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	05/22/2026

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

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation and interview, the facility failed to ensure resident menu tickets were followed. This was evident for 1 of 1 kitchen tray line observation during an annual survey.The findings include:1) On 05/20/2026 at 11:46 AM, an observation revealed the kitchen lunch tray line started.On 05/20/2026 at 11:48 PM, an observation of the dessert prepared for the lunch tray line was brownies.During the lunch tray line, the surveyor observed the following residents had meal tickets that indicated cake with icing, but received a brownie on their lunch tray:Resident #16, #2, #78, #34, #11, #44, #26, #95, #42, #66, #93, #109, #53, #103, #90, #19, #36, #108, #68, #52, #51, #58, #121, #30, #97, #54, #61, #35, #92, #79, #50, #67, #7, #86, #37, #110, #80, #41, #96, and #33.On 05/20/2026 at 1:16 PM, an interview with the Food Services Director (Staff #18) revealed that they did not have enough cake to provide the residents based on the planned meal menu tickets so they served brownies. The surveyor reviewed the concern.2) On 05/20/2026 at 11:52 AM, the surveyor observed Resident #72's menu ticket which indicated, diet cookies, as the dessert. The surveyor observed a brownie be placed on the tray and sent to the unit for the resident to eat.3) On 05/20/2026 at 11:53 AM, the surveyor observed Resident #46's menu ticket which indicated, fresh fruit. Further observation failed to reveal fresh fruit was placed on the tray.4) On 05/20/2026 at 11:53 AM, the surveyor observed Resident #74's menu ticket which indicated, fresh fruit. Further observation failed to reveal fresh fruit was placed on the tray.5) On 05/20/2026 at 11:54 AM, the surveyor observed Resident #109's menu ticket which indicated, do not send sugar. Further observation revealed two packets of sugar on the tray.6) On 05/20/2026 at 12:00 PM, the surveyor observed Resident #103's menu ticket which indicated, does not like chicken thighs,. Further observation revealed chicken thighs (the planned lunch entree) were plated and placed on the residents tray.7) On 05/20/2026 at 12:06 PM, the surveyor observed Resident #51's menu ticket which indicated, banana, orange, and chocolate milk or chocolate milk shake. Further observation failed to reveal chocolate milk (which was present on the beverage cart at time of lunch tray observation) nor a chocolate shake, banana, or orange was placed on the residents tray.8) On 05/20/2026 at 12:11 PM, the surveyor observed Resident #61's menu ticket which indicated, no gravy. Further observation of the resident's plate revealed gravy was poured on top of the chicken thigh.9) On 05/20/2026 at 12:17 PM, the surveyor observed Resident #54's menu ticket which indicated, alternative entree. Further observation of the resident's plate revealed chicken thighs (the planned entree).10) On 05/20/2026 at 12:23 PM, the surveyor observed Resident #110's menu ticket which indicated, fruit cup. Further observation of the resident's plate failed to reveal a fruit cup was placed on the resident's tray.11) On 05/20/2026 at 12:25 PM, the surveyor observed Resident #96's menu ticket which indicated, banana, and ice water. Further observation of the resident's tray failed to reveal a banana or ice water was placed on the tray.12) On 05/20/2026 at 12:29 PM, the Food Services Director (Staff #18) indicated that they had run out of au gratin potatoes (the planned meal starch). On 05/20/2026 at 12:29 PM, the surveyor observed Staff #18 plate Resident #96's food. Further observation revealed the resident received regular mashed potatoes.13) On 05/20/2026 at 12:29 PM, the Food Services Director (Staff #18) indicated that they had run out of chicken thighs (the planned main entree). At the same time, (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
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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	observation of Resident #5's meal ticket revealed, chicken thighs. The surveyor observed veal plated as the main entree and placed on the resident's tray.On 05/20/2026 at 1:16 PM, an interview with the Food Services Director (Staff #18) revealed that the cook reviews the resident menu meal tickets and were expected to prepare special requests. She further indicated the expectation was to prepare the tray/plate as indicated on the resident meal menu ticket. The surveyor reviewed the concerns noted above.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, it was determined that the facility failed to have accurate and complete medical records. This was found to be evident for 1) 5 (#1, #7, #10, #63, and #85) of 10 residents reviewed for advanced directives, 2) 2 (Resident #42 and #74) out of 2 residents reviewed for smoking, 3) 1 (#25) out of 1 resident review for accurate medical diagnosis in the medical record, and 4) 1 (#88) resident reviewed for accurately documented treatment during the annual survey.The findings include: 1) On 05/18/2026 at 11:21 AM, review of Resident #1's medical record revealed a document titled, MQS: Social Services Assessment - V11, dated 1/9/2026 revealed under section A1. the resident did not have an advanced directive and under section A3. advanced directives had not been reviewed. Further review of the document and medical record failed to reveal indication that the resident was offered information to formulate an advanced directive. On 05/18/2026 at 11:31 AM, review of Resident #10's medical record revealed a document titled, MQS: Social Services Assessment - V11, dated 1/9/2026 revealed under section A1. the resident did not have an advanced directive and under section A3. advanced directives had not been reviewed. Further review of the document and medical record failed to reveal indication that the resident was offered information to formulate an advanced directive. On 05/18/2026 at 11:35 AM, review of Resident #85's medical record revealed a document titled, MQS: Social Services Assessment - V11, dated 1/9/2026 revealed under section A1. the resident did not have an advanced directive and under section A3. advanced directives had been reviewed. Further review of the document and medical record failed to reveal indication that the resident was offered information to formulate an advanced directive. On 05/18/2026 at 11:38 AM, review of Resident #7's medical record revealed a document titled, MQS: Social Services Assessment - V11, dated 1/9/2026 revealed under section A1. the resident did not have an advanced directive and under section A3. advanced directives had been reviewed. Further review of the document and medical record failed to reveal indication that the resident was offered information to formulate an advanced directive. On 05/18/2026 at 11:50 AM, review of Resident #63's medical record revealed a document titled, MQS: Social Services Assessment - V11, dated 1/9/2026 revealed under section A1. the resident did not have an advanced directive and under section A3. advanced directives had been reviewed. Further review of the document and medical record failed to reveal indication that the resident was offered information to formulate an advanced directive. On 05/19/2026 at 7:19 AM, an interview with the Director of Social Services (Staff #5) revealed that when residents were admitted and/or readmitted , the facility would ask them if they had an advanced directive. She further indicated that if a resident did not have an advanced directive they would offer them information to formulate one. During the same interview, when asked if it was documented when they offered a resident information to formulate one she said it could be in a progress note. The surveyor asked for Staff #5 to bring any further documentation for the residents noted above that would indicate information was offered to formulate an advanced directive once they noted they did not have one. On 05/20/2026 at 9:40 AM, (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the surveyor reviewed the concern with the Acting Director of Nursing and she indicated that she understood. 2) On 05/19/26 at 12:13 PM, the surveyor performed a record review. Resident #42's and #74's care plans had conflicting interventions regarding smoking. One intervention stated Resident #42 and #74 are able to smoke independently, follow facility policy, and store all smoking materials in their room. The second intervention stated the facility would store Resident #42 and 74's nicotine products and supplies. On 05/19/26 at 12:25 PM, the surveyor reviewed Resident #74's Medication Administration Record (MAR). Resident #74 had two active orders that were conflicting but were being signed by day and night shifts: - Change Oxygen Tubing, Humidifier, and clean filter weekly on Tuesday and as needed for soiling or damage. Every night shift (every Tuesday). Date and label tubing and humidifier bottle. Start date: 07/22/2025 2300 - Change Oxygen Tubing, Humidifier, and clean filter weekly on Wednesday and as needed for soiling or damage. Every day shift (every Tuesday). Date and label tubing and humidifier Bottle. Start Date: 06/11/2024 0700 On 05/20/26 at 9:50 AM, LPN #11 was interviewed. The surveyor inquired about Resident #74's MAR and how staff determined which oxygen tubing order to follow. LPN #11 stated that the day shift order was correct but staff still signed both orders. LPN #11 could not provide an explanation for how he/she determined this. On 05/20/26 at 10:12 AM, the Director of Nursing acknowledged the concern. 3) A record review on 05/19/2026 at 12:19 PM, did not contain a medical diagnosis for Resident #25 related to Glaucoma. The resident's care plan referred to a glaucoma diagnosis and a medication order referred to a glaucoma diagnosis. On 05/19/2026 at 1:19 PM the Director of Nursing (DON) was asked to provide information of when Resident #25's glaucoma diagnosis was made and why it wasn't documented under medical diagnoses. On 05/20/2026 at 9:23 AM, the DON acknowledged the concern that Resident #25 had no active diagnosis for glaucoma on the record. The DON explained that although Resident #25 has physician notes on the chart that referred to the glaucoma diagnosis, it had not been updated in the record. 4) On 05/18/2026 at 7:28 AM, the surveyor observed Resident #88 lying in bed with lower extremities exposed. The surveyor observed the resident's skin appeared rough, cracked, and flaky. A review of the resident's medication administration record (MAR) on 05/18/2026 at 12:11 PM, revealed a physician's order instructing staff to apply Aquaphor ointment to both upper and lower extremities twice daily. Further review indicated that a staff member documented administration of the Aquaphor ointment during the 10:00AM administration time. A follow up observation of Resident #88 was conducted on 05/18/2026 at 2:18 PM, and again on (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	05/19/2026 at 7:14 AM. During each observation, the surveyor observed the resident in bed with the extremities exposed. The resident skin continued to appear rough, cracked, and flaky. A review of the residents' MAR on 05/19/2026 at 2:19 PM revealed the Licensed Practical Nurse (LPN) #27 documented applying Aquaphor ointment during the 10:00 AM administration time. However, the surveyor's observation of the resident at 2:35 PM revealed findings that contradict with the documented treatment. During an interview with LPN #27 on 05/19/2026 at 2:35PM, the LPN stated that the resident is ordered for Aquaphor ointment to be applied twice daily. The surveyor asked whether she applied the treatment to the resident extremities. The LPN stated that she had not because she was waiting for the nursing assistant to bathe the resident first. The surveyor then asked why she documented administration of the Aquaphor ointment although it was not done. The LPN could not provide an explanation. On 05/19/2026 at 2:50 PM, the surveyor reviewed the observation and medical record concerns with the Administrator.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation and interview, it was determined that the facility failed to protect the dignity of residents. This was found to be evident for 2 (5/18/2026 and 5/20/2026) out of 4 observations of the assignment board on the first floor. The findings include:On 05/18/2026 at 9:18 AM, the surveyor observed the staffing board at the first floor nurses station that read, Feeders listed as Rooms 103, 115, 116, 119, 108 in the upper left hand corner.An observation of the staffing board on 5/20/2026 at 7:20 AM, revealed the word Feeders under Employee Name and the following room numbers 103,108, 115, 119 next to the assigned nurses name. During an interview on 05/20/2026 at 8:58 AM, Unit Manager LPN #15 stated, We should never use the word feeder on the assignment board. Staff are supposed to use the word assist.The Director of Nursing acknowledged the concern and stated staff should never refer to residents as Feeders on 05/20/2026 9:37 AM.

