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	02/11/2026

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 - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interviews, it was determined that the facility failed to: 1) ensure that a resident or their responsible party (RP) was offered the opportunity to develop an advanced directive, and 2) ensure two certificates of incapacity included a diagnosis or reason for the incapacity. These failures affected three residents (Resident #8, #10, and #15) out of a sample of three reviewed for advanced directives during the recertification/complaint survey. The findings include: An advance directive is a written statement of a person's wishes regarding medical treatment—often including a living will—made to ensure those wishes are carried out should the person be unable to communicate them to a physician. A physician's certification of decision-making capacity confirms whether a patient can understand their medical situation, appreciate the consequences of their choices, use reasoning, and communicate a treatment preference. Under specific legal standards, such as Maryland law, a certification of incapacity requires the signatures of two physicians (one being the attending physician) and must include the documented reason for the incapacity to ensure the process remains consistent with patient rights. 1) On 2/05/26 at 1:10 PM, a review of Resident #15's medical record revealed the resident was admitted on [DATE] and was cognitively alert and oriented. Further review of the record showed a social service note dated 8/29/25 that contained no information regarding the resident's advance directive status. Additionally, the baseline care plan—which was not completed until 9/25/25 (one month after admission)—left the section review resident's advance directive status blank. During an interview on 2/05/26 at 1:40 PM, Staff #3 (Social Worker) stated that facility staff are required to assess a resident's advance directive status upon admission and offer guidance in completing the forms if the resident is capable and willing. Staff #3 noted that this status should be documented in the social work progress notes. Upon reviewing Resident #15's medical record with the surveyor and noting the absence of this information, Staff #3 validated the concern. 2) On 2/05/26 at 1:13 PM, the surveyor reviewed Resident #8's medical records. The review revealed a Physician Certification of Capacity form signed by Staff #26 (Attending Physician) on 8/23/25 and Staff #27 (Nurse Practitioner) on 8/22/25. However, the form did not include a diagnosis or a clinical reason for the incapacity. In an interview with the Director of Nursing (DON) and Staff #25 (Regional DON) on 2/06/26 at 8:55 AM, they confirmed that providers must evaluate a resident's capacity and document the specific (continued on next page)

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	02/11/2026

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reasons for incapacity on the form. After reviewing Resident #8's certification form with the surveyor, they validated that the form had not been completed properly. 3) A review of Resident #10's clinical record on 2/9/26 revealed that the resident had two certificates of incapacity. The first one was signed by the physician on 8/2/24 but did not include a diagnosis or reason for the incapacity. The second one was signed on 8/8/24 and included the diagnosis of dementia as the reason for the incapacity. The Director of Nursing (DON) and Regional DON (Staff #25) were interviewed on 2/6/26 at 9:05 AM. They were shown the two certificates and expressed an understanding of the need for a diagnosis and/or a reason for any incapacity.

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview it was determined that the facility staff failed to 1) ensure a resident had baseline care plan / care plans within the required timeframe and provided the resident and/or family with a copy of the care plans, and 2) provide evidence in the resident's medical record that this summary had been delivered. This was evident for Four (Resident #8, #9, #40, and #15) out of 18 residents reviewed during the investigation phase of the facility's recertification survey. The findings include: A baseline care plan (BLCP) must be completed within 48 hours of a resident's admission to the facility. It must include initial goals based on admission orders, physician orders, dietary orders, therapy services, and social services. A summary of the BLCP and a current medication list must be given to each resident and/or their representative and documented in the medical record. The completion and implementation of the BLCP is intended to promote continuity of care and communication among staff, increase resident safety, and safeguard against adverse events (undesirable outcomes) that can occur immediately after admission. The Minimum Data Set (MDS) is part of the Resident Assessment Instrument that was Federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned for based on those individualized needs, and that the care is provided as planned to meet the needs of each resident. 1a) A review of Resident #9's clinical record on 2/9/26 revealed that the resident was admitted on [DATE]. The resident had care plans developed by the facility staff on the same day as admission, 12/4/25. Further review revealed that the resident's first care plan meeting was held on 12/12/25, 8 days after the care plans were developed. Care plans are to be developed as a result of the care plan meeting and within 7 days of the comprehensive MDS assessment. Review revealed the facility staff completed an MDS on 12/18/25 which was 6 days after the care plan meeting not prior to the meeting. On 02/09/2026 at 1:40 PM the survey team interviewed the social worker (Staff #3) about the care plan meeting process, she was asked to explain the process for care plan meeting and she stated that: On admission, she sets up an initial care-plan meeting to discuss what the goals are for the resident and what they need to accomplish while in the facility. She stated that each discipline explains their plan of care to the resident/representative during the care plan meeting. They will hold another meeting in 14 days depending on the residents insurance, then every 90 days thereafter. The proper order is to have the assessment first then have a care meeting to discuss what care plans needed to be developed. After the interdisciplinary team makes the decisions as to what care plans would be created, then the care plans are created. 1b) The Social Worker was interviewed on 2/9/26 at 2:03 PM. She was asked how she provided copies of the care plans to the resident and/or family. She replied that she puts a copy of the care plan into the electronic health record (EHR) and a notation if the resident and/or the family requested a copy of the care plan. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the EHR revealed no evidence of the family of Resident #9 receiving a copy of the care plan. 2) A review of Resident #40's clinical record on 2/10/25 revealed the resident was admitted on [DATE]. The first care plan invitation was sent on 6/28/25. This surveyor could not locate an invitation to a care plan meeting prior to 6/28/25. There was also no evidence in the EHR that a copy of the care plans was provided to the resident and/or the family. 3) On 2/06/26 at 7:12 AM, a review of Resident #8's medical record revealed the resident was admitted to the facility on [DATE]. Further review showed that while the electronic medical record (EMR) contained a section for the BLCP, the form was incomplete. The medication list reconciliation, the confirmation of the medication list provided to the resident/representative, physician orders, the BLCP summary, and the signature sections were all blank. 4) On 2/06/26 at 10:00 AM, the surveyor reviewed Resident #15's medical records. The review revealed the resident was admitted to the facility on [DATE]. However, the BLCP form was not created until 9/26/25 (one month after admission). Furthermore, the BLCP summary and signature sections were not filled out; while the form contained the signature of the staff member completing the plan, it lacked required information for the resident. In an interview with the Assistant Director of Nursing (ADON) and Staff #25 (Regional DON) on 2/06/26 at 12:06 PM, they explained that the facility utilizes a remote nurse to create the baseline care plans. This nurse creates the BLCP based on the hospital discharge summary, and on-site nurses are then responsible for adding the medication list and other resident-specific information. They stated that the facility's social worker is intended to hand the BLCP to residents and/or families within 72 hours and noted, All of that data should be documented in the electronic medical records. The surveyor reviewed the medical records of Residents #8 and #15 with the ADON and Staff #25. They validated that there was no evidence to support that the BLCPs were completed for these two residents or that the information was provided to the residents or their family members.

