STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215301	A. Building B. Wing	02/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Roland Park Rehabilitation and Healthcare Center	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)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation and interview with staff it was determined the facility staff failed to provide a safe, clean, comfortable, and homelike environment for residents. This was evident for 1 (Room # 209) of 3 resident rooms observed during review for Safe/Clean/Comfortable/Homelike Environment. The findings include:An interview on 2/20/26 at 11:00 AM, with Resident #2 in room [ROOM NUMBER] for complaint #2682305 revealed the facility's staff failed to ensure a sanitary and safe interior environment.The following was observed by the surveyor. The curtains had red and brown spots scattered throughout the curtains.The floors had paper trash, food and were dirty in appearance throughout.The bedside commode that was over the toilet had brown materials in all the crevices and on the seat of the commode. The bathroom had a strong smell of urine and Feces.On 2/20/26 at 11:30 AM, Administrator was made aware of the findings.On 2/20/26 at 1 PM another observation of the room revealed that the curtains had been replaced, and housekeeping staff were cleaning the bathroom.Cross reference F 921.

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
	215301	A. Building B. Wing	02/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Roland Park Rehabilitation and Healthcare Center	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)
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 the review of a complaint 2748952 regarding a planned discharge, it was determined that the facility failed to provide the receiving facility with a comprehensive discharge summary of the residents stay in the facility. This was evident for 1 of 1 resident (11) reviewed for discharge.The findings include:Review of the complaint 2748952 on 2/23/26 revealed concerns related to the receiving facility not being given a discharge summary from the discharging facility and in addition not receiving all the residents' medications as discussed in pre-discharge planning according to the receiving facility. During an interview on 2/24/26 with the discharging nurse, LPN #3 revealed that she was not familiar with what to do with discharges, she wasn't sure of the process with narcotics and didn't send any with the resident to the receiving facility. She stated that she sent all the non-narcotic medication with [resident], but she wasn't clear on how to discharge a resident. The DON and ADON were then interviewed regarding the discharge with Resident # 11. In the miscellaneous section there was a note where the neurology team from the receiving facility came and picked up a few narcotics and signed a paper with a nurse from this facility. The DON was asked what the process was for discharging a resident with narcotics. She stated that they do so only with a physician's order and showed the surveyor that there were prescriptions printed out for the resident within the copies that were requested prior for the investigation. A review on 2/24/26 at 12:50 PM failed to reveal any order for the narcotics to be sent with the resident or documentation that a discharge note summarizing the residents stay, to include all courses of treatment and care in the facility, was provided to the receiving facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215301	A. Building B. Wing	02/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Roland Park Rehabilitation and Healthcare Center	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)
F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on record review and interview, it was determined that the facility failed to refer residents to the appropriate state-designated authority for Level II Preadmission Screening and Resident Review (PASARR) evaluation and determination. This was evident for 1 resident (Resident #2) of 1 residents reviewed for PASSAR during the complaint survey.The findings include:Preadmission Screening and Resident Review (PASARR) is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care. PASARR requires that 1) all applicants to a Medicaid-certified nursing facility be evaluated for serious mental disorder and/or intellectual disability; 2) be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care setting); and 3) receive the services they need in those settings.On 2/20/26 at 11:00 AM, a review of Resident #2's records revealed a PASSAR Level I screening form dated 10/12/23 which indicated that the resident should have been referred for a Level II evaluation. No Level II PASSAR documentation found in the residents' records.On 2/20/26 at 11:15 AM, an interview with the Director of Social work was conducted. The Level I PASSAR was reviewed which indicated that a Level II referral was required. The Director of Social Work stated that the Resident's diagnosis of intellectual disabilities was overlooked on admission and that a new PASSAR will be completed to reflect Level II is needed for Resident #2.The Social Worker was asked to provide evidence that a PASSAR II referral was done for Resident #2.On 2/24/26 2:15 PM, the Nursing Home Administrator (NHA) was informed that Resident #2 did not have the required referral for PASSAR Level II.