STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215299	A. Building B. Wing	12/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westgate Hills Rehab & Healthcare Ctr	10 North Rock Glen Road Baltimore, MD 21229

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** Based on record review, interviews and complaint #2655446, it was determined that the facility failed to: 1) accurately document assessment in the resident medical record and 2) ensure that the residents receive treatment and care in accordance with professional standards of practice to prevent future skin impairment. This was evident for 2 (Resident #2, #6) of 8 residents records reviewed during the complaint process.The findings include: During the complaint investigation on 12/30/25 at 8:27 AM, the surveyor reviewed Resident #6's medical records. The review revealed that the resident received Nitroglycerin (a potent vasodilator used to treat and prevent chest pain caused by coronary artery disease) on 10/16/25, 10/28/25, and 10/29/25. However, there was no documentation of symptoms or assessments prior to the administration of Nitroglycerin on 10/16/25. In an interview with the Director of Nursing (DON) on 12/31/25 at 8:23 AM, she stated that any change in condition, including chest pain, should be documented in the residents' electronic medical records. During an interview with Staff #6 (Licensed Practical Nurse) on 12/31/25 at 9:08 AM, he explained that if a resident reports unusual symptoms, nurses should check the resident's vital signs, review records for PRN (as needed) medication, notify the physician, and take appropriate action. All of these steps should be documented in the system. The staff member recalled that Resident #6 frequently reported chest pain, which was relieved by medication. The surveyor shared the above concerns with the DON and the Nursing Home Administrator on 12/31/25 around 3:00 PM; they validated the findings. The National Library of Medicine described Moisture-Associated Skin Damage (MASD) occurs when skin is repeatedly exposed to various sources of bodily secretions or effluents, often leading to irritant contact dermatitis, characterized by inflammation with or without denudation of affected skin. 2. On 12/30/2025 at 3:45 PM, a review of complaint #2655446 revealed allegation that Resident #2 was found unclothed and left soiled for extended periods of time. On 12/30/2025 at 3:57 PM, in a telephone interview with the complainant, he/she alleged that Resident#2 developed wounds while admitted in the facility. (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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/31/2025 at 11:29 AM, a review of Resident #2's admission progress notes revealed that the resident was readmitted to the facility on [DATE] and the admission note describe the resident's skin as warm and dry to touch and intact. A review of Resident #2 10/2/2025 hospital discharge summary physical exam revealed that the skin was described as warm and dry and listed the inpatient wound care orders as: None. On 12/31/2025 at 11:50 AM, a review of the 10/3/2025 Interim Skin Check assessment form revealed that Resident #2 had a Stage 3 pressure Ulcer on the left buttock. A review of 10/3/2025 skin and wound note completed by the nurse practitioner revealed that the resident had a Moisture Associated Skin Damage on the left buttock. On 12/31/2025 at 12:10 PM, in an interview with Licensed Practical Nurse (LPN#9), she was asked about the allegation that Resident #2 was left unclothed and/or in soiled clothes for an extended period of time and LPN denied any knowledge of the alleged incident or concern. LPN #9 was also asked about the wound care practices within the facility and she explained that the wound care team (wound nurse and the wound care practitioner) conducted weekly skin assessment. The floor nurses are also required to do skin assessments weekly and on the residents' shower days. LPN #9 was asked to clarify Resident #2 wound care status as there were various documented descriptions of the resident's integumentary status in the medical record in less than a 24 hour period after readmission. The admitting nurse documented on 10/2/25 skin warm, dry and intact, interim skin check assessment on 10/3/2025 documentation revealed stage 3 wound to left buttock and on 10/3/2025 the wound care practitioner's notes identified the same left buttock as MASD LPN #9 explained that Resident#2 came in with a MASD which later progressed to stage 3 left buttock pressure ulcer. LPN #9 explained that she had a decline, she was not eating and we documented on 10/10/2025 that there was a change in condition because the wound progressed to a stage 3. LPN #9 continued to explain that she was the wound care nurse at the time of Resident #2 readmission, and she remembered that the resident came in with a MASD and not a stage 3 left buttock wound as documented. She explained that the assessment was initiated on 10/3/2025; however, it was locked on 10/15/2025 and unfortunately at the time when the document locked it did not capture the accurate assessment of MASD which was seen on 10/3/2025. LPN#9/ wound care nurse explained that it was user error, and she clicked the wrong information on 10/3/2025. 