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	215227	A. Building B. Wing	02/11/2026

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record reviews and staff interviews, it was determined that the facility failed to ensure that care plan meetings were held concurrently with quarterly care plan revisions, and resident and/or their representatives were invited to care plan meetings. This deficiency affected six residents (Resident #5, #7, #9, #17, #40, and #51) of 6 residents reviewed for care planning during the recertification/complaint survey. The findings include: Care plans serve as essential guides for the care residents receive within the facility. They must be developed within seven days of a resident's comprehensive admission Minimum Data Set (MDS) assessment and revised at least quarterly, or more frequently as necessitated by a change in condition. The facility is required to ensure these care plans are developed and revised by an IDT, which includes the attending physician, a registered nurse, a nursing assistant, a representative from dietary services, the resident, and the resident's representative, as practicable. 1) A review of Resident #5's medical records on 2/06/26 at 11:53 AM revealed the resident has resided at the facility for more than four years. A review of the MDS assessments showed quarterly assessments were completed on 5/26/25, 7/21/25, 10/21/25, and 12/23/25, with an annual assessment completed on 4/03/25. However, documentation of care plan meetings was inconsistent with these dates: meetings were dated 7/18/25 (prior to the MDS completion), 8/29/25 (not related to a regular quarterly meeting), and 12/22/25 (prior to the MDS completion). There was no documentation of a care plan meeting corresponding with the May 2025 assessment. 2) A review of Resident #17's medical records on 2/09/26 at 10:05 AM revealed MDS assessments completed on 1/31/25, 4/22/25 (annual), 7/21/25, 10/21/25, and 1/21/26. However, documentation of care plan meetings/revisions occurred on 7/25/25, 10/24/25, and 1/30/26. There was a lack of documentation for care plan meetings for the January and April 2025 assessment periods. During an interview on 2/10/26 at 11:55 AM, Staff #3 (Social Worker) and Staff #12 (Social Work Consultant) explained the facility's care plan process. Staff #3 stated that the Social Worker schedules meetings based on the MDS Coordinator's Assessment Reference Date (ARD) from a shared calendar. The meeting is supposed to be held within one week of the ARD. Upon reviewing the lack of documentation for Resident #5 and #17, Staff #12 noted that Staff #3 was a recent hire (less than three months). Staff #12 acknowledged the missing documentation and stated the facility was aware of the issue and was currently monitoring the Social Work department's role more closely. Additionally, in a phone interview on 2/05/26 at 1:04 PM, the Ombudsman shared concerns that residents were experiencing a lack of assistance due to issues within the Social Work department. During an interview with the Nursing Home Administrator (NHA) on 2/11/26 at approximately 12:00 PM, the surveyor shared these concerns regarding the timing and documentation of care plan meetings and revisions. The NHA validated the findings. 3) On 2/05/2026 at 9:17 AM Resident #51 was asked if s/he has attended a care plan meeting or was invited to one and the resident stated they have not had a care plan meeting since admission. Review of the progress notes and social work notes on 2/09/2026 at 8:48 AM did not reveal that a (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	care plan meeting has been held for this resident since admission on [DATE]. On 2/09/2026 at 1:40 AM staff #3 a social worker director (SWD) was asked to check if Resident #51 had a care plan meeting since admission. The SWD checked the resident's medical records and said she could not find any documentation to indicate that a care plan meeting was held or that the resident or her family members were invited. She was asked how often care plan meeting were held and she said every 90 days or quarterly. She was made aware that this was a concern, she explained that the facility did not have a social worker at that time and agreed that a care plan meeting was missed. 4) A review of Resident #9's clinical record on 2/9/26 revealed that the resident was admitted on [DATE]. The resident had care plans developed by the facility staff on the same day as admission, 12/4/25. No evidence in the clinical record that reflected involvement of the resident and/or family in the development of the care plans. Further review revealed that the resident's first care plan meeting was held on 12/12/25, 8 days after the care plans were developed. Care plans are to be developed as a result of the care plan meeting and within 7 days of the comprehensive MDS assessment. Review revealed the facility staff completed an MDS on 12/18/25 which was 6 days after the care plan meeting not prior to the meeting. The social worker (Staff #3) was interviewed on 2/9/26 at 2:03 PM. She said that she puts a copy of the care plan into the electronic health record (EHR) and a notation if the resident and/or the family requests a copy of the care plan. Review of the EHR on 2/9/26 revealed no evidence of the family receiving a copy of the care plan. 5) A review of Resident #7's clinical record on 2/10/26 revealed that the resident was admitted on [DATE]. Further review revealed that since January 1, 2025, the resident only had care plan meetings on 7/11/25 and 2/6/26. Care plan meetings are held quarterly. The resident should have had four care plan meetings in 2025. On 02/09/2026 at 1:40 PM the survey team interviewed the social worker (Staff #3) about the care plan meeting process, she was asked to explain the process for care plan meetings and she stated that: On admission, she sets up an initial care-plan meeting to discuss what the goals are for the resident and what they need to accomplish while in the facility. She stated that each discipline explains their plan of care to the resident/representative during the care plan meeting. They will hold another meeting in 14 days depending on the residents insurance, then every 90 days thereafter. The proper order is to have the assessment first then have a care meeting to discuss what care plans needed to be developed. After the interdisciplinary team makes the decisions as to what care plans would be created, then the care plans get developed. The Social Worker was interviewed on 2/9/26 at 2:03 PM. She was asked how she provided copies of the care plans to the resident and/or family. She replied that she puts a copy of the care plan into the electronic health record and a notation if the resident and/or the family requested a copy of the care plan. 6) A review of Resident #40's clinical record revealed they were admitted on [DATE]. The resident had a falls care plan that was initiated on 11/7/24 and revised on 12/19/25 but there was no evidence of a care plan meeting on 11/7/24 nor was there evidence of a care plan meeting on any date except 12/19/25 when social worker wrote a note.