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215301	A. Building B. Wing	02/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Roland Park Rehabilitation and Healthcare Center	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)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on medical record review and interview with facility staff and residents, it was determined that the facility failed to provide adequate supervision of Resident #10 with known wandering, aggressive, and inappropriate behaviors to ensure the safety of Resident #10 and other residents. This finding was evident during the review of multiple complaints for 4 of 4 residents(#5, # 8, #7, and #1) on the 3rd floor.The Maryland Office of Health Care Quality (OHCQ) determined that concerns met the Federal definition of Immediate Jeopardy and the facility was notified in writing of this determination at 3:10 PM on 2/19/26.The findings include:1. Review of the medical record for Resident #10 revealed diagnoses including unspecified dementia with unspecified severity with agitation. On 8/24/24 Resident #10 was certified incapable of making any medical decisions secondary to cognitive impairments. Resident #10 was seen by psychiatry on 12/8/25 secondary to assaulting another resident. At that time s/he was assessed as having Vascular dementia, unspecified severity, with other behavioral disturbance, Agitated, Anger, Irritable, Mood Swing, wandering and physical aggression, noncompliance with treatment, short tempered, easily annoyed. The licensed clinical professional counselor also noted that 'The patient is unable to interact meaningfully with assessment due to an unwillingness to communicate thoughts and needs.'On 12/9/25 Resident #10 was seen again for a psychiatric evaluation and consultation. This noted that Resident #10 was still 'noncompliant with rules regarding staying out of other patients' rooms but was not aggressive or combative at this time.'However, at the time of this initial review there were no further available consultations on the medical record since the 12/9/25 visit. This concern was presented to the NHA and DON on 2/19/26. On 2/19/26 at 9pm and 11pm progress notes from psychiatry visits on 12/23/25 and 1/2/26 were uploaded that were not previously available. The 12/23/25 psychiatric notes stated that Resident #10 is seen for a follow-up visit due to [resident] ongoing behaviors that are difficult to redirect. [Resident] appeared confused and disoriented, stating, I don't know where I'm at, and needed reminders about location. The psychiatric note continued that the [resident] exhibits behavior and mood issues, [resident] is unpredictable, sometimes becoming agitated, however no changes were made, only to continue monitoring resident. The 1/2/26 visit stated Resident #10 was assessed and noted as 'noncompliant with rules regarding staying out of other patients' rooms but was not aggressive or combative at this time. Staff are aware of [resident] behavior and are monitoring [resident] to ensure [resident] safety and that of other residents. The speech is disorganized, with loose connections and tangential responses. The patient often provides nonsensical answers to questions and struggles to maintain a coherent conversation. Insight is poor. The patient lacks awareness of hallucinations and disorientation and is confused.' There were no recommendations from the provider, only to continue monitoring Resident #10. Resident #10 was seen again on 1/22/26 for a gradual dose reduction of his/her medications. Although residents on the 3rd floor continued to report Resident #10 entering their rooms, acting inappropriately and making them feel unsafe and scared since the 12/6/25 occurrence, no additional interventions or changes were implemented or recommended at any of the subsequent visits from psychiatry. On 2/19/26 multiple residents reported to the survey team that a 'staff member' was hit the day prior and suffered a black eye. Again, at the time of the review there was nothing in the medical record for Resident #10 regarding this allegation. The survey team requested from the facility any information or investigation into this allegation and the name of the employee.Interview on 2/19/26 at 11:28 AM with GNA staff #2 revealed that on 2/18/26 while cleaning Resident #10's room after a particularly messy bowel movement, she stated that Resident #10 was notably agitated when s/he was brought back and left in his/her room by the DON. Then while GNA #2 was not looking, and busy cleaning (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215301	A. Building B. Wing	02/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Roland Park Rehabilitation and Healthcare Center	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)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the room Resident #10 hit her