based on record review, observation, and interview, it was determined that the facility failed to ensure activities were provided to residents based on their preferences and as indicated in their care plan. This was found to be evident for 1 (Resident #20) out of 1 resident reviewed for activities. The findings include: On 10/27/24 at 01:31 PM, an observation of Resident #20 revealed she/he in bed looking straight ahead at the wall with no activity stimulation. On 10/29/24 at 09:00 AM, review of Resident #20's record revealed a care plan focus of cognitive deficits related to dementia and one of the interventions indicated the resident was to maintain involvement in cognitive stimulation. On 10/29/24 at 09:05 AM, an interview with Activities Director (Staff #16) revealed that she and her activities assistant (Staff #17) would visit residents 1:1 for those that do not like being around people so that they get the person contact, and that they go around to see everyone everyday. Further interview with Staff #16 revealed that they would document the visits and all activities that the resident would attend. She also indicated that they would document if the resident refused. Staff #16 indicated that she also had been providing activities for the assisted living residents. On 10/29/24 at 09:41 AM, review of the activities log binder provided by Staff #16 revealed an October 2024 activity log for Resident #20 which indicated he/she had one, 1 on 1 visit and one pet therapy activity documented. Further review of Resident #20's log failed to reveal any other activities provided/attended nor documentation that indicated the resident refused activities offered for the rest of the month. On 10/29/24 at 11:53 AM, review of Resident #20's Resident Preferences Evaluation dated 10/2/24 at 4:03 PM revealed that the resident indicated it was very important to be provided books, newspapers, and magazines to read, to listen to his/her favorite music, to keep up with the news, be around pets, and to color. On 10/29/24 at 01:23 PM, an interview with Activities Assistant (Staff #17) revealed that they have an activity log to document the activities that a resident attends or is provided, including 1 on 1 visits. Further interview revealed that if a resident refused an activity then they would document it. On 10/30/24 at 10:33 AM, an observation of Resident #20 revealed she/he was laying in bed looking forward with no activity stimulation. (continued on next page)

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	215227	A. Building B. Wing	11/06/2024

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/01/24 at 01:13 PM, an interview with Activities Director (Staff #16) revealed that Resident #20 does not attend many activities as she would not engage in group settings. The surveyor showed Staff #16 the activity log for Resident #20 for the month of October 2024 and she indicated that she was aware that there is only two activities documented and she communicated with Staff #17 the expectations of providing activities and documenting on the activity log. On 11/06/24 at 2:50 PM, the surveyor reviewed the concern at the time of exit regarding the failure to ensure residents are provided activities based on their interests and care plan.

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	215227	A. Building B. Wing	11/06/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49148 Based on record reviews and interviews, it was determined that the facility failed to ensure: 1) a resident was accurately assessed and received immediate treatment after an injury of an unknown source, 2) orders were being implemented by staff and 3) staff were completing assessments of residents admitted or readmitted to the facility. This was evident for 3 (Resident #58, # 23, # 27) out of 26 residents investigated for allegations of abuse. The findings include: 1) On 10/31/2024 at approximately 2:10 PM during review of Resident #58's electronic medical record, the Surveyor discovered a Nurses Note written by Licensed Practical Nurse (LPN) #36, dated 9/23/2024 at 5:13 AM, which stated that the resident was found in another resident's room and appeared to have bitten his/her lip, blood noted [on the resident's chin area]. There was no documentation for an assessment or change in condition note in the resident's electronic medical record. On 10/31/2024 at approximately 2:17 PM, the Surveyor reviewed the facility reported incident file of alleged abuse for Resident #58. A review revealed that at 4:00 AM the resident was found by Geriatric Nursing Assistant (GNA) #37, sitting in room [ROOM NUMBER] and his/her lip was bleeding. GNA #37 retrieved assistance from another GNA to get the resident back to his/her room and notified LPN #36 that the resident's lip was bleeding. An additional review of the FRI file revealed a statement from LPN #36, which stated that he asked Resident #58 if he/she bit his/her lip, and the resident nodded. LPN #36 also stated that he cleaned the resident's face and did no further assessment; he did not notify the family, physician, or administration, and did not write an incident report. On 10/31/2024 at approximately 2:25 PM during an interview conducted with the Administrator, the Surveyor confirmed that LPN #36 should have assessed the resident, notified the resident representative, and immediately reported the injury of an unknown source to administration. On 10/31/2024 at approximately 2:50 PM, the Surveyor discovered a Nurses Note written on 9/23/2024 at 1:47 PM by LPN #38, which stated that the Resident #58 was transferred to the hospital via 911/EMT. Resident representative and Physician aware. A review of the hospital discharge summary on 10/31/2024 at 3:00 PM revealed that Resident #58 suffered a laceration to his/her upper lip that was repaired using sutures and a sprained right knee. 50573 2) On 10/27/24 at 1:40 PM, 10/28/24 at 07:26 AM, and 10/30/24 09:23 AM, observations of Resident #23 revealed she/he was in bed and had a floor mat on his/her right side. On 10/30/24 at 9:41 AM, review of Resident #23's record revealed an active order for bilateral floor mats when in bed. (continued on next page)