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	215227	A. Building B. Wing	02/11/2026

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on resident interview and clinical record review it was determined that the facility staff failed to facilitate resident self-determination through support of resident choice. This was evident for 1 (Resident #23) out of 9 residents reviewed for dining related concerns during the recertification/complaint survey.The findings include: A member of the survey team interviewed Resident #23 on 2/5/26 at 9:41 AM. Resident said their portions of food were too small and he/she had been asking for larger portions but the facility refused. This surveyor interviewed Resident #23 at 12:25 PM on 2/6/26. The resident was asked about the portions that were served. The resident said the portions served were too small. It was observed on 2/6/26 at 12:25 PM that the resident's meal slip said Roasted Red skin potatoes which was the resident's choice, but the resident was served mashed potatoes. The resident only became aware of the change in food items when the meal tray was served. The dietician (Staff #23) was interviewed on 2/9/26 at 1:15 PM. She said the resident was ordered to receive double portions. This surveyor asked how much fish a resident on double portions would receive. She replied that they would get a little bit of everything. Approximately half of an additional portion. She said that the resident had a 12/26/25 care plan meeting. The care plan team discussed that the resident's Body Mass Index (BMI) was high, resident was eating well, and that the team agreed to keep the resident's weight stable. She added the resident's BMI was 44.6 which is incredibly high. She said she did not remember him being part of a plan to lose weight. This surveyor interviewed Resident #23 on 2/9/26 at 11:30 AM and asked if they agreed to a weight loss plan. The resident replied No. The resident said that he/she was okay with the fact that they lost weight. Resident said they were admitted with a weight of almost 400 pounds and had lost close to 180 pounds. However, he/she stated that they never asked if I wanted to lose weight.

