

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215301	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/05/2025
NAME OF PROVIDER OR SUPPLIER Roland Park Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4669 Falls Road Baltimore, MD 21209	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>31982</p> <p>Based on record review and resident and staff interviews, it was determined that the facility staff failed to report a threat of physical violence against a resident as required. This was evident for 1 (#39) of 53 residents reviewed during the survey. The findings include:</p> <p>A complaint alleging that a staff member attempted to poison Resident #39 was investigated on 1/29/25 at 8:03 AM.</p> <p>A review of Resident #39's medical record included a plan of care developed on 9/13/24 for behavioral problems as evidenced by blocking staff access to other residents, verbal aggression to staff and fabrication of care issues.</p> <p>Social Services progress notes revealed that the facility addressed the residents' concerns, but were not able to substantiate the attempted poisoning allegations and offered the resident a room change to another unit. On 1/29/25 at 12:45 PM, the Administrator provided a Service Comment Form, dated 10/10/24, which described the actions taken to address the residents concerns and included The resident was offered a room/unit change, and s/he declined. As a precaution, the accused staff member was removed from that assignment.</p> <p>Resident #39 was interviewed on 1/29/25 at 1:05 PM. S/he indicated that the facility didn't take his/her allegation seriously and their answer is that they didn't have any proof. During the interview, Resident #39 stated that s/he also received several text messages on his/her phone since the alleged incident. S/he briefly showed the surveyor the messages which contained derogatory comments and name calling. However, 1 message stated I wish I had something heavy to bash your head in. The messages were not dated. However, the resident indicated that s/he received the messages after the date s/he felt staff attempted to poison him/her. The resident indicated that s/he sent screen shots of the messages to the Unit Manager (Staff #14,) who then forwarded them to the Social Services Director (Staff #13).</p> <p>In an interview on 1/29/24 at 2:13 PM, Staff #14 confirmed she was aware of the text messages and that she informed Staff #13 who started an investigation. She indicated that Staff #13 did a Google search to find out who owned the phone from which the messages were sent. She indicated she couldn't remember if the police were notified of the threatening message then stated, I believe so.</p> <p>(continued on next page)</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
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Staff #13 was interviewed on 1/29/25 at 2:38 PM. He confirmed that he attempted to identify the sender of the messages. When the number was called, it didn't ring. No match was found when he cross checked the number with the staff list and a Google search was unsuccessful. He indicated that the messages that were sent to Staff #14 involved name calling, referenced poisoning of the water and something about food. When asked, he denied having knowledge of any physically threatening messages. He indicated he had a file of the messages and was asked to provide them to the surveyor.</p> <p>On 1/29/25 at 2:57 PM, the Administrator indicated that the facility was not aware that there was anything of a threatening nature in the text messages that Resident #39 received or reported. He indicated that if the facility had known of any threatening messages, he would have reported them to the State Agency and to the Police, but he had no knowledge of any threatening messages. He stated, We take them very seriously.