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. Based on record reviews and interviews it was determined that the facility failed to identify and notify the Resident's health care Responsible Party (RP)/Guardian of a change to the Resident's plan of care and involved them in the consent process. This was found evident in 4 (Resident #11, #4, #88 and #6) out of 76 residents reviewed for resident rights and representative involvement during the annual survey.The findings include:1) On 5/18/26 at 8:01 AM, the surveyor observed Resident #11 in his/her room in bed with a handrail on the right side of the bed and a half rail on the other side. Next the surveyor reviewed Resident #11's medical record. The review revealed a note written by Social Worker (SW) #5 on 4/16/26 that stated Resident #11 was intermittently confused and that the writer could not contact the listed RP due to the number being invalid. On further review it was revealed that on 4/14/26 nursing staff assessed the necessity of bed rails for Resident #11 and documented that bed rails were currently on bed and recommended that therapy evaluation for further need. The assessment indicated that bilateral grab bars were indicated and also initiated a care plan with an intervention that stated to educate resident and resident RP on the risks and benefits of bed rails, but not limited to entrapment. Below the intervention it was marked that education had been provided to the Resident (Resident Representative) for all care plan interventions related to safety. No further documentation as to who was educated was noted. On 5/21/26 at 7:20 AM, the surveyor reviewed the facility's policy titled, Bed Safety and Bed Rails. The policy stated that before using bed rails for any reason, the staff shall inform the resident or Representative about the benefits and potential hazards associated with bed rails and obtain informed consent. On 5/21/26 at 1:51 PM, the surveyor interviewed the acting Director of Nursing (DON) during the interview the acting DON confirmed that Resident #11's RP did not give consent to the use of bed rails prior to the application. 2) On 5/18/26 05/18/2026 9:16 AM, the surveyor called the number that was listed as spouse and Resident's Responsible Party (PR) in Resident #4's medical record. The son of the spouse answered and stated that the name listed was his name but his parent was the RP of Resident #4 and gave the surveyor their number. Additionally listed were names of 1 son and 1 daughter. Next the surveyor reviewed Resident #4's progress notes. A note dated 3/30/26 from Social Worker (SW) #5 stated that the writer contacted the spouse to schedule a care plan meeting and left a message and also the son to inform him of the care plan meeting scheduled. Next the surveyor reviewed the change in condition notes. Below are the dates and notifications. 3/20/26- Son's name (surveyor called on day one) 3/24/26-Spouse -no name given progress notes stating spouse spoke to Nurse Practitioner. 3/31/26- Son's name (surveyor called on day one) left voicemail return call pending Next the surveyor reviewed the care plan invitation sent for a care plan meeting. The invitation stated Dear (son's name surveyor contacted on day one)-Responsible Party. (continued on next page)