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	215227	A. Building B. Wing	11/06/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/30/24 at 01:38 PM, an interview with Licensed Practical Nurse (LPN, Staff 19) revealed that the nurses know what the fall precautions are for each resident by looking at their orders and they document them every shift. During the same interview, upon review of Resident #23's orders, she indicated that the resident has an order for bilateral floor mats when in bed. On 10/30/24 at 01:41 PM, the surveyor and Staff #19 observed Resident #23 in bed with a floor mat on the right side of the resident but failed to reveal a floor mat on the left side. She indicated that the floor mat was on the other side of the bed during her previous shift worked a few days prior. On 10/30/24 at 02:12 PM, an interview with the Director of Nursing (DON) revealed that the expectation is for staff to follow resident orders and there would be an order for floor mats if they were to be implemented. The surveyor reviewed the concern regarding Resident #23's floor mat order and the failure to ensure staff are following orders. During the same interview, the DON indicated that that resident only has one floor mat implemented because the other side causes a fall risk for her/his ambulatory roommate. She further indicated that she would let the doctor know to change the order to what staff should follow. 3) On 10/27/24 at 12:01 PM, an interview with Resident #37 revealed that he/she had not been assessed since being readmitted to the facility on [DATE] after hospitalization . On 10/30/24 at 09:02 AM, an interview with the DON revealed that when a resident is admitted or readmitted to the facility, the expectation was for the nurse to complete an admission assessment on the resident. The surveyor requested documentation of an admission assessment completed by the nurse for Resident #37's readmission on 10/26/24. On 10/30/24 at 9:30 AM, review of a facility policy labeled Admission Assessment and Follow Up: Role of the Nurse revealed an admission assessment should be completed and documented in the resident record. On 11/01/24 at 10:40 AM, Corporate Infection Control Designee (Staff #3) informed the surveyor that she was unable to find documentation of an assessment completed on Resident #37 upon admission. On 11/06/24 at 2:50 PM, at the time of exit, the surveyor reviewed the concern with the Director of Nursing and the Nursing Home Administrator regarding the failure to ensure orders are implemented by staff and that staff are following facility policy.

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	215227	A. Building B. Wing	11/06/2024

