

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215299	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/03/2025
NAME OF PROVIDER OR SUPPLIER  Westgate Hills Rehab & Healthcare Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>44440</p> <p>Based on record review, and interviews, it was determined that the facility failed to accurately document assessments in a Resident's medical record. This was found evident of 2 (Resident #31 &amp; #113) of 38 residents reviewed during the survey.</p> <p>The findings include:</p> <p>1a) On 3/26/25 at 10:21 AM, the surveyor reviewed Resident # 31's record. The review revealed that a Minimum Data Set (MDS) assessment was completed on 2/19/25 and in section M, skin, it was documented Resident # 31 had one stage 3 pressure ulcer.</p> <p>On 3/28/25 at 1:52 PM, the surveyor reviewed a note written by Wound Nurse (WN) #18 on 2/12/25. The note stated that Resident #31 was readmitted to the facility and on assessment was noted to have a right buttocks sacral wound at a stage 3 and a left hip wound noted at a stage 2.</p> <p>On 3/28/25 at 2:04 PM, the surveyor interviewed Minimum Data Set, Staff # 17. During the interview the surveyor showed Staff #17 the documentation from WN #8 that documented two pressure wounds and asked why only one stage 3 wound was documented on the 2/19/25 MDS assessment. Staff #17 stated that documentation was done in error and would be corrected.</p> <p>1b) On 3/26/25 at 1 PM, the surveyor reviewed Resident #113's medical record. The review revealed that a Minimum Data Set (MDS) discharge assessment, completed on 1/4/25, indicated, in section A, that Resident #113 was sent to a short-term general hospital.</p> <p>On further review the surveyor noted a discharge summary that stated Resident #113 was stable for discharge home and went home with spouse.</p> <p>On 3/27/25 at 1:40 PM, the surveyor conducted an interview with the Cooperate Minimum Data Set (MDS) Staff #9. During the interview Staff #9 stated that Resident #113 was discharged home and that indicating the discharge to the hospital was done in error.</p>

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:  215299	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/03/2025
NAME OF PROVIDER OR SUPPLIER  Westgate Hills Rehab & Healthcare Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45733</p> <p>Based on interview and record review, it was determined that the facility failed to inform residents of a summary of the resident's initial Baseline Care Plan (BCP) within 48 hours of the admission nor to provide a copy of initial instructions for effective and person-centered care. This was found to be evident for 1 (Resident #217) out of 3 residents for new admissions reviewed.</p> <p>The findings include:</p> <p>The Baseline Care Plan (BCP) must be developed and implemented within 48 hours of admission and needs to include the necessary healthcare information to properly care for the resident immediately upon admission to reduce the likelihood of a negative outcome shortly after admission and to provide immediate residents' needs.</p> <p>Interview, on 03/25/25 at 10:36 AM, Resident #217 stated that there was no initial care information shared which he/she was concerned about the diet and swallowing plan of care.</p> <p>Record Review, on 03/26/25 at 12:01 PM, revealed that this resident was hospitalized this March 2025 for acute subdural hematoma and was admitted to the facility on [DATE]. Further record review found that the care plan was entered, however, no medical record contained evidence that the BCP summary was shared or given to the resident.</p> <p>During an interview, on 3/26/25 at 12:19 PM, Social Worker Director Staff #6 revealed that the assigned Social Worker Staff # 21 was a new hire, the only note from her was on 3/25/25 regarding the discharge planning with Resident #217. Staff #6 admitted that BCP was not presented to this resident as a facility's deficiency practice. Further meeting with the Director of Nursing and sharing the above findings, she expected that the facility staff would need to have BCP shared within 48 hours of the admission and a copy given to the new residents.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215299	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/03/2025