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/20/26 at 2:44 AM, the surveyor conducted an interview with Social Worker (SW) #5. During the interview the surveyor reviewed the concern that RP listed in Resident #4's medical record was not Resident 4's actual RP. SW #5 confirmed that the name and number provided in the medical record was not the RP and that the spouse was. She further stated that the spouse had been in the facility several weeks before leaving and was involved in Resident #4's plan of care. She confirmed that there was no reference to his/her name or number in the medical record if the facility needed to get a hold of him/her. On 5/21/26 at 9:34 AM, the surveyor conducted an interview with the Nursing Home Administrator (NHA). During the interview the surveyor reviewed the concern that on two of the change of conditions the staff contacted the wrong RP and until the surveyor inquired the wrong PR was listed in Resident #4's medical record. 3) On 05/18/26 at 9:51 AM, a review of Resident #88's medical record revealed an admission date of 06/23/2025, with multiple diagnoses, including cognitive communication deficit and intellectual disabilities. Further review of the electronic health records (EHR) failed to show evidence of an appointed guardian for Resident #88. On 05/19/26 at 08:50 AM, during an interview, the Social Worker (SW) #5, stated that Resident #88 was admitted to the facility without decision making capacity. She reported she believed the previous social worker had contacted the resident's family regarding guardianship. The SW #5 further stated she was unsure whether the facility had obtained the guardianship documentation. The surveyor requested that the SW #5 review the resident's records to determine whether documentation was present and provide any available guardianship documents. A review of Resident #88's EHR on 05/18/2026 revealed a SW progress note dated 11/25/2025, indicating staff informed the resident's family member that the facility required an appointed healthcare guardian to make healthcare decisions for Resident #88. Further review of the EHR failed to show any evidence of additional attempts by the facility to obtain guardianship documents. On 05/19/2026 at 8:50 AM, the SW #5 provided the surveyor with a social work progress note dated 04/05/2026, indicating that an interdisciplinary care plan meeting was scheduled for 04/21/2026, with the resident's guardian. The SW#5 further stated that this progress note was the only documentation she could locate and acknowledged that the facility did not have guardianship documents for Resident #88. 4) A review of Resident #6's EHR on 05/18/2026, revealed the resident was admitted to the facility in February 2024. Days after admission, the physician certified that the resident lacked decision making capacity. Further review of records failed to show evidence of an appointed healthcare guardian. On 05/19/2026 at 9:13 AM, during an interview with the SW#5, the surveyor inquired about Resident #6's healthcare guardian. The SW stated a family member is the resident's decision maker and confirmed the resident lacked decision making capacity. The SW acknowledged that the medical records failed to show evidence of an appointed healthcare guardian and acknowledged there was no documentation indicating staff helped with obtaining a healthcare guardian.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on record review and interviews, it was determined that the facility failed to formulate an advance directive for a resident. This was evident for 1 (Resident # 74) out of 6 residents reviewed for advance directives.The findings include:On 05/18/26 at 12:03 PM, the surveyor performed a record review for Resident #74 and could not locate an advance directive. The resident's Social Services Assessment stated that advance directives had not been reviewed and the resident did not have one.On 05/19/26 at 7:21 AM, Staff #5 was interviewed. Staff #5 stated that advance directives are documented on admission or created as needed. Staff #5 referred the surveyor to the Social Service Assessment and progress notes for advance directive documentation . On 05/19/26 at 9:08 AM, Staff #5 informed the surveyor that he/she could not find an advance directive for Resident #74. Staff #5 stated that he/she did not ask or offer Resident #74 an advance directive during Resident #74's last quarterly care plan meeting. On 05/19/26 at 9:15 AM, the Director of Nursing acknowledged the concern.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record review and staff interviews, it was determined that facility staff failed to ensure a resident's representative was provided with a written notice of transfer. This deficient practice was evident for 1 (Resident #6) of 3 residents reviewed for transfer notice requirements during the annual survey. The findings include:A review of Resident #6's electronic health record (EHR) on 05/19/2026 at 10:32 AM, revealed the resident was transferred to the hospital in December 2025. Further review of the EHR indicated the resident lacked decision-making capacity. The medical records failed to show evidence that the resident's representative was provided with a written notice of transfer.During an interview with the Social Worker (SW)#5 on 05/19/2026, the SW explained the facility's written transfer notice process. She stated, if the resident's representative is not present at the time of transfer, staff will contact the resident's representative by phone and mail a transfer notice to the representative. The surveyor requested documentation indicating that Resident #6's representative was provided with a written notice of transfer.On 05/19/2026 at 11:19 AM, the Director of Nursing (DON) #2 informed the surveyor that the facility had no evidence or documentation indicating that written transfer notice was provided to the resident's representative.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on record reviews and interviews, it was determined that facility staff failed to ensure the residents' diagnosis and clinical needs were accurately captured at the time of admission and during assessment modifications. This deficient practice was evident for 2 (Resident #6, Resident #67) of 2 residents reviewed for accuracy of assessment during the annual survey. The findings include: Minimum Data Set (MDS) is a standardized, comprehensive clinical assessment tool used in Medicare and Medicaid-certified nursing homes. It evaluates a resident's physical, psychological, and clinical functional status to determine individual care plans, quality measure scores, and Medicare reimbursement. 1.) A review of Resident #6's electronic health record (EHR) on 05/19/2026 at 10:32 AM, revealed the resident was transferred to the hospital in December 2025 and readmitted to the facility January 2026. Review of the resident's admission MDS assessment indicated the resident received hemodialysis. However, the assessment failed to indicate access site through which the resident received hemodialysis. On 5/20/2026 at 10:19 AM, during an interview with the MDS Coordinator #14, the surveyor inquired about resident admission assessment process and what types of hemodialysis access sites are captured during the admission assessment. The MDS Coordinator stated she does not code dialysis catheter or ports. She further stated that she only will code catheters or ports for residents receiving chemotherapy, antibiotics, or intravenous fluids. 2.) A review of Resident #67 medical records on 05/22/2026 at 9:16 AM, revealed the resident transitioned to hospice services on 11/24/2025. Further review of the MDS assessment completed on 12/05/2025 indicated that hospice care was noted, however, the MDS Coordinator failed to update and accurately capture the resident's specific hospice diagnoses. On 05/22/2026, the surveyor presented the MDS concerns to MDS Coordinator #14 and Administrator. Both acknowledged the concern related to the MDS assessments.

