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	07/01/2026

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, it was determined that the facility failed to have evidence that an allegation of sexual abuse was thoroughly investigated for 1(Resident #1) of 1 residents reviewed for alleged sexual abuse. The findings include: On 7/1/26 at 10:40 AM, a record review related to Complaint #3047565 and Incident #3027259 was conducted. The events pertained to the same resident and incident. It was revealed that Resident #1 was admitted to the facility on [DATE]. The active order summary dated 7/1/26 listed diagnoses including, but not limited to: depression, adjustment disorder with depressed mood, muscle weakness, chronic deep vein thrombosis/pulmonary embolism history, and multiple musculoskeletal conditions. The active orders included a neurology consult for evaluation for dementia dated 6/3/26, after the alleged incident that occurred on 5/28/26. On 7/1/26 at 10:50 AM, the review of Resident #1's care plan revealed that Resident #1 had impaired cognitive function or impaired thought processes related to a Brief Interview for Mental Status (BIMS) score less than 13. The care plan included interventions to maintain the resident's routine, provide consistent caregivers as much as possible to minimize confusion, monitor/report changes in cognitive function, and support communication of basic needs. Review of the care plan also revealed Resident #1 had an Activities of Daily Living (ADL) self-care performance deficit related to impaired balance. The care plan documented that Resident #1 required two-person assistance for bed mobility and dressing, and a full mechanical lift transfer. On 06/03/26, after the alleged incident, the care plan was updated to include Resident prefers no male CNAs. On 7/1/26 at 11:00 AM, review of the care plan further revealed a psychosocial well being focus related to Alleged Staff to Resident Sexual Interaction (5/28/26), initiated 05/29/26. Interventions included allowing Resident #1 time to answer questions and verbalize feelings, perceptions, and fears; psych consult; and Resident prefers female caregiver only. On 7/1/26 at 11:05 AM, a review of the facility-reported (Incident #3027529) revealed the facility identified the allegation type as sexual. The report documented that on 5/28/26 at approximately 9:10 PM, Certified Nurse Aide (CNA) #1, reported to Licensed Practical Nurse (LPN) #1 that Resident #1 stated they were inappropriate while providing ADL care. The report documented that the administrator was notified at 9:31 PM, and the incident was submitted to the Office of Health Care Quality on 5/28/26 at 10:35 PM. The initial report documented no serious bodily injury, no injury noted at that time, and no changes observed from Resident #1's baseline. The report documented that the assigned CNA was immediately placed on administrative leave and that notifications to MD/NP, resident representative, police, and ombudsman, as well as resident and staff interviews, were pending at the time of the initial report. On 7/1/26 at 11:15 AM, a review of the facility's follow-up investigation report revealed the facility concluded the allegation of sexual abuse was unsubstantiated. The facility documented that Resident #1 had a BIMS score of 6 and was care planned for impaired cognition. The facility's conclusion stated Resident #1 told LPN #1 that CNA#1 was inappropriate while care was being provided and that, due to how care was provided, they thought they were being raped. The report also stated that during the police interview, Resident #1 reportedly stated they did not report any allegations to anyone. On 7/1/26 at 11:25 AM, the follow-up report documented that Resident #1's Primary Care Provider (PCP) (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessed Resident #1 on 5/29/26. The report stated Resident #1 reported they were sleeping, woke up, and someone was playing with their private area. The report stated the PCP did not identify trauma, bruising, redness, pain, or evidence of insertion. The report also documented the psych NP noted baseline forgetfulness/cognitive impairment, and that Resident #1 did not have a confirmed diagnosis of dementia, with the facility to follow up with neurology. On 7/1/26 at 11:30 AM, a review of CNA #1's written statement revealed CNA #1 documented that they entered Resident #1's room to change Resident #1, and during care, Resident #1 stated CNA #1 touched them inappropriately. Staff #1 documented that they immediately stopped care and reported to the nurse.On 7/1/26 at 11:33 AM, the review of LPN #1's handwritten statement revealed CNA #1 came to the nursing station and reported Resident #1 accused them of something while they were changing Resident #1. LPN #1 documented that CNA #1 refused to state what Resident #1 had accused them of. LPN #1 documented that they and CNA #2 went to Resident #1's room, and Resident #1 stated CNA#1 tried to rape them. LPN #1 documented that they instructed CNA #1 not to return to Resident #1's room and that CNA #2 completed Resident #1's care.Review of CNA #2's written statement revealed CNA #2 was asked to come into Resident #1's room after a situation occurred. CNA #2 documented that Resident #1 was very uncomfortable with CNA #1 changing them, and CNA #2 completed Resident #1's care after LPN #1 directed CNA #1 to leave the room.On 7/1/26 at 11:40 AM, a review of the Situation, Background, Assessment and Recommendation (SBAR) Communication Form dated 5/28/26 at 10:08 PM and completed by LPN #2 revealed that Resident #1 initially alleged CNA #1 touched them inappropriately while providing perineal care following an incontinence episode. Resident #1 was lying on their bed at the time. Resident #1 alleged that she felt like CNA #1 was trying to rape her. The SBAR is concluded with a statement from LPN #2 that Resident #1 reportedly denied that CNA #1 got in bed or on top of them and denied that CNA #1 exposed themself or disrobed. The SBAR documented no visible injuries, Resident #1 denied pain, the physician was notified, and police reportedly interviewed Resident #1, who reportedly stated they did not make complaints or allegations. The investigation file