NAME OF PROVIDER OR SUPPLIER  Westgate Hills Rehab & Healthcare Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44440</b></p> <p>Based on record review and interviews it was determined that the facility failed to develop a comprehensive person-centered care plan. This was found evident of 2 (Resident #101 &amp; #99) out of 16 residents reviewed for falls.</p> <p>The findings include:</p> <p>A.) On 3/26/25 at 7:33 AM, the surveyor reviewed Resident # 101's medical record. The review revealed that Resident #101 had incomplete, non resident centered care plans initiated. The surveyor noted that 5 care plans were written but did not specify why Resident # 101 needed the care plan. These care plans were written as follows:</p> <ol style="list-style-type: none"> <li>1. I have oral/dental health problems r/t (related to), initiated on 9/26/24.</li> <li>2. I use anti-psychotic medication r/t (related to), initiated on 3/7/24.</li> <li>3. I use anti-depressant medication r/t (related to), initiated on 3/16/25.</li> <li>4. At risk for respiratory complications r/t (related to), initiated on 3/17/25.</li> <li>5. Resident has an automatic implanted cardiac defibrillator (AICD) r/t (related to), initiated on 3/17/25.</li> </ol> <p>On 3/27/25 at 1:09 PM, the surveyor conducted an interview with the Director of Nursing (DON). During the interview the DON stated that care plans are initiated on admission and updated and reviewed by the Unit Manager as needed. The surveyor showed the DON the care plans for Resident #101. The DON agreed that the care plans were incomplete and not resident centered.</p> <p>51786</p> <p>B.) On 3/24/25 at 12:09 PM, Resident #99 was interviewed. They stated that they fell in September 2024.</p> <p>On 3/31/25 at 10:15 AM, a review of Resident #99 's medical records was conducted. The review revealed that the resident fell on [DATE] while using a sliding board. However, the resident ' s care plan for transfer was developed on 9/26/2024 to indicate that the resident required 1 staff assist for transfers, using a sliding board.</p> <p>On 4/01/25 at 8:47 AM, an interview with the Director of Rehabilitation (Staff #24) was conducted. They confirmed that Resident #99 was deemed safe to use a sliding board on 8/8/24 indendently with supervision. They also stated that they would expect the care plan to be developed before 9/25/24. Staff #24 stated a re-evaluation of the resident was conducted on 9/26/24 stating that the resident required 1 staff assist for transfers, using a sliding board.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215299	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/03/2025
NAME OF PROVIDER OR SUPPLIER  Westgate Hills Rehab & Healthcare Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/01/25 at 10:14 AM, an interview with the Unit Manager (Staff #15) was conducted. They reported that Resident #99 ' s care plan should have been developed before 9/25/24.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215299	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/03/2025
NAME OF PROVIDER OR SUPPLIER  Westgate Hills Rehab & Healthcare Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>44440</p> <p>Based on record review, and interview it was determined that the facility failed to conduct care plan meetings after each resident assessment and failed to invite a resident to participate in their care plan meeting. This was found evident in 2 (Residents #50 &amp; #217) out of 4 Residents reviewed for care planning.</p> <p>The findings include:</p> <p>On 3/24/25 at 11:20 AM, the surveyor conducted an interview with Resident #50. During the interview Resident #50 stated that he/she had not been invited to participate in a care plan meeting in quite some time.</p> <p>On 3/24/25 at 12:27 PM, the surveyor conducted an interview with the Director of Social Services (SW) #6. During the interview the surveyor asked SW #6 if Resident #50 was invited to participate in care plan meetings. SW #6 stated that she usually reaches out the Resident #50's guardian for care plan meetings. The surveyor asked if there was any rationale that the resident was not invited as well as the guardian. SW #6 stated she would review the records and follow-up.</p> <p>Next the surveyor reviewed Resident #50's Minimum Data Set (MDS) assessment dates. It was noted that Resident # 50 had a MDS assessment on 12/10/24 and 3/10/25. The surveyor requested attendance logs for care plan meetings that should follow the assessments.</p> <p>On 3/27/25 at 7:45 AM, the surveyor reviewed a sign in sheets from care plans held on July 23rd of 2024 and September 24th of 2025. The resident's guardian was noted present via telephone, however Resident #50 was not present and there was no rationale written as to why on the attendance record. No attendance records were given for care plans held after the 12/10/24 and 3/10/25 MDS assessments.</p> <p>On 3/27/25 at 1:44 PM, the surveyor conducted a follow-up interview with SW #6. During the interview the SW#6 stated she was unable to find documentation as to why the resident was not invited. She further stated that no care plan meetings were conducted following the 12/10/24 and 3/10/25 MDS assessments and that she had a plan going forward to get caught up on care plan meetings. After the interview SW#6 confirmed that a care plan meeting was set up for Resident #50 and that both the resident and his/her guardian were both invited to attend.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215299	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/03/2025