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	05/22/2026

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review and interview, it was determined that the facility failed to develop and implement patient-centered comprehensive care plans to meet the needs of residents. This was found to be evident for 1 (#13) out of 8 residents reviewed for comprehensive care plans. The findings include: During a record review on 05/19/2026 at 10:00 AM, the surveyor noted a diagnosis for dementia by did not find a care plan for dementia care for Resident #13. The surveyor requested the Director of Nurses (DON) provide a care plan for dementia. On 05/19/2026 at 11:11 AM, the DON stated the facility did not have a care plan for dementia care and the expectation is that there should be one.

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	05/22/2026

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on review of resident medical records and interview with facility staff, it was determined that the facility failed to hold care plan meetings after the completion of the Minimum Data Set assessment. This was evident for 2 (Resident #4 and #88) out of 2 residents reviewed for care planning during the survey.Care plans are developed for residents to guide the care that residents receive in the facility. They are required to be developed within 7 days of completion of a resident's admission comprehensive Minimum Data Set (MDS) assessment and revised at least every quarter (or more often as needed). The facility is required to have care plans developed and revised by an interdisciplinary team.The findings include:1) On 5/18/26 at 2:13 PM, the surveyor reviewed Resident #4's progress notes and noted on 3/20/26 Social Worker (SW) #5 wrote that a care plan meeting was scheduled for 3/24/26 at 11 AM. The surveyor on unable to find any other documentation to indicate a care plan took place after this date. Next the surveyor reviewed Resident #4's Minimum Data Set (MDS) assessments and noted Resident #4 had a MDS quarterly MDS assessment on 4/27/26. On 5/20/26 at 1:28 PM, the surveyor intervened SW #5. During the interview SW #5 stated that the care plan meeting scheduled on 3/24/26 was moved to 4/1/26 per family request. She further stated no additional care plan meetings were held and that care plan meeting are suppose to occur after MDS assessments. 2) During an interview with the Social Worker (SW) #5 on 05/18/2026 at 1:37PM, the SW #5 explained the facility's care plan meeting process, including who attends and the frequency of care plan meetings. She stated that meetings are conducted quarterly, annually, and at the request of the resident and/or resident representative. The surveyor inquired about Resident #88's care plan meetings and informed SW #5 that seven months lapsed between meeting. The SW #5 acknowledged that the resident's care plan was conducted outside the required quarterly timeframe and stated the previous social worker failed to conduct meeting regularly. On 05/19/2026 at 8:50 AM, the SW #5 provided the surveyor with a social work progress note dated 04/05/2026 , indicating that an Interdisciplinary Team care plan meeting was scheduled for 04/21/2026.

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	05/22/2026

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on record review and observation, it was determined that the facility failed to ensure staff maintain professional standards of practice when an active order was signed off. This was evident for 1 (Resident #9) of 3 residents reviewed for pressure ulcers.The findings include:On 05/18/2026 at 12:01 PM, review of Resident #9's medical record revealed a skin and wound progress note dated 5/15/26 at 9:11 AM, that indicated the resident has a sacral wound and a wound on their buttock, both of which were noted to be stage 3 pressure ulcers.At the same time, further review of Resident #9's medical record revealed an active order to turn and reposition the resident every two hours, and as needed. On 05/19/2026 at 8:17 AM, an observation of Resident #9 revealed the resident was in bed lying on their back. On 05/19/2026 at 10:26 AM, an observation of Resident #9 revealed the resident was in bed lying on their back. On 05/19/2026 at 12:36 PM, an observation of Resident #9 revealed the resident was in bed lying on their back. On 05/20/2026 at 7:03 AM, an observation of Resident #9 revealed the resident was in bed lying on their back. On 05/20/2026 at 9:02 AM, an observation of Resident #9 revealed the resident was in bed lying on their back. On 05/20/2026 at 11:02 AM, an observation of Resident #9 revealed the resident was in bed lying on their back.On 5/22/2026 at 9:35 AM, review of the Treatment Administration record revealed the order was signed off on 5/18/26 and 5/19/26 day shift which indicated the turn and reposition was done throughout the shift.On 5/22/2026 at 9:38 AM, an interview with Licensed Practical Nurse (Staff #26) revealed that the nurse and geriatric nursing assistant assigned to a resident were expected to turn and reposition the resident as ordered throughout the shift. Further interview revealed she would also ask the geriatric nursing assistant assigned to the resident if they had turned and repositioned the resident throughout the shift and that was when they signed off on the order as completed.On 5/22/2026 at 9:40 AM, the surveyor reviewed the concern with the Acting Director of Nursing and she indicated that she understood.