contains officer contact information, badge number, and police report number, but no evidence of the report obtained by Baltimore County Police. On 7/1/26 at 11:45 AM, a review of staff abuse questionnaires dated 6/2/26 revealed staff were asked whether they saw a staff member touch Resident #1 inappropriately while care was being provided in Resident #1's room, and whether Resident #1 reported to them that a staff member touched her inappropriately while care was being provided. Multiple staff answered No. However, the investigation did not document whether those staff were present in Resident #1's room during the care interaction or whether their responses were based on direct observation of the care provided by CNA #1.One staff questionnaire documented that Resident #1 reported they felt uncomfortable and that the concern was reported to Certified Medication Aide (CMA) #1. CMA #1's questionnaire documented that Resident #1 informed CMA #1 and other unit staff regarding the incident and accused CNA #1 of rape. CMA #1 provided a written statement (Complaint #3047465) regarding the incident on 5/28/26 detailing observing CNA #1 approaching the nursing station at approximately 9:02 PM after exiting Resident #1's room. CMA #1 explains that CNA #1 stated Resident #1 was accusing them of rape. CMA #1 explained that they assessed Resident #1, and the resident stated CNA #1 got on top of them, told them to be quiet, and tried to insert their penis. Resident #1 stated CNA #1 jumped off of them after they yelled for them to stop. CNA #1 jumped off the right side of the bed and pulled up his pants, according to Resident #1's statement provided to CMA #1. On 7/1/26 at 11:50 AM, the surveyor entered the unit. The unit staffing assignment listed CNA #1 as working on the unit, and the surveyor observed Staff #1 on the floor. Review of the assignment revealed CNA #1 was not assigned to Resident #1. Resident #1 was observed at 11:52 AM participating in a movie activity in the dining/day room area. On 7/1/26 at 11:55 AM, the surveyor interviewed Resident #1. Resident #1 appeared to have baseline confusion. However, Resident #1 provided an account that was generally consistent with the complaint statement and CMA #1's written statement. Resident #1 stated CNA #1 was inappropriately touching (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	them, was on top of them, and attempted to insert his penis. Resident #1 stated that when they yelled for CNA #1 to stop and get off of them, CNA #1 jumped off the bed, pulled their pants up, and rushed out of the room. Resident #1 stated they still saw CNA #1 on the unit. Resident #1 also stated they felt safe in the facility and that staff who provided their care treated them with dignity and respect.On 7/1/26 at 1:50 PM, during an interview with the Nursing Home Administrator (NHA) stated the facility relied on CNA #1's self-report, LPN #2's assessment note, staff statements, the police interaction, lack of physical findings, Resident #1's BIMS score, and Resident #1's inconsistent statements to conclude the allegation was unsubstantiated. The NHA stated CNA #1 reported the incident themself and stated Resident #1 was uncomfortable with them providing care. The NHA stated that staff statements included in the investigation file were handwritten and obtained independently.On 7/1/26 at 2:02 PM, the NHA also expressed concern that CMA #1 was a disgruntled employee with a history of progressive disciplinary issues. The NHA expressed concern that CMA #1 did not immediately provide the written statement in accordance with the facility's abuse reporting protocol, but instead left it under the NHA's door. The NHA also stated concern that Resident #1 may have been coached and that the language used by Resident #1 was uncharacteristic of Resident #1's baseline. The facility did not provide evidence that coaching was confirmed or that it investigated and resolved the concern before concluding the allegation was unsubstantiated.On 7/1/26 at 2:37 PM, upon further review of the facility's investigation file, there were materially different accounts of the allegation. These included:Resident #1 accused CNA #1 of inappropriate touching during care.Resident #1 reportedly stated CNA #1 tried to rape them.Resident #1 reportedly stated they woke up to someone playing with their private area.Resident #1 later reportedly denied to police making any complaints or allegations.Resident #1 reportedly denied that CNA #1 got in bed/on top of them or exposed/disrobed themself.Resident #1 told the surveyor on 7/1/26 during an interview at 11:53 AM that CNA #1 was on top of them, touched them inappropriately, attempted to insert their penis, pulled up their pants, and left when they yelled for them to stop.Although the facility identified reasons to question Resident #1's allegation, including cognitive impairment, inconsistent statements, lack of visible injury, and staff questionnaires, the facility did not provide evidence that it reconciled these materially conflicting accounts before concluding the allegation was unsubstantiated.On 7/1/26 at 3:10 PM, the review of the investigation revealed that the facility's conclusion appeared to rely on the least serious version of the allegation that Resident #1 was uncomfortable with the way CNA #1 provided care without documented analysis explaining why more serious accounts in the investigation file were discounted.The facility was not required to substantiate the allegation solely because Resident #1 made a report. However, the facility was required to provide evidence that the allegation had been thoroughly investigated. The investigation file contained materially conflicting evidence regarding the nature of the allegation. The facility did not provide documented evidence showing how it reconciled Resident #1's allegation, CNA #1's self-report, LPN #1's statement, LPN #2's assessment note, CNA #2's statement, provider documentation, police-related documentation, staff questionnaires, Resident #1's cognitive impairment, and Resident #1's later statement to the surveyor before concluding the allegation was unsubstantiated. Therefore, the facility failed to have evidence of a thorough investigation of the allegation.