NAME OF PROVIDER OR SUPPLIER  Westgate Hills Rehab & Healthcare Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide activities to meet all resident's needs.</p> <p>45733</p> <p>Based on observation, medical record review and interview, it was determined that the facility failed to provide meaningful on-going personalized activities for the residents who were confined in their rooms. This was evident for 1 (Resident #104) out of 5 residents reviewed for personalized activities.</p> <p>The findings include:</p> <p>Observation, on 03/24/25 at 11:18 AM, 03/25/25 at 09:06 AM and 03/26/25 at 2:36 PM (over 30 minutes for each observation) found that Resident#104 was lying flat in bed, kept staring at the walls and kept falling asleep. No activity staff were in the room or nearby.</p> <p>Record Review, on 03/24/25 at 1:12 PM, found that Resident #104 was admitted to this facility on 12/11/24, with diagnoses of a new cerebral infarction due to thrombosis resulting in a new tracheostomy and feeding tube, past medical history: diabetes mellitus and depression.</p> <p>Interview, on 03/27/25 at 11:06 AM, Activity Director Staff # 20 revealed that for the population like Resident #104's who cannot participate in group/social activities that activity staff visited in their rooms often.</p> <p>Record review, on 03/27/23 at 12:31 PM, Resident #104's care plan indicated that based on Resident #104's new low cognitive baseline after the cerebral infarction and several chronic disease processes, the resident needed more personalized activity. Review activity staff's documentation from the month of February to March 2025 revealed that only had 3 one-to-one visits in total on: 2/18 &amp; 2/25 in February and 03/04 in March 2025.</p> <p>A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care.</p> <p>During the interview, on 3/31/25 at 10:22 AM, Activity Director Staff #20 stated that if residents could not participate in group/social activities, then one-to-one meaningful on-going personalized activities were offered frequently. After sharing above 3 visits in 2 months findings, she admitted that there were lacking meaningful one-to-one activities to this confined to his/her room's resident. Further, the Director of Nursing was made aware that this resident lacked providing one-to-one meaningful on-going personalized activities to support this residents' needs as a deficit practice.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215299	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/03/2025
NAME OF PROVIDER OR SUPPLIER  Westgate Hills Rehab & Healthcare Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assist a resident in gaining access to vision and hearing services.</p> <p>51786</p> <p>Based on interviews and record review, it was determined that the facility failed to provide services to maintain a resident's vision. This was evident for 1 (Resident #66) out of 11 residents reviewed for vision during the annual recertification survey.</p> <p>The findings include:</p> <p>On 3/24/25 at 11:48 AM, Resident #66 was interviewed. They stated that their vision had decreased since their admission to the facility.</p> <p>On 3/28/25 at 10:28 AM, a review of Resident #66's medical records was conducted. The review revealed a progress note dated 2/20/25 with instructions for the resident to follow up with an eye specialist on 3/20/25 at 8:35 AM. Further review of the record failed to show that Resident #66 went for their follow-up eye appointment.</p> <p>On 3/31/25 at 2:03 PM, an interview with the Administrator was conducted. The Administrator acknowledged that there was no documentation that Resident #66 went for their follow-up eye appointment scheduled for 3/20/25.</p> <p>On 3/31/25 at 2:49 PM, an interview with the Director of Nursing (DON) was conducted. They reported that Medical Records was responsible for scheduling residents' follow-up appointments and transportation.</p> <p>On 3/31/25 at 2:59 PM, an interview with Medical Records (Staff #13) was conducted. They stated that they were unaware that Resident #66 had an eye appointment on 3/20/25 at 8:35 AM.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215299	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/03/2025