3. On 12/31/2025 at approximately 2:20 PM, a review of Resident#2 medical records revealed that a change of condition form was completed on 10/10/2025 to indicate to the resident's physician that the wound deteriorated from MASD to a Stage 3 left buttock pressure ulcer. However, there was no documented evidence to support that facility notified resident primary care practitioner of the resident's wound upon readmission on [DATE] as required. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On12/31/2025 at approximately 2:25 PM, a review of Resident#2 orders revealed no documented evidence to support that the facility obtained orders and implement intervention to appropriately treat the resident's wound. However, documentation showed that the Nurse Practitioner on 10/3/2025 made the following recommendations: Wound # 1 Left L buttock MASD. Treatment Recommendations:1. Cleanse with soap and water, pat dry. 2. apply Barrier Cream to base of the wound. 3. secure with Leave open to air.4. change Daily. PREVENTATIVE MEASURES: Provide in-house preventive measures to avoid skin and wound complications. Continue to apply barrier cream q shift and prn to protect skin integrity. Moisturize patient skin daily. Optimize nutrition. Follow with PT recommendations. Continue to monitor for changes in skin integrity and notify wound team if any changes occur. NEW RECOMMENDATIONS: See plan and preventative measures above. Patient has MASD, ensure patient is changed when soiled , keep area dry and cleanEducation was provided to the staff, patient regarding the patient's wound, dressing care, and general treatment recommendations. A review of the Medication Administration Record and Treatment Administration Record revealed no documented evidence to support that the facility implemented wound care treatment plans to prevent additional skin impairment concerns at the time of admission. Further review of Resident #2's medical record revealed that wound care orders were initiated on 10/12/2025 and were as follows: 10/12/2025 low air loss mattress when in bed for pressure ulcer management every shift; 10/13/2025 turn and reposition resident every 2 hours for pressure ulcer; 10/13/2025 wound care: to left buttocks, cleanse with normal saline, pat dry, apply collagen/calcium alginate. Cover with bordered foam, every day shift for wound care; and on 10/15/2025 Resident #2 order stated house barrier cream with each incontinent episode, GNA may apply. Every shift. On 12/31/2025, in an interview with LPN #6, he was asked how the facility documented Activities of Daily Living (ADL) and resident care needs. He explained that on the Geriatric Nursing assistant (GNA) flowsheet in the Electronic Medical Records (EMR) extensive documentation can be found about things such as resident's functional needs for ADLs, bowel/bladder functions and if the resident was incontinent of urine and/or stool the GNA's documentation would also indicate every shift the type of care that was provided. The care plan was also another way to document the level of functionality for each resident. He was asked if he was familiar with Resident #2 and he stated he vaguely remembered the resident, but he was unable to provide any additional details about the resident's care needs. A review of the resident GNA flowsheet revealed that Resident #2 was assessed for bowel and bladder incontinence once per shift and skin checks were documented once per shift. The GNA flowsheet revealed that skin checks were to be completed each shift, and when given the option to identify if Resident #2 had skin impairment on the GNA flowsheet such as: 0) scratch, 1)red area, 2)discoloration, 3)skin tear 4) open area and/or 5) observed none of the above, 9 out of 10 GNA documented None of the above observed for the dates of 10/2/2025 to 10/9/2025. However, the wound care nurse assessment and the nurse practitioner's progress note on 10/3/2025 suggested that the resident had skin impairment on the left buttock. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/31/2025 at 2:30 PM, in another interview with LPN #6, he was asked to describe the admission/readmission process, and he explained that any nurse can complete the admission assessment. The nurse should complete the following for an admission/readmission: admission screening (which included a physical assessment); Admission/readmission evaluation packet; Braden scale; and Functional abilities and goal. When asked by the surveyor he explained that the skin assessment was to be completed as a part of the admission screening assessment. The surveyor asked about the process for wound care upon admission and he replied that the nurse should review hospital discharge summary to see if discharge summary indicated that the resident had wound care orders. The nurse would contact the doctor about the orders to decide whether or not they wanted to initiate, continue or change the wound orders. He explained that during the admission process the nurse would be required to confirm that all orders were reviewed with the practitioner and the nurse can also document in a progress note that the concerns were communicated and orders were received from the doctor. On 12/31/2025 at 3:05 PM, in an interview with the Director of Nursing (DON), the DON was asked about the wound care process at the facility. She explained that a wound care Nurse Practitioner (NP) and the facility's wound care nurse conducted weekly wound rounds for residents with existing wounds. The facility's wound care nurse will also conduct a monthly sweep for residents who don't have wounds. If a resident was newly admitted and available when the weekly wound rounds are being done, the wound care team would see the newly admitted resident as well. If the resident was admitted on off-hours the floor nurse would be responsible for the initial skin assessment and then the wound care nurse would follow up on Monday. The surveyor asked the DON what type of treatment would be offered to a resident with moisture associated skin damage (MASD) and she explained that a barrier cream after incontinent care and watching the wound closely would be standard practice. However, if the wound nurse practitioner assessed the wound, they may provide other wound care orders for us to follow. The DON was notified of the following concerns: inconsistency with Resident #2 skin assessment documentation less than 24 hours after admission (the resident's admitting nurse documented: skin intact on10/2/2025; the facility's wound care nurse documented: pressure ulcer stage 3 on left buttock on 10/3/2025 and the NP documented MASD on 10/3/2025). There was also no indication that the wound care treatment was initiated upon admission. The resident wound care treatment was started on 10/12/2025, which potentially contributed to a decline in the resident skin integrity. The DON stated that she will review resident's hospital records. On 12/31/2025 at 3:53 pm, the DON stated that she reviewed the resident's hospital record which did not indicate that the resident had a wound upon discharge from the hospital.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. Based on a review of records and interviews, it was determined that the facility failed to assess or document residents' behaviors regarding mental illness. This was evident for one resident (Resident #7) out of eight residents reviewed during this complaint survey. The findings include: On 12/30/25 at 1:50 PM, the surveyor conducted a phone interview with the complainant for case #2659413. During the interview, the complainant reported that they were not informed of Resident #7's worsening agitation, wandering, and/or behaviors, such as entering other residents' rooms and touching their belongings. The complainant stated that when the resident was ready to be readmitted to the facility, management resisted, claiming that Resident #7 had worsening behavioral issues that resulted in the facility increasing its budget to address the problems.The surveyor reviewed Resident #7's medical records on 12/30/25 at 2:15 PM. The review revealed that the resident had resided at this facility since October 2025 with a diagnosis of dementia with behavioral disturbance. Additionally, the resident was prescribed medications (Risperidone, Divalproex, and Trazodone) for those diagnoses upon admission; however, there was no order/documentation for behavior monitoring. During a phone interview with the Psychiatric Nurse Practitioner (Staff #5) on 12/30/25 at 5:23 PM, she recalled Resident #7's condition as aggressive, including making false accusations and wandering. The surveyor asked how Staff #5 became aware of the resident's condition. She stated, It was a verbal report; there was no documentation that I referred to.In an interview with the Director of Nursing (DON) on 12/30/25 at 5:49 PM, she stated that Resident #7's behavioral issues were documented in the care plan and that behavior monitoring for every shift should have been documented in the Treatment Administration Record. The surveyor reviewed Resident #7's medical records with the DON. The DON verified that there was no assessment or documentation of the resident's behavior.