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	05/22/2026

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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 and interviews, it was determined that the facility failed to ensure that a resident received treatment and care in accordance with the comprehensive person-centered care plan and professional standards of practice. This was evident for 3 (Resident #11, #16 and #74) out 76 residents reviewed during the annual survey. The findings include: 1) On 5/18/26 at 1:43 PM, the surveyor reviewed Resident #11's medical record. The review revealed an order for Resident #11's right elbow to have wound treatment with betadine solution and to be covered with foam dressing daily starting on 4/17/25. Next the surveyor reviewed the April and May Treatment Administration Records (TAR)s. The surveyor noted several days were left blank and are listed as follows: 4/17/26, 4/23/26, 4/27/26 4/29/26 4/30/26, 5/6/26, 5/8/26, 5/12/26, and 5/13/26. 2) On 5/18/26 at 7:49 AM, the surveyor conducted an interview with Resident #16. During the interview Resident #16 alleged that his/her dressing changes were not always completed. On 5/18/26 at 1:15 PM, the surveyor reviewed Resident #16's medical record the review revealed Resident #11 had an order written 5/7/26 for wound care to the right lateral (outer) foot to be completed every day. Additionally on 5/7/26 an order was placed for wound care to the sacrum to be done every day shift. Next the surveyor reviewed the May Treatment Administration Records (TAR). The surveyor noted 3 days were left blank for both the foot dressing and the sacral dressing; 5/8/26, 5/12/26 and 5/13/26. On 5/21/26 at 9:20 AM, the surveyor conducted an interview with the acting Director of Nursing (DON). During the interview the surveyor reviewed the concern about multiple days of treatments not being documented as completed. The acting DON stated she would look into the concern. At the time of exit no additional documentation was provided as to rationale for the treatments not documented as completed. 3) On 05/20/26 at 9:40 AM, the surveyor reviewed Resident #74's electronic health record. Resident #74 has diagnoses of Chronic Obstructive Pulmonary Disease (COPD), asthma, acute and chronic respiratory failure, and dependence on supplemental oxygen. Resident #74's Medication Administration Record (MAR) included assessments and treatments he/she was supposed to receive as ordered. The lack of ongoing clinical assessments and identification of changes in condition makes it challenging to attain or maintain, or improve the resident's highest practicable physical, mental and psychosocial well-being. The following assessments and treatments were not signed off as completed by staff for various dates in May 2026: - Advair Diskus, Aerosol Powder Breath Activated, 100-50 MCG/DOSE (Fluticasone-Salmeterol) 1 inhalation inhale orally every 12 hours for Asthma. - Is the resident short of breath when lying flat? Check every shift. - Apply oxygen at 5L/ Minute via nasal cannula every shift (related to COPD). - Apply foam ear protectors to oxygen nasal cannula tubing. Check for placement every shift (related (continued on next page)

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	05/22/2026

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to COPD). - Appraise and observe patient every shift for changes in physical/mental condition every shift. On 05/20/26 at 9:55 AM, LPN #11 claimed staff completed the required treatments and assessments, but could not explain the numerous blank entries in the MAR. On 05/20/26 at 10:12 AM, the Director or Nursing acknowledged the concern.

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	05/22/2026

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on record review and interview, it was determined that the facility failed to flush a gastrostomy tube in accordance with professional standards of practice. This was found to be evident for 1 (#12) out of 1 resident reviewed for gastrostomy tube flushing. The findings include:During a record review on 5/20/2025 at 8:30 AM, the surveyor noted an order written on 2/5/2025 at 18:00 that read, Flush G-Tube Q 6 Hours four times a day for hydration There was no mention of what or how much to flush the gastrostomy tube with.During an interview on 5/20/2025 at 9:30 AM, the Director of Nursing acknowledged the concern and stated, The order is incomplete. It should have specified the amount in the order.

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	05/22/2026

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, medical record review, review of facility's policy and interview, it was determined that the facility staff failed to ensure residents received respiratory care consistent with professional standards of practice by providing oxygen at flow rate inconsistent with prescribed orders. This was evident for 2 (Resident #46 and #10) of 3 residents reviewed for respiratory care.Nasal cannula- a medical device used to provide supplemental oxygen therapy to people who have lower oxygen levels.The findings include:1) On 5/18/26 at 8:23 AM, the surveyor observed Resident #46's oxygen concentrator (the machine that delivers supplemental oxygen) dialed at 4.5 liters of oxygen per minute (l/min). No humidification bottle was noted. The nasal cannula tubing was directly attached to the concentrator. No label was noted on the tubing. Shortly after this observation, Licensed Practical Nurse (LPN) #4 walked into the room. The surveyor asked LPN #4 what Resident #46's ordered rate of oxygen was and LPN #4 stated he would look up the order to confirm. On return to the room LPN #4 stated it was supposed to be at 3 l/min and adjusted the oxygen level to the appropriate rate after assessing the resident. He asked the Resident if he/she had adjusted the rate. Resident # 46 responded that he/she had not adjusted the rate and the concentrator was out of reach to do so. Next the surveyor reviewed Resident #46's oxygen orders. An order was placed on 8/8/25 for 3 l/min of oxygen via nasal cannula. Additionally, an order was also placed on that same day for the oxygen tubing and humidifier to be changed weekly as well as cleaning the filter. The order stated to date/label oxygen tubing and humidification bottle on the date changed. On review of the Treatment Administration Record (TAR) it was noted staff were signing off both tubing and humidification bottle changed and labeled weekly on Mondays. 2) On 5/20/26 at 11:27 AM, the surveyor reviewed Resident #46's care plan. The review revealed Resident #46 had a care plan for oxygen use with an interventions that stated to add humidity as needed. On 5/21/26 at 7:35 AM, the surveyor observed Resident #46's oxygen at 3 l/min, however there was no humidification bottle. Resident #46 stated that he/she had a preference to not have humidification. Next the surveyor reviewed the policy titled Oxygen Administration. The equipment noted as necessary was a humidification bottle. Further in the policy it states to be sure there is water in the humidification jar and that the water level is high enough that the water bubbles as oxygen flows through. On 5/21/26 at 11:45 AM, the surveyor conducted an interview with the acting Director of Nursing (DON). During the interview the surveyor reviewed the observations of the incorrect rate being administered as well as the concern that staff were documenting that they were changing the humidification bottle when Resident #46 did not utilize it. The acting DON stated that the care plan and order should have been updated to what the Resident was currently receiving. On 05/18/2026 at 7:46 AM, an initial observation of Resident #10's oxygen revealed it was at 3.5 liters per minute (the amount of oxygen the resident received in a minute). On 05/19/2026 at 8:10 AM, review of Resident #10's medical record revealed an active order for oxygen at 2 liters per minute. (continued on next page)

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	05/22/2026

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/19/2026 at 8:19 AM, an observation of Resident #10's oxygen revealed it was at 3.5 liters per minute. On 05/19/2026 at 8:21 AM, the surveyor requested dual observation of the oxygen level with Licensed Practical Nurse (Staff #15). Staff #15 indicated the oxygen level was at 3.5 liters per minute. On 05/19/2026 at 8:34 AM, during an interview with Staff #15, the surveyor requested for her to look at the active order for Resident #10 to confirm the amount of oxygen they were ordered for. She confirmed the resident was ordered for 2 liters per minute. On 05/20/2026 at 9:41 AM, the surveyor reviewed the concern with the Director of Nursing and she indicated that she understood.