NAME OF PROVIDER OR SUPPLIER  Westgate Hills Rehab & Healthcare Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>44440</p> <p>Based on observation, record review, and interviews it was determined that the facility failed to provide treatment to prevent further decreased range of motion for a resident. This was found evident of 1 (Resident #27) out of 5 residents reviewed for mobility.</p> <p>The findings include:</p> <p>On 3/24/25 at 9:47 AM, the surveyor observed Resident #27 laying on his/her left side with both knees pulled up to the chest. On further observation Resident #27's fingers were contracted on both hands.</p> <p>On 3/28/25 at 7:26 AM, the surveyor reviewed Resident #27's medical record. The review revealed that Resident #27 had an order written on 11/26/24 for bilateral knee extension braces for 6 hours daily as tolerated, to decrease the risk of further knee flexion contracture. Additionally, an order written on 7/30/24 was written for Resident #27 to wear resting hand splints on right and left hands after hand hygiene was performed and for no longer than 2 hours at a time.</p> <p>Next the surveyor reviewed Resident #27's electronic medical record. Nowhere in the record was it recorded that the splints were applied as ordered.</p> <p>On 3/31/25 at 9:30 AM, the surveyor observed Resident #27 again turn on his/her left side with bilateral knees noted to the chest. Again no splints or braces were on.</p> <p>On 3/31/25 at 2:01 PM, the surveyor conducted an interview with the Director of Nursing (DON). During the interview the DON confirmed that braces and splints should be documented when applied. The surveyor reviewed the concern that Resident #27 had not been observed with splints applied and there was no documentation in the medical record to record they were applied as ordered.</p> <p>On 4/1/25 at 2:17 PM, the surveyor conducted a follow-up interview with the DON. During the interview the DON stated that Resident #27 did have an order for splints, however the orders were never transferred to the Treatment Administration Record (TAR) and so there was no documentation to support that the splints were utilized as ordered.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215299	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/03/2025
NAME OF PROVIDER OR SUPPLIER  Westgate Hills Rehab & Healthcare Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>44440</p> <p>Based on observations, interviews with staff, and record review, it was determined that the facility failed to implement an intervention, determined to be necessary, for a resident who was identified as a fall risk. This was evident of 1 (Resident #101) of 5 Residents reviewed for accidents during the annual survey.</p> <p>The findings include:</p> <p>On 3/25/25 at 8:43 AM, the surveyor conducted a telephone interview with Resident #101's spouse. During the interview the spouse stated that Resident #101 had fallen out of bed several times. Resident #101's spouse further stated at one point his/her spouse had a special mattress to help keep him/her in bed. However, after a room change Resident #101 no longer had that mattress.</p> <p>On 3/26/25 at 7:33 AM, the surveyor reviewed Resident #101's medical record. The review revealed that on 3/12/25 Resident #101 moved to his/her current room.</p> <p>On further review the surveyor noted that Resident #101 had an actual fall care plan that stated Resident #101 was at risk for falls related to involuntary movement of both lower extremities and Resident #101 was unaware of his/her own boundaries. This care plan was initiated on 2/8/25. One of the interventions listed was for Resident #101 to have a perimeter mattress for spatial awareness and border definition.</p> <p>On 3/27/25 at 10:56 AM, the surveyor observed Resident #101 in bed, low to the ground, with fall mats on the floor next to the bed. However, no border mattress was noted.</p> <p>On 3/27/25 at 10:59 AM, the surveyor interviewed Unit Manager UM #7. During the interview the nurse confirmed that Resident #101 had the perimeter mattress when he/she was located in a different room but was not sure why the mattress did not transfer with the resident when the room was changed.</p> <p>On 3/27/25 at 11:07 AM, the surveyor asked the Director of Nursing (DON) if Resident #101 was in the perimeter mattress that he/she was care planned to be in. The surveyor and DON observed Resident #101's mattress. The DON confirmed that Resident #101 was not in a perimeter mattress. She further stated she would look into the reason why Resident #101 was not provided with a perimeter mattress.</p> <p>On 3/28/25 at PM the surveyor reviewed Resident 101's falls. On 3/19/25 and 3/24/25 Resident #101 was documented as having a fall from bed. On both of these occasions Resident #101 was in his/her new room in which the perimeter mattress was not provided. The DON was made aware of the concerns that Resident #101 fell from the bed on two occasions, both in which not all of the interventions that were identified in the resident's care plan were provided.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215299	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/03/2025