</p> <p>On 1/29/25 at 3:05 PM, Staff #13 provided the surveyor with a photo of the resident's phone with 1 text message which included foul language and name calling but was non-threatening. The message contained no identifiable date. He denied having copies of any additional text messages.</p> <p>In an interview on 2/3/25 at 10:24 AM, the Administrator was asked what measures were taken by the facility after he was made aware on 1/29/25 that Resident #39 had received a threatening message. He stated, I think they called the police and indicated he would find out.</p> <p>The Director of Nursing (DON) followed up with the surveyor on 2/3/25 at 10:55 AM. She indicated she spoke to the resident on 1/29/25 and again this morning and that the resident indicated that s/he does not feel threatened, so the police were not called.</p> <p>She confirmed that after the facility became aware that there was a threatening text message sent to the resident, they did not report the incident as required.</p> <p>On 2/3/25 at 11:42 AM, the Administrator indicated that he sent a report to the state agency and called the police to report the issue today.</p> <p>Review of the Facility Report revealed it was sent to the State Agency on 2/3/25 11:37 AM, after surveyor intervention.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>31982</p> <p>Based on record review and interview with staff, it was determined that the facility staff 1) failed to prevent further potential exploitation while an investigation was in progress, and 2) failed to have evidence that all alleged violations are thoroughly investigated. This was evident for 2 facility reported incidents reviewed for 1 (#11) of 53 residents reviewed during the survey.</p> <p>The findings include:</p> <p>1) Facility Reported Incident (FRI) #MD00197317 was reviewed on 1/27/25 at 11:17 AM. The report indicated that Resident #11 alleged that Staff #12 a Geriatric Nursing Assistant (GNA) took his/her wallet, which contained \$15.00, while making his/her bed on 9/21/23. The facility reported the incident, conducted an investigation, was unable to substantiate the allegation, and submitted their final report to the state on 9/27/23.</p> <p>The facility's report and investigation documentation failed to reveal that Staff #12 was suspended pending the outcome of the investigation. Staff schedules revealed that Staff #12 worked 7AM-3PM on 9/21/23.</p> <p>The Administrator was asked to provide evidence that Staff #12 was suspended after the allegation pending the result of the facility's investigation. On 1/28/25 at 8:41 AM, the Administrator confirmed that he was not able to find evidence that Staff #12 was suspended. He indicated that he reached out to former staff in an attempt to locate the information but had not heard back. No further information was provided prior to the exit conference on 2/5/25.</p> <p>2) During the survey entrance conference on 1/24/25 at approximately 8:15 AM. The Director of Nursing (DON) was given a list and asked to provide the facility's investigations pertaining to each of the 20 FRI's scheduled for review during the survey.</p> <p>On 1/27/25 at approximately 10:00 AM, the Administrator indicated he was unable to locate the investigation for FRI #MD00195004. He indicated that the abuse allegation occurred during the facility's prior ownership and the incident investigation record was retained by the prior owner. He added that he reached out to the prior owner for the records. On 1/28/25 at 8:41 AM, the Administrator was asked about the status of the investigation record. He indicated that he had not received anything from the prior owner and would reach out to them again. He returned at 10:15 AM on 1/28/25 and reported that he called all the former administrators, and no one knows where the missing investigation is. He stated that the facility should have all resident records going back 5 years and he would be shocked if the documentation was within the facility because we've looked everywhere.</p>