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 50573 Based on record review and interviews it was determined that the facility failed to ensure that all nursing staff had competency evaluations. This was evident for 3 (GNA #30, GNA #31, GNA #10) of 5 randomly selected nursing staff reviewed for competencies. The findings include: Nursing competence is defined by the American Nurses Association as an expected level of performance that integrates knowledge, skills, abilities, and judgment. A review of random staff files on 11/01/24 at 07:43 AM revealed the following: 1. Geriatric Nursing Assistant (GNA, Staff #10) was hired in March 2024. No competency evaluation was found for Staff #10. 2. Geriatric Nursing Assistant (GNA, Staff #30) was hired in August 2016. No competency evaluation was found for Staff #30. 3. GNA, Staff #31 was hired in June 2018. No competency evaluation was found. On 11/01/24 at 08:29 AM, an interview with the Director of Nursing (DON) revealed that competencies for staff should be annual, and for new hires it should be at the 90 day mark as well as the year mark. The surveyor requested for the competencies completed for Staff #10, Staff #30, and Staff #31. On 11/06/24 at 09:57 AM, Chief Operations Officer of the [sister company] Staff #22 informed the surveyor that they are unable to find any performance evaluations for the 3 staff members requested. On 11/06/24 at 2:50 PM, at the time of exit, the surveyor reviewed the concern regarding the failure to ensure nursing staff have annual and new hire competencies.

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	215227	A. Building B. Wing	11/06/2024

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 50573 Based on observation it was determined the facility failed to post the required nursing staffing data on the Daily Staffing Schedule. This was evident for 6 out of 6 days observed during the survey. The findings included: On 10/27/24 at 9:00 AM, 10/28/24 at 7:15 AM, 10/29/24 at 7:00 AM, 10/30/24 at 7:00 AM, 10/31/24 at 7:30, and 11/01/24 at 7:00 AM, upon entrance into the facility, the surveyor made observations which revealed a posted staffing sheet for the shifts throughout the day but failed to reveal the facility's census as well as the actual and total number of hours worked by Geriatric Nursing Assistants (GNAs), Licensed Practical Nurses (LPNs), and Registered Nurses (RNs). On 11/01/24 at 2:31PM, the surveyor reviewed the concern with the Chief Operations Officer (Staff #14) that the facility's daily staffing sheet does not meet the required nursing staff data.

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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. 49148 Based on record review and interview with staff, it was determined that the facility failed to have a system in place to ensure that the attending physician and/or Director of Nursing had documented and signed in the medical record to show they have reviewed an irregularity or recommendation identified by the pharmacist. This was evident for 3 (Resident #19, #41, and #50) of 5 residents investigated for Unnecessary Medications, Psychotropic Medications, and Medication Regimen Review during the survey. The findings include: A Medication Regimen Review (MRR) is when a consultant pharmacist completes a comprehensive review of each resident's medication regimen and clinical record. It must be completed at least monthly for each resident. It contains recommendations related to a resident's medication regimen that must be addressed by the resident's physician. 1. On 11/6/2024 at 9:45AM, a review of Resident #19's electronic medical record revealed the clinical pharmacist identified an irregularity during the resident's MRR and made a recommendation on 2/4/2024, 3/4/2024, 4/7/2024, 5/5/2024, 6/4/2024, 7/8/2024, 8/13/2024, and 9/7/2024. Further review of Resident #19 's electronic medical record failed to reveal documentation that the attending provider or Director of Nursing reviewed any of the recommendations made by the clinical pharmacist for 2/4/2024, 3/4/2024, 4/7/2024, 5/5/2024, 6/4/2024, and 7/8/2024 and failed to reveal any action taken to address them. The attending physician reviewed the MMR and recommendations for 8/13/2024 on 10/3/2024 and reviewed the recommendations from 9/7/2024 on 10/25/2024. According to the facility's MRR policy, reviewed on 11/6/2024 at 9:49AM, the policy indicated that all non-urgent recommendations/irregularities must be addressed within 30 days of the consultant pharmacist monthly visit. 2. On 11/6/2024 at 9:50AM, a review of Resident #41's electronic medical record revealed the clinical pharmacist identified an irregularity with the resident's medication therapy and made a recommendation on 7/17/2024 and 9/9/2024. Further review of Resident #41's electronic medical record failed to reveal documentation that the attending provider nor Director of Nursing (DON) reviewed any of the recommendations made by the clinical pharmacist for 7/17/2024 and 9/9/2024 within 30 days of the monthly visit. 3. On 11/6/2024 at 10:07AM, a review of Resident #50's electronic medical record revealed the clinical pharmacist identified an irregularity during the resident's MRR and made a recommendation on 5/5/2024, 6/4/2024, 7/9/2024, and 9/6/2024. Further review of Resident #50's electronic medical record failed to reveal documentation that the attending provider or Director of Nursing (DON) reviewed any of the recommendations made by the clinical pharmacist for 5/5/2024, 6/4/2024, 7/9/2024, and 9/6/2024 and failed to reveal any action taken to address them. (continued on next page)