in the face. GNA staff #2 had a visibly large left black eye, however she stated she has a lot of makeup on so it was actually worse than it appeared. A change in condition note, entered on 2/18/26 by the facility DON documented that the resident was falling and GNA #2 attempted to catch him/her and that is how the black eye occurred. When GNA #2 was asked if that was what occurred, she stated that the resident was agitated when the DON brought the resident to their room and left them in a chair. GNA #2 continued to say that she was not totally focused on the resident because she was cleaning up the mess in the room. She further stated before she knew it, Resident #10 was getting up, was agitated and she ended up with a black eye. She stated that she is not sure if the resident was falling, and that is not what she reported to the DON, though that was what was entered in the change in condition report by the DON.Further interview with GNA #2 revealed that those type of incidents with Resident #10 'happen maybe once a month as [resident] had punched Resident #5 last month, December' and as far as wandering in resident rooms, we just try to redirect him/her.The DON was interviewed on 2/19/26 at approximately 12:00 PM. She was asked about the state of Resident #10 on 2/18/26 and what was reported to her on 2/18/26 from GNA #2. She stated that GNA #2 told her that she was helping Resident #10 from falling. The DON then demonstrated her arm flinging back as that was how GNA #2 acquired a black eye. The DON, also in the presence of the NHA at this time, was asked if there was anything put in place regarding this incident and the other alleged incidents regarding Resident #5, #8 , #7 and #1 who had yet to be interviewed by the survey team but had reportedly put in grievances. The DON stated that they had sent out referrals and the staff are familiar with the resident so they redirect him/her as needed. 1a. On 2/19/26 at 9am, an interview with Resident #5, who was A & O x3 sitting in the dining room, revealed that the perpetrator, Resident #10, came into his/her room on 12/6/25 around 7pm. Resident #5 stated that s/he was in bed and that Resident #10 grabbed both of his/her hands at once and then released one of his/her hands and punched him/her in the face about five times. Resident #5 stated that s/he screamed for help and 3 nurses and a few GNA's came to the room. The police were called and responded at 7:45 PM. The perpetrator was removed from the room and redirected to his/her room. The perpetrator was placed on one-to-one for 2 days. Resident #5 stated that the perpetrator has dementia and nothing could be done. Resident #5 was tearful and stated that the week of 2/9/26 the perpetrator walked in and out of Resident #5's room. Resident #5 stated, I'm in fear and afraid to go to sleep at night. I'm scared when the perpetrator walks in the dining room and when he/she gets close to me I always back up. The Resident was tearful. Resident #5 stated I'm scared of him/her. I want to cry. Resident #5 stated that s/he was never offered another room and that the facility staff did not put up the STOP sign banner to remind him/her not to come in the room. On 2/19/26 at 9 AM, an observation by a surveyor revealed that the STOP banner was not being used.On 2/19/26 at 9:00 AM, a medical record review of Resident #5 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition (scores 13-15), assessed on 11/9/25. Resident #5 has mobility issues and relies on a wheelchair.1b. Interview with Resident #8 on 2/19/26 at 8:16 AM revealed multiple concerns related to Resident #10 who s/he reported comes into his/her room often and will go under the 'STOP' sign banner that is posted at his/her door. Resident #8 further stated that yelling at Resident #10 to leave the room doesn't work. When asked what s/he does when coming in the room, Resident #8 stated that s/he will grab items off of the tables and dressers. Resident #8 also reported to this surveyor that there was an incident recently when Resident #10 was in the room and went to the roommates side of the bed by the window, pulled his/her pants down and was about to pull his/her pull up down and the roommate, [Resident #1], started yelling and I [Resident #8] was yelling and s/he was hitting [Resident #10] with his/her (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215301	A. Building B. Wing	02/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Roland Park Rehabilitation and Healthcare Center	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)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	grabber. Resident #8 became tearful at this time and was asked by this surveyor if s/he is scared and s/he stated, oh yeah we are all scared.Medical record review of Resident #8 on 2/19/26 at 9:30 AM revealed an assessed brief interview for mental status (BIMS assessment tool used to measure cognitive impairment in long-term care residents 13-15 intact cognition) score of 15 from 12/31/25. Additionally, Resident #8 has diagnoses of depression, anxiety and often relies on a wheelchair for mobility. 