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	05/22/2026

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Number of residents sampled: Number of residents cited: Based on record review and interviews, it was determined that the facility failed to ensure annual performance review and regular in-service education were conducted for certified nurse aides (CNA)1. This deficient practice was evident for 2 of 5 CNA1 employee files reviewed during the annual survey.The findings include:On 05/20/2026, a review of CNA1 #9 and CNA1 #12's employee files failed to show documented evidence of an annual performance review and related in service education based on the outcomes of the 2025 performance review.During an interview conducted with Human Recourse (HR) #16 on 05/20/2026 at 11:42 AM, she explained that CNA1's annual performance review are completed yearly based on the employee's hire month. She further stated that unit managers and/or Director of Nursing are notified of upcoming annuals performance reviews that are due. The surveyor informed HR #16 of the missing annual performance reviews and related in service education for CNA1 #9 and CNA1 #12. HR #16 stated she would continue to searching for the missing documents and follow up with the surveyor.On 05/21/2026 at 9:39 AM, HR#16 acknowledged the facility was unable to provide documented evidence of annual performance review and related in-service education for CNA1 #9 and CNA1 #12.

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	215299	A. Building B. Wing	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on medication administration observation, medical record review and staff interview, it was determined the facility failed to ensure a medication error rate of less than 5 percent during the medication pass observation. This finding was evident for 5 medication errors out of 26 opportunities which resulted in a medication error rate of 19%. Facility stock supply medications- Are mostly common over the counter medications in multidose containers to be shared amongst residents that are prescribed those medications. Examples would be vitamins and/or supplements. Aspirin Enteric-Coated (EC) or Delayed-Release (DR) is a form of aspirin with a special coating that prevents the tablet from dissolving in the stomach. Instead, it passes into the small intestine, where it is absorbed. This form is designed to prevent stomach irritation, ulcers, and gastrointestinal bleeding. The findings include: On 5/21/26 at 7:39 AM, the surveyor observed Certified Medicine Aide (CMA) #23 prepare medications for Resident #106. During the preparation CMA #23 took one table of the facility's stock vitamin C that was 250mg. The surveyor observed CMA #23 given Resident #106 this medication with the rest of the morning medications prepared. Next the surveyor reviewed Resident #106's Medication Administration Record (MAR) to reconcile the medications observed given to medication orders. On review the surveyor noted that the ordered dose for Ascorbic Acid (vitamin C) was 500mg not 250mg. On 5/21/26 at 8:14 AM, the surveyor observed CMA #23 prepare medications for Resident #104. CMA #23 took 1 tablet of 81mg chewable aspirin and 400mg tablet of guaifenesin from the stock medication. The surveyor observed CMA #23 given Resident #104 both of these medications with the rest of the morning medications prepared. Next the surveyor reviewed Resident #104's Medication Administration Record (MAR) to reconcile the medications observed given to medication orders. On review the surveyor noted that the ordered form of aspirin was Enteric-Coated, however, Resident #104 was given the chewable form. On further review Resident #104's order for guaifenesin was for extended release and 600 mg, however, Resident #104 was given 400 mg without the extended release form. On 5/21/26 at 1:14 PM, the surveyor conducted an interview with CMA #23. During the interview CMA #23 confirmed that the incorrect dose and/or form was given from the floor stock medication. On 5/21/26 at 8:27 AM, the surveyor observed CMA #24 prepare medications for Resident #40. Right before administering the medications to Resident #40 CMA #24 asked Resident #40 if he/she was having any pain. Resident #40 stated he/she had a headache and agreed to receive Tylenol in addition to scheduled morning medications. Next the surveyor observed CMA #24 return to the medication cart and add two tablets of 325mg Acetaminophen (Tylenol) to the medications prepared for Resident #40 and return to administer them. Next the surveyor reviewed Resident #40's Medication Administration Record (MAR) to reconcile the medications observed given to medication orders. On review the surveyor noted that the ordered form (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215299	A. Building B. Wing	05/22/2026

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

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of aspirin was Delayed Release however, Resident #40 was given the chewable form. On further review it was noted that the Tylenol given was not signed off as given on the MAR. On 5/21/26 at 1:15 PM, the surveyor conducted an interview with CMA #24. During the interview CMA #24 confirmed that the incorrect form of aspirin was given from the floor stock medication and that she had forgotten to sign out the Tylenol that was administered. She stated she would sign them out now. On 5/21/26 at 1:24 PM, the surveyor updated the acting Director of Nursing (DON) of the concerns during the medication administration.

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	05/22/2026

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

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation and interview, it was determined the facility failed to provide palatable food at an appetizing temperature. This was evident for 1 out of 1 observation of a kitchen tray line and test tray.The findings include:On 05/20/2026 at 11:46 AM, the surveyor observed the kitchen tray line for lunch begin.On 05/20/2026 at 12:33 PM, the test tray plate was prepared.On 05/20/2026 at 12:36 PM, the test tray plate arrived at the unit.On 05/20/2026 at 12:46 PM, the last resident lunch tray was delivered.On 05/20/2026 at 12:47 PM, the surveyor requested Assistant Dietary Director (Staff #19) who was present to take the temperature of the food on the test tray plate. The temperatures were as follows: Tilapia (a type of fish) was 108.5 degrees Fahrenheit, mashed potatoes and gravy were 116.2 degrees Fahrenheit, and sauteed mixed squash was 130.7 degrees Fahrenheit. On 05/20/2026 at 12:50 PM, two surveyors tested the entree and sides, which failed to be a palatable taste and at an appetizing temperature.On 05/20/2026 at 1:28 PM, the surveyor reviewed the concern with the Food Services Director (Staff #18).