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	215227	A. Building B. Wing	11/06/2024

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/6/2024 at 10:19AM, the Surveyor conducted an interview with DON #2 and Corporate Designee #3. During the interview, the DON confirmed that the MRR policy had not been followed for some time now. The DON informed the Surveyor that since her employment started about a month ago, she had reviewed and audited some of the MRR's that were overdue while making sure they are followed up by the appropriate attending physician.

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	215227	A. Building B. Wing	11/06/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 50573 Based on medical record review and staff interview, it was determined that the facility staff failed to ensure that a psychotropic medication prescribed as needed (PRN), had an end date that was limited to 14 days. This was evident for 1 (#55) of 5 residents reviewed for medications. The findings include: On 10/31/24 at 07:48 AM, review of Resident #55's medical record revealed an active order for hydroxzine by mouth every 8 hours as needed with an order date of 9/19/24 but failed to be limited to 14 days. Hydroxyzine is used to help control anxiety and tension caused by nervous and emotional conditions. On 11/01/24 08:20 AM, review of the facility policy labeled Psychotropic Medication Use revealed that, PRN orders for psychotropic medications are limited to 14 days. On 11/01/24 at 08:29 AM, the surveyor reviewed the concern with the NHA regarding the facility's failure to ensure PRN psychotropic medications are limited to 14 days.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49148 Based on observations and interview with staff, it was determined that the facility failed to ensure that medication and medical treatment supplies were stored safely. This was evident for 1 of 1 medication room and 1 of 1 medical supply room observed during the survey. The findings include: 1. On [DATE] at 10:02 AM, the Surveyor observed the medication room located behind the nursing station. The Surveyor observed the following expired items: a box of Banatrol Plus with an expiration date of [DATE] on the shelf above the med cart and 3 packs of Curad Xeroform Petroleum dressing, with the expiration date of ,d+[DATE], in the wound cabinet. Further observation of the medication room revealed Sodium Polystyrene Sulfonate ordered for two days for Resident #37 and a bag with 3 unopened vials of Ceftriaxone Sodium injection solution to be reconstituted and a opened and undated vial of Lidocaine ordered for 3 days for Resident #1. On [DATE] at 10:24 AM, during a review of Resident #37's electronic medical record, the Surveyor discovered an order on [DATE] for Sodium Polystyrene Sulfonate completed on [DATE]. During a review of Resident #1's electronic medical record, the Surveyor discovered an order on [DATE] for Ceftriaxone Sodium Injection Solution completed on [DATE]. During an interview conducted with the Director of Nursing (DON) #2 and Corporate Designee #3, the Surveyor reviewed the expired items and the left over medications for Resident #37 and Resident #1 after completed their course for those medications. The DON confirmed that those medications are not in use and should have been returned to the pharmacy or destroyed. The DON proceeded to remove the items from the medication storage room. 2. On [DATE] at 9:15 AM, the Surveyor observed the medical supply room (labeled linen room). The Surveyor noted 3 1.5L Jevity Complete Balanced Nutrition with Fiber 1.5cal bottles, which expired on [DATE]. During an interview conducted with the DON on [DATE] at 9:25 AM, the Surveyor and the DON confirmed the expired bottles of Jevity Complete Balanced Nutrition with Fiber and those bottles were removed from the medical supply room.