1c. Resident #7, observing the interview with the surveyor and Resident #8, flagged this surveyor over and wanted to discuss 'the resident who wanders into everyone's room.' At 8:28 AM in Resident #7's room we began discussing his/her concerns related to Resident #10. S/he stated that secondary to his/her medical condition s/he is not able to fend off an intruder in the room and it is very stressful and scary. S/he said look at me, I only have one leg. S/he continued reporting that Resident #10 comes into this room when the roommate is not present and it is very scary. Resident #7 is observed in the 'b' bed by the window and the roommate's bed is by the door, so it would be visible walking by the doorway when the roommate is not in the room. Resident #7 stated I yell at [resident] to leave then [resident] will go into the bathroom. This surveyor asked if staff was aware of his/her concerns of Resident #10 coming into the room and Resident #7 stated 'yes, I have told them and keep telling them.' S/he further stated that 'it's a lot of stress when you try to sleep in a room alone and here [resident] comes in.' Medical record review on 2/19/26 at 9:30 AM of Resident #7 revealed an assessed BIMS score of 15 from a 10/19/25 minimum data set. S/he has a dependence on staff for some activities of daily living including meal setup and bathing and the reliance on a power wheelchair to mobilize around the facility. 1d. Resident #1 was interviewed on 2/19/26 at 12:32 PM. S/he was interviewed secondary to a complaint submitted by a family member who had considerable concerns about Resident #1 as they are bedbound, and Resident #1 called them about Resident #10 coming into the room and exposing themselves on repeated occasions. Resident #1 stated to this surveyor that Resident # 10 'will come in at night and pull his/her pants off and stand at my bed. S/he has hit my friend and staff, what makes me think that s/he won't hit me? Next time s/he comes in here and invades my privacy I'm going to fight [resident] back.' Medical record review for Resident #1 on 2/19/26 at 12:50 PM revealed a 1/16/26 BIMS revealed a score of 15, showing s/he is cognitively intact. Resident #10 was observed on the unit on 2/19/26 at approximately 12:40 PM walking up and down the halls. Resident #10 was observed walking up the hallway and stopping at each doorway. Residents, male and female, could be heard from inside of their rooms yelling for Resident #10 to 'stay out/stay away/get out.' Resident #10 would then proceed and continue walking to the next room, during this observation, staff were observed at the nurses station or walking around the unit. At no time did any staff intercede and direct Resident #10 elsewhere as most of the residents in their rooms were observed eating and this was an interruption and potential intrusion. On 2/19/36, at 3:10 PM an Immediate Jeopardy was called related to a lack of supervision which resulted in a resident inappropriately wandering into multiple resident rooms and verbally or physically assaulting residents with no documented interventions in place after 12/10/25.The facility submitted an initial plan of action to the surveyor and the Office of Health Care Quality for review at 5:10 PM on 2/19/26. This initial plan was not accepted. A revised plan was submitted at 5:18 PM on 2/19/26, which was not accepted. Another revised plan was submitted at 5:50 PM on 2/19/26, which was not accepted. The facility submitted a subsequent revised plan of action at 6:32 PM on 2/19/26, which was reviewed by the surveyor and the Office of Health Care Quality. The plan was accepted at 6:35 PM on 2/19/26 but the Immediate Jeopardy was not removed until 2/24/26 at 1:58 PM after the plan of correction was verified to have been implemented.The facility plans of removal included the following: The identified resident was evaluated by 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
	215301	A. Building B. Wing	02/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Roland Park Rehabilitation and Healthcare Center	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)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	medical director and prescribed antianxiety medication 3 times a day and put on a 1:1 assignment starting at 3:00 PM until further notice. Additionally, the residents with the identified concerns are to be assessed by the social worker. An ad hoc quality assurance meeting was held with the interdisciplinary team and education will be completed with the facility staff on the Dementia protocol and Unmanageable Residents. The plans were presented on 2/19/26 at 5:10 PM, with adjustments made and resubmitted at 5:18 PM, again at 5:50 PM and a final plan submitted and accepted at 6:32 PM on 2/19/26.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215301	A. Building B. Wing	02/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Roland Park Rehabilitation and Healthcare Center	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)