NAME OF PROVIDER OR SUPPLIER  Westgate Hills Rehab & Healthcare Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0711</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit.</p> <p>44440</p> <p>Based on record review and interviews it was determined that the facility failed to have the medical provider thoroughly review and accurately prescribe medications after a resident's readmission. This was found evident of 1 (Resident #68) out of 2 residents reviewed for pain.</p> <p>The findings include:</p> <p>On 3/25/25 at 11:16 AM, the surveyor conducted an interview with Resident #68. During the interview the resident stated that he/she had been in and out of the hospital and had a lot of neuropathical pain.</p> <p>On 3/28/25 at 7:38 AM, the surveyor reviewed Resident #68's Medication Administration Records (MARs). The review revealed that Resident #68 had an order for gabapentin to be given at bedtime for neuropathic pain and to start on 12/30/24 however, the medications was discontinued on 1/28/25.</p> <p>On further review it was noted that Resident #68's was readmitted to the facility from a hospital stay on 1/28/25. This was the same day the gabapentin was discontinued.</p> <p>Next the surveyor reviewed the hospital discharge paperwork. The discharge recommendations lists Resident #68's diagnoses and for Neuropathic pain it states, to continue gabapentin, however when it lists medications that are new, discontinued or to be continued gabapentin is not listed in any of the three categories.</p> <p>On 3/28/25 at 11:12 AM, the surveyor reviewed Nurse Practitioner (NP) #10's re-admission progress note dated 1/28/25. In the note NP #10 wrote to continue gabapentin for neuropathic pain. However, NP #10 wrote a progress note on 1/30/25 that had no mention of gabapentin or the rationale for discontinuing the medication.</p> <p>On 3/28/25 at 2:26 PM, the surveyor conducted an interview with NP #10. During the interview NP #10 could not recall the rationale for discontinuing the gabapentin. She further stated that the resident never stated that he/she was in pain on assessment nor was there any communication that his pain was not controlled but she would assess the resident.</p> <p>On 3/31/25 at 10:34 AM, the surveyor conducted a follow-up interview. During the interview NP #10 stated she believed gabapentin order was missed. She further stated that after speaking with Resident #68 she had reordered the gabapentin.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215299	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/03/2025
NAME OF PROVIDER OR SUPPLIER  Westgate Hills Rehab & Healthcare Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>51786</p> <p>Based on medical record review and interviews, it was determined that the facility failed to provide medication as ordered. This was evident for 1 (Resident #74) out of 5 residents reviewed for change in condition during the annual recertification survey.</p> <p>The findings include:</p> <p>SBAR (Situation, Background, Assessment, and Recommendation) is a structured communication tool used to facilitate clear and concise information sharing, especially in healthcare, to improve communication and patient safety.</p> <p>Furosemide is a diuretic medication also known as a water pill. It is used to treat fluid retention caused by congestive heart failure.</p> <p>On 3/25/25 at 11:58 AM, a review of Resident #74's medical records was conducted. The review revealed an SBAR note for Shortness of breath dated 3/18/25. The provider's recommendation to nursing staff was to administer 40mg of furosemide in addition to the prescribed medication.</p> <p>Further review of the resident's medication administration record failed to show that Resident #74 received an additional 40 mg of furosemide.</p> <p>On 3/31/25 at 10:01 AM, the surveyor requested documentation to show that Resident #74 received an additional 40 mg of furosemide or a rationale for why the medication was not administered.</p> <p>On 3/31/25 at 2:01 PM, an interview with the Administrator was conducted. They stated that the facility was unable to provide any documentation that the medication was provided to Resident #74.</p> <p>On 4/01/25 at 11:49 AM, a brief interview with the Director of Nursing (DON) was conducted. Per DON, the facility did not have evidence that Resident #74 was given the medication. They further stated that the nurse who received the provider's recommendation did not follow the expected facility's practice of documenting administered medications.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215299	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/03/2025