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	215227	A. Building B. Wing	11/06/2024

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 50573 Based on observation and interviews, it was determined that the facility failed to ensure that a resident was served a meal according to a predetermined menu that incorporated the resident's preferences. This was evident for 3 (Resident #32, #17, #8) of 5 Resident trays observed during a meal. The findings include: 1) An observation made on 11/01/24 at 11:51 AM in the kitchen during the tray line revealed Resident #32's meal ticket which indicated a regular diet and a peanut butter jelly sandwich was written in as a request. On 11/01/24 at 12:14 PM, the surveyor observed Resident #32 who was eating her/his food from their tray which failed to reveal a peanut and butter jelly sandwich. The surveyor observed GNA (Staff #23) near and requested that they look at the meal ticket together and she confirmed that the ticket indicated a peanut butter and jelly sandwich which was not on the tray. 2) An observation made on 11/01/24 at 11:51 AM in the kitchen during the tray line revealed Resident #8's meal ticket which indicated a regular meal but did not list rice which was the starch of the meal. On 11/01/24 at 12:34 PM, the surveyor observed Resident #8 with their meal tray on the bedside table. The surveyor requested the Certified Dietary Manager (CDM, Staff #24) observe the meal tray which included rice. Upon observation of the meal ticket she confirmed that it did not include rice on the meal ticket. On 11/06/24 at 2:50 PM, the surveyor reviewed the concern at the time of exit regarding the failure to ensure residents receive what is indicated on their meal ticket. 3) An observation made on 11/01/24 at 11:51 AM in the kitchen during the tray line revealed Resident #17's meal ticket which indicated roasted red skin potatoes as the starch. On 11/01/24 at 12:21 PM, the surveyor observed Resident #17 eating their meal which revealed rice and failed to reveal roasted red skin potatoes which was indicated as the starch on the meal ticket. GNA (Staff #10) who was observed nearby was asked to observe the meal ticket and compare it to the food on the plate. She confirmed it indicated roasted red skin potatoes. On 11/01/24 at 2:50 PM, an interview with CDM (Staff #24) revealed the expectation was that what was on the meal ticket was what the resident should receive. The surveyor reviewed the two other findings of residents who did not receive what was indicated on their meal ticket. On 11/06/24 at 2:50 PM, the surveyor reviewed the concern at the time of exit regarding the failure to ensure residents receive what is indicated on their meal ticket.

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	215227	A. Building B. Wing	11/06/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50573 Based on observations, facility protocol, and staff interviews, it was determined that the kitchen failed to store food items so as to maintain the integrity of the specific item. This was evident in one of the kitchen refrigerators, the dry storage area and the cooking area. The findings include: 1. On 10/27/24 at 09:07 AM, an initial observation of one of the kitchen fridges revealed orange slices in a container labeled use by 10/24/24, dijon mustard labeled use by 7/14/24, a block of yellow american cheese opened and undated, an undated opened container of mayo, an undated opened container of relish, and undated opened container of chopped garlic. Further observation of items in the same kitchen fridge revealed a food that the surveyor was unable to identify that was used and undated. The surveyor requested the cook (Staff #25) to identify the food and he was unable to and threw out the food. 2. On 10/27/24 at 9:27 AM, an observation of dry storage foods revealed three opened pasta bags undated, a box of opened rice undated, an opened bag of croutons undated, two opened bags of cereal undated, and a container of oats that were opened and undated. On 10/27/24 at 09:32 AM, an interview with the Certified Dietary Manager (CDM, Staff #24) revealed the expectation was for opened items to be labeled with dates they were opened and when to use by. On 10/27/24 at 9:54 AM, an observation with CDM (Staff #24) of items in the area where the cooks work revealed opened and undated peanut butter, soy sauce, and oil. The CDM threw out the three items and indicated they should be labeled. On 10/27/24 at 10:00 AM, the surveyor reviewed the concern with the CDM regarding the failure to ensure food is dated when opened. On 11/06/24 at 2:50 PM, at the time of exit, the surveyor reviewed the concern with the Director of Nursing and the Nursing Home Administrator regarding the failure to ensure food items are stored properly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215227	A. Building B. Wing	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgeway Rehab Center	5743 Edmondson Avenue 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 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. 48167 Based on observations, resident medical record review, and staff interview it was determined the facility failed to maintain accurate physician orders for the use of oxygen for Resident #15. This was evident for 1 resident out of 6 residents reviewed during the survey. The findings include the following: During observation rounds on 10/30/2024 at 9:30 AM Resident #15 was observed to be on 2 liters of oxygen by nasal cannula. During an interview and observation rounds on 10/30/2024 at 10:07 AM staff #18 verified and stated that Resident #15 was receiving 2 liters of oxygen by nasal cannula and that he/she was not able to find a physician's order stating that the resident was to be receiving oxygen, and the resident had been on oxygen for a long time and should be on oxygen continuously. Review of the Resident #15's medical record on 10/30/2024 at 10:45 AM revealed no physician orders for resident to receive oxygen. During an interview on 10/30/2024 at 11:00 AM staff #21 stated that there was no physician order for Resident #15 to receive oxygen and that the physician would be notified for clarification orders.