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	215227	A. Building B. Wing	02/11/2026

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation and staff interview it was determined that the resident failed to ensure a resident room had two chairs and to ensure a resident's furniture was maintained in a homelike manner. This was evident for one nursing unit (Rose Hall) out of the two nursing units.The findings include:A survey team member observed on 2/5/26 during the initial tour of the facility that one room (205) did not have any chairs, and another room (206) had a bedside table that had chipped edges. This surveyor toured on 2/20/26 at 2:48 PM the rooms noted to have had issues on the initial tour. This surveyor knocked on the door for room [ROOM NUMBER]. The resident acknowledged the surveyor and nodded when asked for permission to enter the room. This surveyor looked around the room and observed that there were no chairs in the room. Visitors, as well as the residents themselves, did not have a place to sit.This surveyor then went to room [ROOM NUMBER]. This surveyor observed that the bedside table for B bed was chipped around the edges. The chipped areas were not only unsightly but could have scratched the resident. This surveyor took the Administrator for a tour of these two rooms on 2/11/26 at 12:55 PM. He was taken to room [ROOM NUMBER] which did not have chairs. He confirmed the absence of chairs and stated that he would get chairs for the room. He was then taken to room [ROOM NUMBER] on 2/11/26 at 1:02 PM. He observed the bedside table and confirmed that it was chipped. He was then shown that the plastic edging from around the footboard of B bed was off of its track and dangling from the footboard. The edging had not been observed to be off its track during previous observations. He stated that he would have both fixed immediately.

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	215227	A. Building B. Wing	02/11/2026

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on medical record reviews, a review of complaint #2734220, and staff interviews, it was determined that the facility failed to make prompt efforts to resolve resident grievances. This deficiency was evident for one of three residents (Resident #5) reviewed for grievances during the recertification/complaint survey.The findings include:During the investigation of complaint #2734220 on 2/05/26 at 9:31 AM, it was revealed that Resident #5's family expressed safety concerns regarding a roommate (Resident #41). The family reported that Resident #41 had been standing over Resident #5 in an intimidating manner.In a phone interview on 2/05/26 at 11:30 AM, the complainant stated that Resident #41 exhibited several behavioral issues, including taking other residents' items, appearing undressed, and blocking doorways. The complainant stated, We did not feel safe with the roommate . We requested a room change, but the facility did not take it seriously. The room was finally changed the day after the incident occurred.A review of Resident #5's medical records on 2/10/26 at 9:31 AM revealed a progress note written by RN #13 on 2/01/26 at 2:50 PM. The note indicated that Resident #5's family had requested a room change because Resident #41 continued to enter Resident #5's personal space and bother them.In a phone interview on 2/10/26 at 12:53 PM, RN #13 stated that a nurse aide reported a conflict between Resident #5 and Resident #41. RN #13 said, I went to the room to de-escalate the situation; Resident #41 was sitting in a chair, and there was no aggressive behavior between the two residents. Because a family member requested a room change, I documented the request. When asked by the surveyor if any further action was taken, RN #13 verified that no further steps were taken by facility staff at that time.Further review of the medical record on 2/10/26 at 1:30 PM showed that Resident #5's room was eventually changed on 2/02/26 at approximately 10:00 PM following the family's request.On 2/11/26 at 8:30 AM, the surveyor requested all grievance forms for Resident #5. The Director of Nursing (DON) provided only one form, dated 9/15/25, regarding a bed issue. The DON stated, This was the only grievance for [Resident #5].During an interview on 2/11/26 at 1:31 PM, Staff #25 (Regional Director of Nursing) confirmed that the facility should have addressed the request timely, as the resident did not feel comfortable with the roommate. Staff #25 validated the surveyor's concerns.

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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 medical record reviews and staff interviews, it was determined that the facility failed to ensure that each resident's medication regimen was free from unnecessary medications and/or chemical restraints. This was evident by the facility utilized psychotropic medications without adequate clinical indications for use. This deficient practice was identified in one (Resident #8) of five residents reviewed for unnecessary medication regimens during the recertification/complaint survey.The findings included:Lewy Body Dementia (LBD): A progressive brain disease associated with abnormal protein deposits (alpha-synuclein). It is characterized by fluctuating alertness, vivid visual hallucinations, and Parkinsonian motor symptoms.Psychosis: A symptom involving a loss of contact with reality, often manifesting as hallucinations or delusions.Clonazepam: A benzodiazepine used to treat anxiety, panic disorders, and seizure disorders by slowing the central nervous system.Clozapine: A potent antipsychotic medication primarily indicated for treatment-resistant schizophrenia or schizoaffective disorder.On 2/06/26 at 7:27 AM, a review of Resident #8's medical records revealed that the resident had diagnoses including, but not limited to, Lewy Body Dementia (LBD), Parkinson's disease, anxiety, and depression. Current medication orders included:Clozapine 12.5 mg scheduled for AM administration for AntipsychoticClozapine 25 mg scheduled for PM administration for AntipsychoticClonazepam 0.5 mg scheduled for bedtime for antipsychotic.During an interview on 2/09/26 at 10:24 AM, Staff #8 (Psychiatric Nurse Practitioner) reviewed Resident #8's medications with the surveyor. Staff #8 stated, Clonazepam should be used for schizophrenia or the treatment of anxiety. The resident might have some schizophrenia symptoms.However, upon a joint review of the attending provider's documentation and the resident's past medical history, there was no diagnosis or clinical documentation of schizophrenia to justify the use of these medications in this manner. Staff #8 validated the concern, confirming there was no documented indication for the current antipsychotic and benzodiazepine regimen relative to the resident's specific diagnoses.