NAME OF PROVIDER OR SUPPLIER  Westgate Hills Rehab & Healthcare Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>44440</p> <p>Based on record review and interviews it was determined that the facility failed to have a process in place that ensured a resident's medication irregularity reports were reviewed by the primary care physician and the actions taken based on the recommendations were being documented. This was found evident of 1 (Resident #50) of 5 residents reviewed for medication regimen review</p> <p>The findings include:</p> <p>Medication Regimen Review (MRR) or Drug Regimen Review is a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication. The MRR includes review of the medical record in order to prevent, identify, report, and resolve medication-related problems, medication errors, or other irregularities. The MRR also involves collaborating with other members of the Inter Disciplinary Team (IDT), including the resident, their family, and/or resident representative.</p> <p>On 3/26/25 at 9:43 AM, the surveyor reviewed Resident #50's medical record. The review revealed that on 8/30/24, 12/28/24 and 1/26/25 a Pharmacist completed a MRR and wrote, see report for comment. No reports were found in Resident #50's electronic medical record. The surveyor requested the reports from the Director of Nursing (DON).</p> <p>On 3/31/25 at 10:44 AM, the surveyor interviewed Nurse Practitioner (NP) #10. During the interview the surveyor asked NP #10 about the process for reviewing irregularity reports generated by the Pharmacist. NP #10 stated that the DON or nurse responsible prints the reports and gives them to her to review. She further stated she reviews the reports, documents her decision, and signs the report after review. The report is then returned to the DON or nurse and the orders are implemented if indicated on the report. NP #10 stated she was unaware of what happens to the reports when she returns them to the DON or nurse.</p> <p>On 3/31/25 at 1:48 PM, the surveyor conducted an interview with the DON. During the interview the DON confirmed that NP #10 explained the process correctly. She also confirmed that she had to get Resident #50's pharmacy reports from the Pharmacist and that the report and response to the reports were not part of Resident #50's medical record.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215299	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/03/2025
NAME OF PROVIDER OR SUPPLIER  Westgate Hills Rehab & Healthcare Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44440</b></p> <p>Based on observations and interviews with staff, it was determined that the facility failed to store medication in a locked compartment. This was found evident on 1 random observation on the second floor.</p> <p>The findings include:</p> <p>On 3/27/25 at 10:43 AM, the surveyor observed an unlocked medication cart in the hallway between room [ROOM NUMBER] and 207.</p> <p>On 3/27/25 at 10:46 AM, the surveyor walked to the cart and was able to open the top drawer and observed multiple medications and supplies. On further inspection the 7 other drawers with medications are also able to be opened. While at the medication cart, the surveyor observed Staff #23 walked by and the surveyor asked Staff #23 who was responsible for the medication cart. Staff #23 stated Nurse #8 was responsible and that she would find her.</p> <p>On 3/27/25 at 10:47 AM, the surveyor interviewed Nurse #8. During the interview Nurse #8 confirmed that she was responsible for the medication cart and that it should not be left open. Nurse #8 further stated that she was working with two medication carts because the Certified Medication Aide (CMA) had called out sick and the assignment was readjusted. She stated she must have left that one open by accident.</p> <p>On 3/27/25 at 11:13 AM, the Director of Nursing (DON) was made aware of the observation. The DON stated that the medication carts should be locked and that she would provide staff with education.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215299	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/03/2025