F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, it was determined that the facility failed to develop and implement a process to determine if residents with a history of trauma received the appropriate trauma informed care. This was evident for 1 (#5) of 2 residents reviewed for trauma informed care.The findings include:On 2/19/26 at 8am, a review of complaint 2689128 which reported that resident #5 alleged that Resident #10 enter the room around 7 pm and grabbed both of resident's hands and was punched in the face about five time.A medical record review for Resident #5 on 2/19/26 at 8:30AM, revealed the resident was admitted to the facility on [DATE]. Further review revealed no evidence that a trauma informed assessment or care plan had been completed to ensure the resident received trauma informed care after the incident.On 2/19/26 at 9 AM, an interview with Resident #5 revealed that Resident #5 was tearful and stated that I'm in fear, and afraid to go to sleep at night. I'm scared when the perpetrator walks in the dining room.On 2/20/25 at 10am, an interview with the Director of Social Work confirmed that Resident #5 trauma informed assessments should be done after a change in condition and will be completed for the resident.On 2/25/26 at 2:15 PM, the Administrator confirmed resident trauma informed assessments should be done at admission and after a change in condition and the Director of Social Work is addressing the issue. Cross reference F 689.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215301	A. Building B. Wing	02/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Roland Park Rehabilitation and Healthcare Center	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)
F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. Based on medical record review and interview with facility staff, it was determined that the physicians failed to have their notes in the medical record timely after seeing the resident. This was evident for 1 of 1 (#10) Residents reviewed during a complaint survey.The findings include:Review of the medical record for Resident #10 on 2/19/26 at 9:30 AM revealed multiple visits and completions of psychiatric evaluation and consultations by a psychiatric NP, staff #8. However, a closer review of these assessments noted that the completion date and the uploaded date into the miscellaneous section of the resident's medical record were not the same, sometimes with a month in between evaluation and upload date. This concern was reviewed with the facility NHA on 2/20/26 at 8:49 AM. The NHA reported that Resident #10 was visited by the psychiatric NP multiple times after an incident that occurred on 12/6/25. These notes included visits on 12/23/25, 1/2/26 and 1/22/26 that were not on Resident #10's record during review the day prior on 2/19/26. He was notified of the regulatory concern at that time of the concern. The NHA and DON were interviewed on 2/24/26. The concern about the evaluations being uploaded after the visits was reviewed again. This surveyor wanted to talk to the medical records staff to discuss the process. However, it was then that the DON stated that staff #1 uploads the documents from NP staff #8 as soon as she gets it, that it's the process that the notes and NP #8 go through to get the notes to the facility. The requirements in the federal regulations were reviewed. During exit the concerns were reviewed again. The regional nurse staff #4 asked for some clarification, if the content of the notes mattered with the timing of the upload. It was reviewed at that time that there were notes completed with medication changes that had a delay in uploading as well. Specifically, there was a note completed 8/18/25 that was uploaded 8/21/25 regarding an increase in Trazadone. However, it was reviewed again that it is not just about notes with medication changes, the concern was about the availability of physician notes on the medical record after visiting a resident and completing an assessment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215301	A. Building B. Wing	02/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Roland Park Rehabilitation and Healthcare Center	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)
F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on record review and staff interview, it was determined that facility staff failed to complete a facility assessment with all the information as required. This was evident during the extended survey review. The findings include:During review of the facility assessment, secondary to completing the extended survey, it was determined that the facility assessment provided revealed what the facility offers, however it is not based on a ‘facility assessment.'At entrance to the facility on 2/19/26 a resident matrix was requested and provided. On this matrix it notes a resident with a tracheostomy. Record review on 2/20/26 at 1:00 PM revealed that this Resident #12, also has a gastrostomy tube in place for nutritional support. However, review of the facility assessment failed to show that any current residents are in need of tracheostomy or gastrostomy support, only that the facility ‘offers' those services. Additionally, it notes that they have ‘supportive care' for behavioral/mental health