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	215227	A. Building B. Wing	02/11/2026

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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 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 medical record reviews and staff interviews, it was determined that the facility failed to ensure Minimum Data Set (MDS) assessments were accurately coded. This was evident for one resident (Resident #8) out of five reviewed for active diagnoses and unnecessary medications during this recertification/complaint survey.The findings include:The Minimum Data Set (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 must be accurate to ensure that each resident receives appropriate care.A review of Resident #8's medical record on 2/06/26 at 7:27 AM revealed diagnoses including, but not limited to, Lewy Body Dementia (LBD), Parkinson's disease, anxiety, and depression. However, the most recent MDS, dated [DATE], failed to code psychiatric/mood disorders. Specifically, Section I (Active Diagnoses, items I5700-I6100), which includes anxiety, depression, bipolar disorder, psychotic disorder, schizophrenia, and Post-Traumatic Stress Disorder (PTSD), was not completed for this resident.During a phone interview on 2/11/26 at 10:14 AM, Staff #2 (MDS Coordinator) verified that Resident #8's most recent MDS only coded dementia and Parkinson's disease. Staff #2 stated, I tried to refer to all the records from providers. I missed Resident #8's diagnoses. I should have included the other mental health conditions like anxiety and depression.In a subsequent interview on 2/11/26 at approximately 11:00 AM, Staff #25 (Regional Director of Nursing) was informed of these concerns and validated the findings.

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	215227	A. Building B. Wing	02/11/2026

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, record review, and staff interviews, it was determined that the facility failed to ensure that a resident who was unable to carry out ADL's, was provided the necessary services to maintain good grooming and personal hygiene. This was evident for 1 (Resident #1) of 1 resident reviewed for grooming during the recertification/complaint survey.The findings include:Activities of daily living (ADL) are skills required to manage one's basic physical needs, including personal hygiene and grooming, dressing, toileting, transferring or ambulating and eating.On 2/05/2026 at 10:59 AM Resident #1 was observed lying in bed, their fingernails were outgrown with brown stains on the inside. Their facial hair was unshaven, about 4 inches long, with dry food particles stuck on it. Resident #1's toenails were thick, protruding out, about 3/4 inch long. The resident was wearing a hospital gown; it had brownish stains towards the chest area. A shirt with a pair of pants was placed on top of the baseboard at the foot of the bed, the resident looked unkept.A second observation was done on 2/10/2026 at 2:00 PM. Resident was observed again in bed with only a diaper on, they were not wearing any personal clothing, their fingernails and toenails were still not trimmed and had brown stains underneath.On 2/10/2026 at 2:07 PM a review of the care plan documented: Resident has ADL self-care deficit related to (r/t) infection. Some of the interventions written under the grooming tab had: Assist to groom. Personal Hygiene Keep nails short. Body check by geriatric nursing assistant (GNA) with AM care every day (qd). Body checks by nurse every week'.On 2/10/2026 at 3:05 PM in an interview with Staff #15, a GNA assigned to the resident's care, she was asked who was responsible for the residents grooming and she said it's the GNA's. She was asked if she noticed that resident's fingernails were dirty and needed trimming and that resident needed a shave. She stated that resident's son visited that day and requested that resident be given a shower, that grooming will be done during the shower.On 2/10/2026 at 3:19 PM Staff #6, the assistant director of Nursing (ADON) was brought to the resident's room and made aware of the observations. She was asked who cuts the toenails for the residents and she said it's done by the podiatrist. She inspected them and confirmed that the nails were dirty and outgrown, the facial hair needed to be trimmed and that resident looked unkept. She said she will talk to the GNA.