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	05/22/2026

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview it was determined that the facility failed to ensure food was stored in accordance with professional standards of practice for food service safety. This was evident during the initial tour of the kitchen upon entry into the facility. The findings include:On 05/18/2026 at 7:08 AM, an initial observation of the kitchen refrigerator revealed a ziplock bag of approximately 5 pizza slices, 2 peanut butter and jelly sandwiches which indicated use by 5/16/26, and an opened container of tomato juice, all of which were opened, without a label or date.On 05/18/2026 at 7:10 AM, an initial observation of the kitchen freezer revealed whole grain breaded alaska [NAME] square (fish patty), tilapia filet which looked to to freezer burnt, golden breaded veal (a type of meat) and beef patties, and biscuits which were all opened exposed to the freezer air, without a label or date.On 05/18/2026 at 7:13 AM, an initial observation of the kitchen dry storage room revealed 3, 4lb containers of peanut butter, ground nutmeg seasoning, pickling spice seasoning, 2 seasoning containers of parsley flakes, thyme, garlic salt, kansas city steak seasoning, fish seasoning, italian seasoning, black pepper, ground ginger, barbeque seasoning, and cajun seasoning, which were all opened, without a labeled date.On 05/18/2026 at 7:24 AM, an interview with Dietary Aide (Staff #27) revealed the expectation of staff when opening a new container of an item for the first time was to label it with the date and make sure it was sealed closed. She further indicated when they prepare items such as sandwiches, or put away extra food, it would be the same expectation.On 05/18/2026 at 9:53 AM, an interview with Food Services Director (Staff #18) revealed the manager was in charge to ensure items were labeled and dated, as well as tossing items past their best by date. The surveyor reviewed the concern.

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	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, it was determined that the facility staff failed to ensure and maintain hospice documentation was available in the resident's medical records. This deficient practice was evident for 1 (Resident #3) of 2 residents reviewed for hospice services during the annual survey.The findings include:During an interview with Resident #3 on 05/18/2026 at 9:25 AM, when asked whether hospice services were being received, the resident replied, no. However, review of the resident medical records identified the resident as receiving hospice services.On 05/21/2026 at 7:13 AM, a review of the resident's electronic medical records (EHR) failed to show evidence of a hospice plan of care, hospice medications orders, hospice physician orders, a hospice election form, and physician certification of terminal illness. The surveyor informed the Administrator of the missing documents. The Administrator stated she would follow up with the medical records department and provide an update to the surveyor. On 05/21/26 at 11:40 AM, the Director of Nursing (DON)#2 informed the surveyor that she had to contact the hospice service provider to obtain hospice records for Resident #3. The surveyor inquired whether the facility had maintained the hospice documentation prior to the surveyor's request. The acting DON#2 reiterated that she had to reach out to the resident's hospice service provider to obtain the hospice document.On 05/21/2026 at 1:21 PM, the DON #2 provided the surveyor with the resident's hospice comprehensive care plan report. The DON #2 stated that the hospice nurse brought the document to the facility that day. The DON #2 also provided copies of the hospice consent and electron form, hospice physician medication orders, hospice physician orders, and physician certification of terminal illness.Review of the documents indicated they were transmitted to the facility on [DATE] at 12:47 PM. The DON #2 acknowledged that the required hospice documentation was not available in the resident's medical records prior to the surveyor's request.

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	215299	A. Building B. Wing	05/22/2026

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interviews, it was determined that the facility failed to follow standard precautions and enhanced barrier precautions. This was evident in 1) 1 (CMA #24) out of 1 staff members observed during the infection control task, 2) 1 (#6) out of 1 resident, and 3) 1 out of 2 observations of shared equipment disinfection during medication administration observed during the annual survey.The findings include: 1) On 5/21/26 at 8:39 AM, the surveyor observed Certified Medication Aide (CMA) #24 prepare medications for Resident #108. The surveyor observed CMA #24 bring Resident #108 his/her medication, however Resident #108 stated he/she was not feeling well and did not want to take the medications at that time CMA #24 asked if she could take Resident #108's blood pressure. Resident #108 agreed the blood [NAME] was taken using a portable blood pressure machine. On 5/21/26 at 8:55 AM, the surveyor observed Certified Medication Aide (CMA) #24 prepare medications for Resident #84. The surveyor observed CMA #24 bring Resident #84 his/her medication and prior to administration asked if she could take Resident #84's blood pressure. Resident #84 agreed and the surveyor observed CMA #24 utilize the same portable blood pressure machine and cuff used from Resident #108. No disinfecting of the machine or cuff was noted between uses. On 5/21/26 at 9:10 AM, the surveyor conducted an interview CMA #24. During the interview CMA #24 confirmed that it is the expectation to disinfect equipment between resident use and that she had just forgotten. 2) Enhanced Barrier Precaution (EBP) refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. On 05/18/2026 on 7:56 AM, the surveyor observed EBP sign posted on the door of Resident #6's room. The surveyor entered the room and observed Certified Nursing Assistant1 (CNA1) #6 providing care without wearing a personal protective gown. The surveyor also observed a clear plastic bag containing soiled linen located on the left side of the resident's bed. The surveyor exited the room. When CNA1 #6 exited the room carrying the clear plastic bag of soiled linen, the surveyor inquired about the EBP sign posted on the resident's door and asked whether the resident was currently on EBP precaution. CNA1 #6 confirmed the resident was on EBP and stated the resident had been placed on EBP for a small wound that had since healed. She further stated that the resident doesn't have any viruses or anything like that. A review of Resident #6's electronic health record (EHR) on 05/19/2026 at 10:12 AM, revealed the resident was admitted to the facility on [DATE]. Further review revealed a physician's order dated 01/15/2026 instructing staff to assess and document the resident's hemodialysis port site three times daily. A physician's order dated 03/20/2026 directed staff to provide treatment for the resident's left hip wound daily. An additional physician's order dated 03/29/2026 instructed staff to administer enteral feedings through a feeding tube four times daily. Further review revealed a physician's order dated 04/14/2026, instructed staff to implement EBP for Resident #6 for the presence of a hemodialysis port and left hip wound. On 05/19/2026 at 2:50 PM, the surveyor reviewed the observation and EHR concerns with the (continued on next page)

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	05/22/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator. 3) Standard precautions refer to the infection prevention practices that apply to all residents, regardless of suspected or confirmed diagnosis or presumed infection status. Standard precautions are based on the principle that all blood, body fluids, secretions, excretions except sweat, regardless of whether they contain visible blood, non-intact skin, and mucous membranes may contain transmissible infectious agents. Furthermore, equipment or items in the resident's environment likely to have been contaminated with infectious body fluids must be handled in a manner to prevent transmission of infectious agents. Standard precautions include hand hygiene, proper selection and use of personal protective equipment, safe injection practices, respiratory hygiene/cough etiquette, environmental cleaning and disinfection, and reprocessing of reusable resident medical equipment. On 05/20/2026 at 9:30 AM, the surveyor observed a towel on the floor in the [NAME] hallway. LPN #11 stated the towel was on the floor due to a spill from a food cart. Shortly after, Staff #20 was observed assessing the spill, touching the dirty towel with his/her bare hands while he/she held onto a pair of gloves. Staff #20 proceeded to the clean utility closet where he/she touched the door handle, retrieved the clean supplies, put his/her gloves on, and cleaned the spill. On 05/20/26 at 10:00 AM, the surveyor interviewed the Infection Preventionist (IP). The IP stated that the expectation is for all staff to perform proper hand hygiene. On 05/20/26 at 10:05 AM, the Administrator and the IP acknowledged the concern.