providers. It does not say who, therefore the qualifications are not there-i.e. NP, Dr, SW, what support is provided and what type of clientele is served at the facility. The assessment does say what type of clientele they ‘can' serve, however, not an assessment of what the current population for the assessed year was. During multiple tours of the facility from 2/19/26 through 2/24/26, multiple residents were observed in bed requiring the support of staff for activities of daily living, additionally there were multiple residents observed independently mobilizing wheelchairs or walking around the facility. The actual assessment of the current population was not available in the assessment. This concern was reviewed with the NHA on 2/20/26 at 1:40 PM and again with the NHA during exit on 2/24/26.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215301	A. Building B. Wing	02/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Roland Park Rehabilitation and Healthcare Center	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)
F 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ staff that are licensed, certified, or registered in accordance with state laws. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of employee files and interviews with facility staff it was determined that the facility failed to employee staff with active professional licenses relevant to their hired job descriptions. This was evident during the review of 1 of 2 employee files, (Staff #7)The findings include: On 2/20/26 at 8am, the surveyor reviewed complaint #2682305 which alleged that Register Nurse (Staff) #7 was employed as a Supervisor RN at the facility without an active license from 12/5/22 to 8/30/23. The state of Maryland's Board of Nursing (MBON) does not recognize staff #7 license due to graduation from a program that is not recognized and approved by the Board.A record review on 2/21/26 at 9:30 AM, of staff #7's personnel file, showed staff #7's RN license was issued in Virginia only (compact designation) on 10/18/22 from [NAME], FL 33610. Staff #7 RN license was suspended in Virginia on 3/13/23. Staff #7's personnel file also listed his/her primary address as Maryland.On 2/24/26 8:54 an interview with the Human Resources Representative (HR) Revealed that all Register Nurse who received their license from Florida had a choice to sit for the Maryland Boards of nursing to be retested or forfeit the license. Staff #7 forfeit his/her RN license. HR Staff do not remember when this occurred/or could provide documentation as requested. HR staff stated that the facility did a state only background check on staff #7 on 10/25/2023. Staff #7 had an active Maryland LPN (Licensed Practical Nurse) license and her role changed from RN to LPN supervisor. The surveyor requested when staff #7 role was changed from RN to LPN. The HR staff did not remember the date or provide documentation as requested. On 2/24/26 at 12 PM interview with Staff #7 Revealed that she went to VMT Education Center, located in [NAME], D.C and graduated in 2001. Staff #7 stated that she sat for the Maryland boards for her LPN license in 3/2003. The Surveyor asked why she/he waited so long to sit for the boards? and the reply was I still own the school money, and they would not release my transcript. Resident #7 denied going to any other schools to obtain his/her LPN license.On 2/24/26 at 12:20 PM, a review of VMT Education Center and the Maryland Board of Nursing Revealed that VMT is not recognized by the MBON and was removed on 2/25/2003 because it did not meet qualification for LPN. A review on the MBON revealed that staff #7 Received the LPN license on 10/6/2003. Eight months later. After the interview with Staff #7 the information was discussed with the Regional Nurse. Staff #7 was suspended until further investigation by the facility staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215301	A. Building B. Wing	02/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Roland Park Rehabilitation and Healthcare Center	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)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations it was determined that the facility failed to maintain a safe, sanitary, comfortable, and functional environment for the residents in room [ROOM NUMBER].The findings include:An interview on 2/20/26 at 11:00 AM, with Resident #2 in room [ROOM NUMBER] for complaint #2682305 revealed the facility's staff failed to ensure a safe interior environment.On 2/20/26 at 1Pm, a tour of room [ROOM NUMBER] with the Maintenance Director revealed unattended maintenance needs: The grab bar in the bathroom next to the toilet was not firmly attached to the wall.The floor tile to the bathroom was missing and cracked. This made it difficult for the residents to roll in and out of the bathroom using a wheelchair or walker.The cable cover plate was not attached to the wall.The ceiling had evidence of water damage with marked brown areas.The nightstand had a broken handle.room [ROOM NUMBER] has damaged walls with peeling paint and scrapes throughout greater at the head of the beds. Cross reference F 584.