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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. Based on record review, staff and resident's interviews, it was determined that the facility failed to 1), act on a physician's recommendations for Resident #51 and 2), administer medications as ordered by the physician for Resident #3. This was evident during the recertification/complaint survey.The findings include1) On 2/05/2026 at 9:10 AM Resident #51 told the surveyor that they were ordered Mirtazapine 15mg for appetite/ antidepressant. Resident #51 stated that the medicine makes them drowsy and s/he can't wake up or function normally and would consider taking half a dose instead of the full dose. The Resident was asked if they told any of the staff and the Resident said they made the nursing staff and their physician aware of it.A review of the physician's order on 2/11/26 at 9:30 AM revealed an order written on 2/2/26 for Resident #51. It read: Mirtazapine Tablet 15 MG, Give 1 tablet by mouth at bedtime for depression/poor appetite. Further review of the February 2026 medication administration record (MAR) revealed the resident has been getting the full dose of the medication every night.On 2/11/26 at 9:45AM, review of a consulting physician's progress note revealed that Resident #51 was seen on 2/6/26 by the Physiatrist-a medical doctor who specializes in helping people regain function after surgery, stroke or injury. The physician documented in his progress note that Resident #51 complained of dizziness and loopiness since starting the above medication. The physician recommended to reduce the dose of Mirtazapine to 7.5 mg to improve tolerance while still providing therapeutic benefits because the resident was experiencing significant loopiness and dizziness .The physician documented that the resident was in agreement and that he discussed the dose reduction with the assistant director of nursing (ADON).Further review did not indicate that the facility acknowledged his recommendation or acted on it.On 2/11/2026 at 12:10 PM, the Interim director of nursing (DON) was asked if she was aware of the residents' complaints and of the doctor's recommendations, and she said no. She was asked the process for addressing recommendations from consulting physicians. She stated that the consulting physician would send emails to the primary team about his recommendations. The primary team or attending physicians would follow up by approving or disapproving the recommendation with a written note or with a new order to effect a change. The Interim DON was made aware that a recommendation was made but was not followed up by the primary team and that this was a concern. She agreed and said she will bring it to the attention of the primary team.2) On 2/06/2026 at 10:57 AM review of the physician's order for Resident #3 revealed an order written on 1/6/26. It read, Hydralazine HCL oral tab 25mg. Give 1 tab by mouth every 8 hours for Hypertension (HTN). Further review of the medication administration record (MAR) for January 2026 revealed that this medication was not signed off to indicated they were given on 3 different days. The dates were 1/7/26 at 2200, 1/16/26 at 2200 and 1/17/26 at 0600. Review of the nurse's notes did not indicate that a note was written as to why the blood pressure medication was not given.In an interview with the director of nursing (DON) on 2/9/26 at 2:15PM, she was asked to explain the process for med administration and documentation. She stated that once medications are given, the nurse is expected to sign to indicate that they were given. If the resident refuses the med, there is a code to chart to indicate so. She was shown the MAR with the 3 days that were not signed and asked what that indicated. She stated that it meant that the medication was not given on those days. She was made aware that the resident did not get her medications on those 3 days and there was no explanation for it. She agreed that this was a concern.

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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 a review of resident medical records and interviews with facility staff, it was determined that the facility failed to timely address and communicate significant weight loss. This deficiency was evident for one (Resident #5) of two residents reviewed for nutrition during this annual survey.The findings include:During a phone interview on 2/05/26 at 11:53 AM, Resident #5's family stated the resident did not receive adequate hydration, which resulted in multiple hospital transfers. As part of the investigation into this concern, the surveyor reviewed Resident #5's medical records regarding hydration and nutritional status.A review of medical records on 2/09/26 at 8:57 AM revealed a pattern of hospital transfers and readmissions: the resident was transferred on 9/08/25 and readmitted on [DATE]; then transferred again at the resident's request on 9/12/25 and readmitted on [DATE]. The medical record documented the following weights:9/02/25: 185 lbs (Bed scale)9/11/25: 161.4 lbs (Bed scale) - Significant loss of 23.6 lbs (12.7%)9/12/25: 161.4 lbs (Bed scale)9/18/25: 165 lbs (Mechanical lift)10/17/25: 166.2 lbs (Mechanical lift)10/23/25: 155 lbs (Mechanical lift) - Significant loss of 11.2 lbs (6.7%)A review of the Registered Dietitian (RD) progress notes on 2/09/26 at 10:10 AM showed that Staff #9 (RD) documented the following on 9/19/25: Weight loss has been noted upon readmission . loss has not been planned and may be due to a history of nutrient intake less than needs. Interventions included adding cookies and pudding at bedtime and 30ml of liquid protein twice daily. On 10/24/25, Staff #9 noted a recommendation for a re-weight and an additional 30ml of liquid protein. However, there was no evidence in the record to support that these significant weight changes were reported to the family or the attending physician.During an interview on 2/09/26 at 9:31 AM, the Director of Nursing (DON) and Staff #25 (Regional DON) stated that the RD communicates daily with nursing leadership via email, and this information is passed to floor nurses and Geriatric Nurse Aides (GNAs) for monitoring. When asked how significant weight changes are reported to responsible parties and providers, the DON stated, The Dietitian notifies the family and contacts providers regarding changes. It should be documented in the electronic medical record.In a phone interview on 2/09/26 at 11:09 AM, Staff #9 (RD) contradicted this, stating she only provides recommendations to facility staff and does not contact families or providers directly. She stated, I believe it's the nurses' job. Regarding the 9/11/25 weight loss, Staff #9 acknowledged the note was not written until eight days later, stating, I had been out when it was noted. When asked why the same intervention was used for the second weight loss on 10/23/25, Staff #9 stated, I don't know why there were the same interventions.During a follow-up interview on 2/09/26 at 11:45 AM, the Assistant Director of Nursing (ADON) stated their role was to follow up on labs or medications, but not to notify the family of changes in condition, claiming, It's the dietitian's role. The surveyor shared concerns regarding the lack of evidence that Resident #5's weight loss was timely addressed or communicated. The ADON and Staff #25 validated these concerns.