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	215299	A. Building B. Wing	05/22/2026

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation and interview it was determined the facility failed to ensure a resident had access to the call bell. This was evident for 2 (#1, #63, and #44) of 31 residents reviewed for call light access during the initial pool review.The findings include: 1) On 05/18/2026 at 8:35 AM, an observation of Resident #1 failed to reveal that the call bell was anywhere within reach of the resident nor was it visible to the surveyor. On 05/18/2026 at 8:36 AM, an observation of Resident #63 failed to reveal that the call bell was anywhere within reach of the resident nor was it visible to the surveyor. On 05/18/2026 at 8:37 AM, an interview with Licensed Practical Nurse (Staff #15) revealed that resident call bells should be within reach of them. The surveyor requested dual observation of Resident #1 and #63. On 05/18/2026 at 8:38 AM, during the dual observation, Staff #15 was initially unable to find Resident #1's call bell. She later identified it hanging on the wall where the call bell is plugged in. It was out of reach and out of sight of Resident #1. At the same time, Staff #15 found Resident #63's call bell behind the head of the bed tangled in the bed remote controller. On 05/18/2026 at 8:54 AM, review of Resident #1 and #63's medical record revealed they were dependent on staff and would not be able to get out of bed or reach either of the call bells where they were found. On 05/20/2026 at 9:40 AM, the surveyor reviewed the concern with the Director of Nursing and she indicated that she understood. 2) On 5/18/25 at 8:10 AM, the surveyor observed Resident #44 lying in bed with his/her call light on the floor. Resident #44 reported he/she was in pain and was waiting for the nurse to come around to give him/her some pain medications. Resident #44 reported he/she did not know where his/her call light was. On 5/18/26 AM, the surveyor walked into the hall and asked Licensed Practical Nurse (LPN) #4 if he was assigned to Resident #44 and after confirming both he and the surveyor walked into Resident #44's room. The surveyor showed LPN #4 the call light that was on the ground next to Resident #4's bed. LPN #4 confirmed the call light should be in reach and not on the floor.

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	215299	A. Building B. Wing	05/22/2026

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct mandatory training, for all staff, on the facility?s Quality Assurance and Performance Improvement Program. Based on record reviews and staff interviews, it was determined that the facility failed to ensure staff received Quality Assurance and Performance Improvement (QAPI) training. This deficient practice was evident with 2 of 5 employee files reviewed during the annual survey.The findings include:On 05/20/2026, a review of Certified Nursing Assistant1 (CNA1) #9 and CNA1 #6's employee files failed to show documented evidence of QAPI training completed in 2025.During an interview with Staff Educator #7 on 05/20/2026 at 11:44 AM, she explained the annual training and competency requirements for nursing assistants including QAPI. She further stated that since her hire date in December 2025, she had developed a training program to ensure compliance with annual training requirements. The surveyor informed the Staff Educator #7 and Human Resources (HR) #16 of the missing 2025 QAPI training for CNA1 #9 and CNA1 #6. Both the Staff Educator #7 and HR #16 stated they would search for the missing training documents and follow up with the surveyor.On 05/21/2026 at 9:39 AM, HR#16 acknowledged the facility was unable to provide documented evidence of annual QAPI training for CNA1 #9 and CNA1 #6.

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	215299	A. Building B. Wing	05/22/2026

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. Based on record reviews and staff interviews, it was determined that the facility failed to ensure staff received Infection control training. This deficient practice was evident with 1 of 5 employee files reviewed during the annual survey.The findings include:On 05/20/2026, a review of Certified Nursing Assistant1 (CNA1) #12 employee file failed to show documented evidence of infection control training completed in 2025.During an interview with Staff Educator #7 on 05/20/2026 at 11:44 AM, she explained the annual training and competency requirements for nursing aides including infection control. She further stated that since her hire date in December 2025, she had developed a training program to ensure compliance with annual training requirements.The surveyor informed the Staff Educator #7 and Human Resources (HR) #16 of the missing infection control training for CNA1 #12. Both the Staff Educator #7 and HR #16 stated they would search for the missing training documents and follow up with the surveyor.On 05/21/2026 at 9:39 AM, HR#16 acknowledged the facility was unable to provide documented evidence of annual infection control training for CNA1 #12.

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	215299	A. Building B. Wing	05/22/2026

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F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide training in compliance and ethics. Based on record reviews and staff interviews, it was determined that the facility failed to ensure staff received compliance and ethics training. This deficient practice was evident with 3 of 5 employee files reviewed during the annual survey.The findings include:On 05/20/2026, a review of Certified Nursing Assistant1 (CNA1) #9 , CNA1 #6, and CNA1 #12 employee files failed to show documented evidence of Compliance and Ethics training completed in 2025.During an interview with Staff Educator #7 on 05/20/2026 at 11:44 AM, she explained the annual training and competency requirements for nursing assistants including compliance and ethics. She further stated that since her hire date in December 2025, she had developed a training program to ensure compliance with annual training requirements. The surveyor informed the Staff Educator #7 and Human Resources (HR) #16 of the missing 2025 compliance and ethics training for CNA1 #9, CNA1 #6, and CNA1 #12. Both the Staff Educator #7 and HR #16 stated they would search for the missing training documents and follow up with the surveyor.On 05/21/2026 at 9:39 AM, HR#16 acknowledged the facility was unable to provide documented evidence of annual compliance and ethics training for CNA1 #9, CNA1 #6, CNA1 #12.

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	215299	A. Building B. Wing	05/22/2026

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. Based on observations, interviews, and record review, it was determined that the facility failed to post the daily required staffing information. This was found to be evident for 1 (lobby desk) out of 2 desk areas observed for staff posting. The findings include:On 05/18/2026 at 7:33 AM, the surveyor observed a staffing sign posted at the front desk in the facility lobby dated Friday May 15, 2026.The Administrator and Director of Nursing were shown a picture of the lobby sign that was posted on 05/19/2026 2:00 PM . They acknowledged the concern that the signage was not updated over the weekend.