NAME OF PROVIDER OR SUPPLIER  Westgate Hills Rehab & Healthcare Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44440</b></p> <p>Based on observations and interviews it was determined that the facility staff failed to properly store food in accordance with professional standards for food service and safety. This was found evident in 1 of 3 kitchen observations and 1 out of 2 unit storage refrigerators during the survey. This has the potential to affect all residents.</p> <p>The findings include:</p> <p>On [DATE] at 8:15 AM, the surveyor made an initial tour of the kitchen. The observation of the kitchen refrigerator revealed two containers that were labeled cottage cheese. The first one was labeled with a received on date of [DATE] and a sell by date of [DATE]. The second container had a received on date of [DATE] and a sell by date of [DATE] date. Also noted was a small block of lunch meat. There was no label that identified the product however, the item had a label that stated, opened on [DATE] and use by [DATE]. Next to the lunch meat there was a package of hot dogs. The package was not secured closed and allowed the product to be open to air.</p> <p>On [DATE] at 8:28 AM, the surveyor observed the freezer. During the observation a water bottle was noted on the shelf with a dark liquid substance in it. The contents were not frozen, indicating it was recently placed into the freezer. No label was noted on the bottle. On further observation a cut of meat was noted in a pan with cellophane covering the meat. However, the cellophane was not air tight and the meat appeared to have freezer burn.</p> <p>On [DATE] at 8:31 AM, the surveyor observed the dry storage area. The surveyor noted that a package of ziti and a package of long pasta were opened but no label was present to determine when the package was opened and when the product needed to be used by.</p> <p>On [DATE] at 8:41 AM, the surveyor interviewed the Certified Dietary Manager (CDM) #4. During the interview the surveyor reviewed the observations with CDM #4. She stated that she would remove the cottage cheeses, deli meat and hot dogs. She further stated she would remove the personal water bottle stored in the freezer along with the meat that appeared to be freezer burned. Additionally, the CDM stated that she would remove the improper dry storage item.</p> <p>On [DATE] at 6:29 AM, the surveyor observed the 2nd floor nourishment food refrigerator with Staff #22. Staff #22 stated that staff are the only ones with access to the refrigerator and it was locked with a key entrance. Upon opening the refrigerator, the surveyor noted two plastic bags tied up. One bag had been labeled with a Resident room number on it. In the bag was deli meats that had not yet expired however, the 2nd bag had no label as to who it belonged to or a date that the bag was placed into the refrigerator. Staff #22 confirmed that the bag should have been labeled and would speak to the day shift staff to find out why the bag was not labeled or dated and to find out how long it had been in the refrigerator.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215299	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/03/2025
NAME OF PROVIDER OR SUPPLIER  Westgate Hills Rehab & Healthcare Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Dispose of garbage and refuse properly.</p> <p>44440</p> <p>Based on observation and interviews, it was determined that the facility failed to maintain the outdoor garbage storage area in a manner to prevent the harboring pests.</p> <p>The findings include:</p> <p>On 3/24/25 at 8:54 AM, the surveyor made an observation of the outside dumpster that was utilized by the kitchen staff. The dumpster was located just outside the kitchen receiving doors. Noted along the back side of the dumpster was approximately 6 inches high of thick accumulated plastic bags, leaves, pine needles and plastic cups. This accumulation was located between the dumpster and the concrete wall behind the dumpster.</p> <p>On 3/24/25 at 8:56 AM, the surveyor conducted an interview with the Director of Maintenance Staff #5. During the interview Staff #5 stated that the accumulation should not be there and that he would have that area cleared.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215299	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/03/2025
NAME OF PROVIDER OR SUPPLIER  Westgate Hills Rehab & Healthcare Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51786</b></p> <p>Based on observations and staff interviews, it was determined that the facility failed to ensure that the residents' clean clothes were stored in a manner that minimized the potential spread of infection. This was evident during the infection control investigation task of the recertification survey.</p> <p>The findings include:</p> <p>On [DATE] at 1:44 PM, an observation of the facility's laundry room was conducted. There were 6 green bags observed in the dirty laundry room.</p> <p>On [DATE] at 1:45 PM, an interview with the Environmental Director (Staff #14) was conducted. When asked if the clothes in the bags were clean, they reported that the clothes were clean and belonged to residents who were either hospitalized or had expired.</p> <p>On [DATE] at 8:49 AM, the Director of Nursing (DON) was notified of the potential risk of accidental contamination in the laundry room.</p>