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	215227	A. Building B. Wing	02/11/2026

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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. Based on a review of employee files and interviews, it was determined that the facility failed to implement a system to ensure nursing staff were competent in their respective skill sets. This deficiency was evident in 3 (Staff #29, #30, #31) out of 5 employee files reviewed for competencies during the recertification/complaint survey.The findings include:On 2/10/26 at 7:00 AM, the surveyor reviewed the competency records of five randomly selected staff members. The review revealed the following:-Staff #29: Hired in December 2024 as a GNA, resigned, and was rehired in December 2025. The employee file lacked documentation of competency upon their rehire in 2025.-Staff #30 and #31: Hired in December 2024 as RNs. The employee files for Staff #30 and #31 lacked records verifying clinical skill competency.During an interview on 2/10/26 at 7:18 AM, Staff #1 (Business Officer) stated that HR verifies competency records for new hires and that the nursing department conducts annual evaluations. However, upon a joint review of the files for Staff #29, #30, and #31, Staff #1 verified that no skills or competency evaluations were present in the records.In an interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on 2/11/26 at 2:30 PM, the above concerns were shared with them, and they validated it.

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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** Based on Observation and staff interviews, it was determined that the facility failed to appropriately label and store drugs and biologicals in accordance with accepted professional standards. This was evident for 2 of 4 medicine (Med) carts, including the med room fridge observed on the nursing unit during the recertification/complaint survey.The findings include:On [DATE] at 10:20 AM the nurse med cart was checked in the pink hall with Staff #24 a licensed practical nurse (LPN). These meds were found with no labels to indicate when they were opened: -Fluticasone Propionate 50 mcg/inhale nasal spray 16gm-Tuberculin Purified Protein Derivative Diluted/Aplisol, 5 Tu/0.1 ml-5ml bottle These medications were also found expired in the pink hall med cart:-Levetiracetam 100mg/ml solution oral solution with expiration of [DATE]-H-Chlor 120.125% solution with expiration date of [DATE]. On [DATE] at 10:50 AM Observation of the med room with Staff #6 the assistant director of nursing (ADON) revealed expired meds kept in the med fridge. They include:-Cath-Flo Activase 2mg injection. Expired [DATE]-Trulicity 0.75mg/0.5ml Pen- Inject 0.75mg sq once a day every Friday. Expired [DATE].-Tresiba Flex touch 200 unit /ml- Inject 62unit sq 2 times a day-Expired [DATE]/25.-Gabapentin 250mg/5ml liquid -500mg bottle -Give 10ml by mouth3x daily.-3 bags of Intravenous (IV) Daptomycin 700mg/100ml in-0.9% NSS, Infuse IV at 100ml/hour once daily for bacteria for 15 days. Expired[DATE].-3 Mils of 12 ml pen -Novolin N flex pen vial 100unit/ml inject per sliding scale for Expired. [DATE].-Intravenous (IV) Imipenem/Cilastatin 1gm/250ml in 0.9% Normal Saline-Infuse iv at 166 ml/hour over 90 mins q6h for UTI Expired. [DATE] at 2PMOn [DATE] at12:21 PM in an interview with Staff #20, a registered nurse (RN), she was asked the process for checking for expired meds and she stated that it's supposed to be done weekly and with each med administration by each nurse. If expired meds are found, they should be discarded and a replacement ordered.On [DATE] at 2:26 PM the director of nursing (DON) was made aware of the concern. She stated that it is the responsibility of night shift nurses to check the med room fridge and med carts daily. She explained that a new unit manager has been hired and part of their responsibility would be to provide oversight. She agreed that this was a concern.

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	215227	A. Building B. Wing	02/11/2026

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and clinical record review it was determined that the facility failed to obtain a dental consult and/or a dental visit for all residents. This was evident for one (#10) out of one resident reviewed for dental concerns. The findings include: This surveyor reviewed Resident #10's clinical record on 2/5/26. The clinical record review revealed that the resident was admitted on [DATE]. Further review revealed that there were no dental consults since admission in the clinical record. The Director of Nursing (DON) was interviewed on 2/9/26 at 3:30 PM. She was asked about the lack of dental consults. She replied that there have been no complaints from the resident or from the family, so a dental consult/visit was never obtained. This surveyor explained that the regulation states that an evaluation from an outside source needs to be done on an annual basis. She expressed an understanding of the findings.

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	215227	A. Building B. Wing	02/11/2026

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on a review of meal service times and staff interview it was determined that the facility staff failed to ensure meals were served less than 14 hours apart. This was evident for all residents receiving a meal tray. The findings include: A review of meal service times revealed that the facility serves dinner with the last food cart having a delivery time of 5:20 PM and the first breakfast cart has a delivery time of 7:40 AM. This represents a 14 hour and 20-minute gap. The Food Service Manager (Staff #28) was interviewed on 2/11/26 at 10:30 AM. This surveyor shared the above finding with her. She stated that the time listed for the food cart that is delivered to the assisted living does not count. She said she understood the finding and would adjust the time the carts went up to reflect a time span of less than 14 hours.