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F 0851 Level of Harm - Potential for minimal harm Residents Affected - Some	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 50573 Based on record review and interview, it was determined that the facility failed to ensure the required staffing information based on payroll data was submitted for the quarter to the Centers for Medicare/Medicaid services (CMS) as required. The findings include: On 11/01/24 at 1:51 PM, review of the CASPER Payroll-Based Journal (PBJ) Staffing Data Report document from the CMS revealed that the facility had not submitted the required staffing information for the quarter. On 11/06/24 at 12:34 PM, an interview with the Chief Operations Officer revealed that the incident occurred with the previous owners of the facility. On 11/06/24 at 2:50 PM, during the exit, the surveyor reviewed the concern regarding the facility's failure to ensure that the PBJ staffing data was submitted as required.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 30440 Based on administrative record review and interviews with facility staff it was determined the facility failed to have an Infection Preventionist Designee onsite at the facility to provide oversight to the facility's Infection Prevention and Control Program. This was found to be evident during the survey. Findings include: During the entrance conference on 10/27/24 at 10:52 AM with the Administrator (Staff # 1) and the Director of Nursing (DON) (Staff # 2) who were present, the Administrator stated that the DON had been working at the facility for approximately 1 month and would be going to an Infection Control training class. During the interim she stated that the facility was utilizing the Corporate Infection Control Designee (Staff # 3) who is certified, but she does not work in the building. The Administrator was made aware that it is a requirement that the Infection Control Designee needs to work onsite at the facility and not off-site in a corporate role. An interview was conducted with the Corporate Infection Control Designee on 10/27/24 at 1:45 PM and she stated that she was helping the facility but is aware that the Infection Preventionist is to be working onsite and not as a consultant. She further stated that the facility is in the process of hiring to fill this position.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 48167 Based on observation and interviews it was determined the facility failed to maintain patient care equipment in working and safe operating conditions. This was evident for 3 hand sanitizer dispensers and 1 out 2 DS Smart vital sign machines observed during the survey. The findings include the following: During observation rounds and interview on 10/31/2024 at 3:09 PM the Maintenance Director staff #29 verified that there were 3 hand sanitizer dispensers located outside of rooms #108 - #115 that did not have sanitizer and/or the dispensers were not secured on the wall. During observation rounds and interview on 11/01/2024 at 10:01 AM with staff #3, a DS Smart vital sign machine was not being used by staff, would not turn on and the machine connection wires did not fit properly into the machine. Staff #3 verified and stated that the machine was broken, and it would be replaced immediately. Staff #3 further stated that there was not enough working vital sign equipment on the floor for staff to use to obtain resident vital signs. During an interview on 11/01/2024 at 10:10 AM staff #12 stated that the DS Smart vital sign machine had been broken, the wires did not fit into the machine and, that there were not enough machines that work to take the residents vital signs.