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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.</p> <p>37296</p> <p>Based on the review of a complaint, staff interview and medical record review, it was determined that the facility failed to adequately prepare a resident for discharge. This was evident for one resident during the review of 1 of 3 complaints regarding discharges. (Resident #23)</p> <p>The findings include:</p> <p>Review of the complaint #MD00203025 on 6/10/24 at 9:45 AM revealed concerns regarding Resident #23's discharge planning and preparation nor was the resident provided their personal belongings prior to the discharge.</p> <p>A review on 02/02/25, of the discharge that occurred on 2/01/23 and the completed paperwork revealed that Resident #23 had not signed any discharge paperwork, including the discharge instructions/post discharge plan review, and the resident property list. The discharge paperwork did not include wound care for the resident.</p> <p>The facility DON was interviewed on 02/04/25 at 9 AM. The facility process on discharge was reviewed. She stated that the staff are to review the discharge planning and have the resident sign it and then it is scanned into the computer. Additionally, this is the process for the resident property list. Neither one of these processes were completed for Resident #23.</p> <p>The DON identified concerns of discharge preparations secondary to the complaint and further identified a lack of documentation on behalf of the facility as well as the staff's failure to follow the facility process related to discharge planning and preparation.</p>		

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<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>42886</p> <p>Based on medical record review and staff interview, the facility staff failed to address a resident's concerns (resident # 49) of not being able to see from glasses received from a contracted provider in 8/2024. This was evident for 1 of 53 residents reviewed during a complaint survey.</p> <p>The findings include:</p> <p>On 1/27/24 at 1:00pm, Ombudsman #3 reported that resident #49 complained that he/she was unable to see from glasses they received from the facility's vision vendor in 8/2024. Ombudsman #3 stated that he/she explained the resident's concerns in an email to the Director of Nursing (DON) in 11/2024. Resident #49 stated that he/she hasn't received new glasses as of 1/2025.</p> <p>Review of resident #49's medical records on 1/28/25 at 10:30am revealed that the resident had a optometry exam on 8/12/24 and received glasses as a result of the optometry exam. The resident received new glasses on 8/20/24.</p> <p>Interview with the Director of Nursing (DON) on 1/28/25 at 11:00am revealed that DON was unaware of resident #49's issues with his/her glasses. The surveyor pointed out that ombudsman #3 contacted the DON by email explaining the resident's complaints with his/her glasses. The DON stated that he/she would research the issue and complaint.</p> <p>Interview with the DON on 2/4/25 at 11:00am revealed that the DON received the email but failed address resident #49's concerns with his/her glasses. The DON stated that resident #49 was scheduled for another vision appointment in 2/2025 and the issue with the resident's glasses would be addressed at that time.</p>

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<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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42886</p> <p>Based on surveyor observation and staff interview, the facility staff failed to provide supervision to prevent an accident when the facility staff failed to remove low-hanging extension cords from the 3rd floor ceiling. This would affect all residents and visitors on the back of the 3rd floor unit.</p> <p>The findings include:</p> <p>On 1/24/25 at approximately 10:30am, a surveyor touring the 3rd floor unit observed extension cords connected to temporary lights hanging from the ceiling tiles at the back of the unit. The surveyor observed that the extension cords were hanging low enough to hinder any resident or visitor walking in the area adjacent to rooms [ROOM NUMBERS].</p> <p>Interview with the Director of Nursing (DON) on 1/24/25 at 11:00am revealed the facility's 3rd floor back unit sustained a water leak at 1/10/25 at approximately 5:00pm. The water leak affected the back end of the 2nd and 3rd floors.</p> <p>Interview with the DON, Administrator and the Maintenance Director on 1/24/25 at 2:00pm revealed the water leak from the sprinkler system on 1/10/25 at approximately 5:00pm caused the ceiling lighting to malfunction on the back of the 3rd floor unit. Contractors hired to repair the systems affected by the water leak installed temporary lighting on the back of the 3rd floor unit that required extension cords to be installed in the ceiling tile. The surveyor pointed out that he/she observed that the installed extension cords were hanging low enough to hinder any resident or visitor ambulating in the area.</p> <p>The survey team observed that that the installed extension cords at the back of the 3rd floor unit were fully installed in the ceiling and were no longer a accident hazard for the resident and visitors.</p>		

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<p>F 0691</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services.</p> <p>30428</p> <p>Based on medical record review and interviews, it was determined that the facility failed to implement physician care orders for a resident admitted with a colostomy. This was evident for 1 (#41) of 3 residents reviewed related to a complaint about colostomy care.</p> <p>The findings include:</p> <p>On 1/24/25 at 2:43 PM, a review of the medical record for Resident #41 revealed that s/he was admitted to the facility post colostomy (a surgical procedure that creates an opening (stoma) in the abdomen through which waste from the large intestine (colon) can be discharged into a bag) at the beginning of May 2024.</p> <p>Further review on 1/28/25 at 9:36 AM failed to reveal any orders in place for the care and treatment of the ostomy from 5/29/24 -7/18/24 during the resident's intermittent stay in the facility when the resident went to the hospital and returned to the facility.</p> <p>This concern was reviewed with the facility DON and the Regional DON on 1/28/25 at 1:07 PM. No further documentation that care was provided to the survey team that Resident #41 received care for their ostomy between 5/29/24 and 7/18/24</p>