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	215227	A. Building B. Wing	02/11/2026

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on medical record reviews and staff interviews, it was determined that the facility failed to ensure that key essential personnel were present during monthly Quality Assurance (QA) meetings. This deficiency was evident in three of the eight monthly QA meeting attendance sheets reviewed during this recertification/complaint survey.The findings include:On 2/11/26 at 11:29 AM, the surveyor reviewed the facility's Quality Assurance and Performance Improvement (QAPI) meeting attendance sheets from February 2025 to the present. The review revealed that key essential personnel did not sign in for the following dates:-04/30/25: The Infection Preventionist was not in attendance.-06/25/25: There was no evidence of attendance by the Medical Director.-December 2025 (date not clearly documented): There was no evidence of attendance by the Director of Nursing.During an interview with the Nursing Home Administrator (NHA) on 2/11/26 at 12:40 PM, the NHA reviewed the QAPI attendance sheets with the surveyor and validated the absence of documentation regarding the attendance of these key personnel.

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	215227	A. Building B. Wing	02/11/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on Observation and staff interviews, it was determined that the facility failed to 1), ensure that laundry staff utilize appropriate Infection control measures in the laundry room and 2), have hand sanitizers available in the resident's room for infection prevention in 14 of 31 residents' rooms. This was evident during the recertification/complaint survey.The findings include1) On 2/10/26 at 9:14 AM, an inspection of the facility's laundry room was conducted and on the clean folding table were observed personal items such as: a black handbag, an animal print material , 2 cells phones, one plugged into the wall socket and charging on the table, 2 clear 12 oz plastic soda cups, one containing a small amount of brown liquid, an open bottle of Pepsi cola about 3/4 full. On the dirty side were also observed the absence of a gown or mask for sorting/handling dirty laundry, only gloves were seen.In an interview with the laundry aid, Staff #21 on 2/10/26 at 9:20 AM, she was asked about the process for sorting laundry. She explained that dirty laundry are not sorted, because they come in a special laundry bag. They are put in the washer with the clothing. She was asked what sort of personal protective equipment (PPE) was required for use in handling dirty laundry and she said, just gloves. She was asked about gowns, and she said there are no gowns provided by the facility for use and that she was not taught to use gowns when handling dirty laundry. She was asked if she got any training on infection control and the use of PPE's and she said no. She was asked if she was told not to leave any personal items including food and drinks on the clean laundry folding table and she said no.On 2/10/26 at 9:26 AM, Staff # 22, the director of housekeeping, was asked in a separate interview if the laundry staff were trained on the use of PPE and she said that staff do get monthly training on infection control processes such as handwashing and PPEs use. She was asked what sort of PPE the laundry staff are required to use with dirty laundry. She said that when the linens are heavily soiled, staff are expected to use gloves, gowns and facemasks. She was asked about the folding table in the clean side and what was allowed on it and she said no food, drinks or personal items. She was made aware of the findings and that this was a concern. She stated that the laundry aides should not put personal items on the clean folding table.2) On 2/11/2026 at 11:03 AM -an observation of the resident's rooms in the pink hall was conducted and revealed that some rooms (200, 211, 210, 214, & 212) did not have any hand sanitizers. Rooms 101,103, 104, 105,110, 112,114, 113, and 115 on the green hall were also observed not to have any hand sanitizers.Staff #8 a certified medicine aide (CMA) was asked on 2/11/26 at 11:13 AM the expectation on staff before entering or leaving any resident's room and between resident's care. She stated that the staff are expected to perform hand hygiene by either washing their hands or sanitizing with alcohol-based rubs. She was asked where the sanitizers are located, she said on the walls or in the resident's room. She confirmed with the surveyor that there were no hand sanitizers in the above rooms.On 2/11/2026 at 12:10 PM the Interim director of nursing (DON) was made aware of the above concerns, and she stated that hand sanitizers were placed outside the resident's rooms but were taken down during painting and facility renovation. The sanitizers were placed in each resident's room and housekeeping was supposed to make sure that each room had them. She agreed that it was a concern.

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	215227	A. Building B. Wing	02/11/2026

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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 administrative record reviews and staff interviews, it was determined that the facility failed to implement a process for tracking nurse aide participation in required training. Specifically, the facility did not ensure all aides received the mandated 12 hours of annual training, including abuse prevention and dementia management, nor did it address areas of weakness identified in performance reviews. This deficiency was evident for two of two Geriatric Nursing Assistants (GNA #29 and #32) reviewed during the recertification/complaint survey.The findings included:On 2/09/26 at 11:23 AM, the surveyor reviewed randomly selected employees' files. The review revealed that as below:-GNA #29: Hired in December 2024, resigned, and re-hired in December 2025. There was no evidence to support the employee receiving dementia training upon re-hire.-GNA #32: Hired in April 2025. There were no records indicating the employee received dementia training upon hire.During an interview on 2/10/26 at 8:56 AM, Staff #25 (Regional Director of Nursing) stated that the previous Director of Nursing (DON) maintained the training records; however, the facility was having difficulty locating or organizing them. Staff #25 noted, Those [found in the files] were all we could find for their training. Staff #25 validated the findings and the absence of dementia training records for newly hired staff.